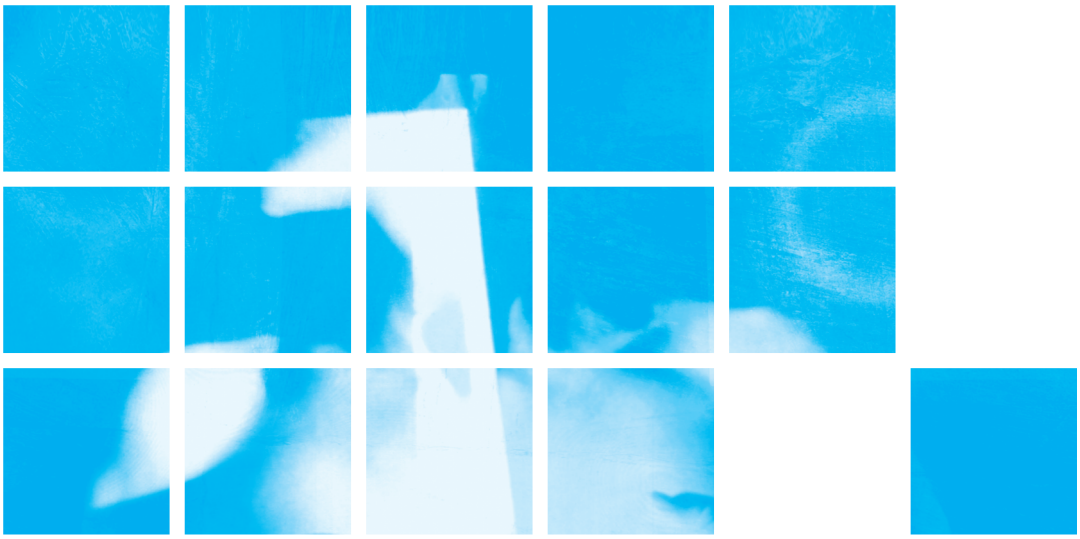

Chapter 12

Health and Illness

Key issues in this chapter:

- Historical and contemporary 'measures' of health and illness in relation to gender.
- Mental, emotional, physical and reproductive gendered health issues.
- Lifestyles, life-chances, gender and health.
- The gendered experience of health care.
- The relationship between health, gender and other 'measures' of stratification.

At the end of this chapter you should be able to:

- Recognise the significance of different historical and current definitions and measures of health and illness.
- Explain the relationship between gender roles, masculinity and femininity, and health and illness.
- Understand the gendered aspects of health care.
- Recognise the need to take a gendered perspective, whilst acknowledging that other measures of stratification (e.g. class, ethnicity and age) are also important.

Introduction

The dawn of gender-specific drugs

By Vivienne Parry, presenter of *One Man's Medicine*

Some medicines that are safe for men are known to be lethal for women. But until recently, many medicines were not tested on women. Now that they are, more differences between the ways men and women respond to drugs are being discovered all the time. Could this be the beginning of gender prescribing?

Radio 4's *One Man's Medicine* takes a look at why men and women are so different when it comes to taking their medicine.

'What's not good science is to treat half the population with a drug you haven't tested on them' said Professor Lesley Doyal.

One Man's Medicine, a three-part series, was broadcast on Radio 4 between 6 and 20 August 2003.

Stop and think 12.1

With reference to the extract above why do you think it has taken so long for pharmaceutical industries to decide to test drugs on women as well as men. Also, can you identify any problems with the title of the programme on which this news was announced?

The relationship between gender and health began to be taken seriously in the 1970s. As A. Cribb (2000) notes it was then that gender began to be considered alongside other variables such as 'race' and ethnicity, socio-economic status, and geographical area when explaining patterns and experience of health and illness. It is no coincidence that at the same time there was also a growth in feminist research and in the activity of the women's movement, both of which contributed directly to the growth of the women's health movement. However, at this time researchers equated studies of gender, health and illness almost exclusively with women. It was the growth of interest in men's studies in the 1980s that led to consideration of the relationship between concepts of health, masculinity, men's lives and their experience of illness (Cribb, 1997).

However, despite the growing recognition of the importance of gender differences when explaining patterns of health and illness they are arguably still not taken seriously enough:

> masculine bodies can claim to 'represent' the interests of all other bodies. Male bodies can thus claim to literally incorporate other bodily interests within their own, including the interests of health, because they are the bodies which are seen to incarnate the desirable social order. Hence the health of the heterosexual male body can be made to stand for the health of the body politic in its entirety. Conversely, a threat to the health of this body can seem like a comprehensive threat to public health.
>
> (Walby, 1996: 342)

As we shall see this can have negative consequences for women and for men.

In this chapter we look at how gender differences have been present in health debates and practices, historically and contemporarily. Then we examine mental health, followed by a discussion on lifestyles and identities in relation to health issues. Reproductive issues are a very gendered area and these are presented next. We then turn to the issues of gendered health care and different differences.

'Measuring' gender differences in health: past, present and future

Historically we know that there are parallels in the way sexual difference and racial difference have been considered. In the development of eugenic policies from the middle ages through to the middle of the twentieth century analogies were drawn between women and non-European peoples in terms of physiological characteristics and psychological characteristics. Both women and colonised people were viewed as inherently primitive. For example, Darwin commented, 'some at least of those mental traits in which women

may excel are traits characteristic of the lower race', and the craniologist F. Pruner argued, 'The Negro resembles the female in his love of children, his family and his cabin' (cited by Alsop *et al.*, 2002: 19–20).

Still thinking historically we know that the sixteenth and seventeenth centuries were particularly significant to our current understanding of the relationship between gender, health and illness in the western world. The scientific knowledge which emerged at the time insisted that women were not just different from but physically, psychologically and socially inferior to men (Doyal, 1995: 2). Women were thought to be 'sensitive, intuitive, incapable of objectivity and emotional detachment and immersed in the business of making and maintaining personal relationships' (Oakley, 1981: 38). Therefore they were considered naturally weak and easy to exploit and their psychological characteristics implied subordination, for example, submission, passivity, dependency and so on. If women adopted these characteristics they are considered well adjusted (Miller, 1976; Oakley, 1981), if deficit in relation to the male 'ideal'.

In the nineteenth century, middle-class women were thought to be particularly weak and susceptible to illness: menstruation was thought to be an 'indisposition' or illness which sapped women's energy, making it necessary for them to rest; childbirth was termed 'confinement' and a long period of bed rest was thought to be necessary after the birth of a baby; and the menopause was considered a disease which marked the beginning of senility (Webb, 1986). Working-class women though were not believed to be susceptible to the same problems: they were seen as physically stronger and emotionally less sensitive and well able to work 14 hours a day outside of the home and still be able to 'cook, clean and service their husbands, and bear children without such suffering' (Webb, 1986: 6). In addition, working-class women were seen as potentially polluting through their work in the kitchen, the nursery and the brothel (Abbott *et al.*, 2005). Historically then middle-class women were considered 'sickly' and working-class women 'sickening'. Our view of the ill/healthy man is of course also historically and socially constructed. Just as social definitions of femininity are key to an understanding of a healthy woman social definitions of masculinity are key to definitions of a 'well-shaped man' (Buchbinder, 1998: 355).

There are of course legacies from historical 'measures' and explanations. Evidence from recent research suggests that women appear to feel less healthy than men and perceive themselves to be more ill than men making more use of health services (Annandale and Clark, 1996; Cribb, 2000). In addition when asked to think of someone they think of as healthy both men and women are likely to choose a man (Blaxter, cited by Miers, 2000). Furthermore, research suggests that psychologists and clinicians are more likely to define women's rather than men's health problems as psychological and definitions of mental health are often related to traditional, essentialist notions of masculinity and femininity: healthy men are thought to be independent, logical and adventurous and healthy women less aggressive, more emotional and easily hurt (Teri, 1982; Webb, 1986; Buchbinder, 1998; Miers, 2000). In addition it is argued that women's lives are more closely scrutinised by (patriarchal) medical science through the manufacture and mass-production of drugs designed to control the natural process of women's bodies from menstruation to menopause (Oudshoorn, 1994; Abbott *et al.*, 2005).

In A Closer Look 12.1 we provide evidence of differential perceptions of gendered health status.

This construction of women's health as poor has consequences for men too in that there is an implicit assumption that men's health is 'good' (Annandale

A closer look 12.1

Gender differences in health perceptions

The Oxford Regional Health Authority Lifestyle Survey of 13,000 randomly selected adults living in Berkshire, Buckinghamshire and Northamptonshire provides helpful data relating to exercise, smoking, alcohol consumption and dietary habits . . . More female than male respondents described their health status as poor, although they reported fewer examples of health-damaging behaviour.

(Cribb, 1997: 229)

and Clark, 1996; Watson, 2000). The result of this is that men's poor health remains invisible and this is problematic because 'it is important to look at the social context of men's health . . . [and] the assumption of absolute difference undermines our ability even to understand women's health (as different)' (Annandale and Clark, 1996: 32).

Stop and think 12.1

Describe a healthy person. Does your description fit the average male and/or the average woman?

Attention to twentieth-century mortality and morbidity rates show that the phrase 'women get sick and men die', does have some truth in it but is an oversimplification when studying the complex relationship between gender, health and illness (Annandale, 1998; Miers, 2000). Pamela Abbott and colleagues (2005) point out that a gendered health pattern is found in all societies with women on average living longer than men. However, there are social class differences between women within societies and the male–female gap in life expectancy varies significantly between countries. Russia has the largest male–female gap in life expectancy in the world of about fourteen years whereas in some countries in South East Asia, as well as parts of sub-Saharan and West Africa the gap is much smaller or even eliminated altogether, mainly, Abbott and colleagues add, due to the low value placed on female children:

> A study conducted at a family health centre in Bangladesh . . . found that boys were seen more than twice as often by doctors as girls. In India and Latin America girls are often immunized later than boys or not at all. In some places, boys tend to be given more and better food than girls. Breastfeeding and weaning practices are also thought to favour boys in many developing countries. Hence, 'surveys of girls' and young women's health show that, globally speaking, childhood is a period of relative inequality.
>
> (United Nations, 2003: 25, cited by Abbott *et al.*, 2005: 121)

In societies where women do live longer it is inevitably the case that women make more use of health services as health service use increases with age. In addition when consultations related to menstruation, pregnancy, childbirth, post-natal care and menopause are taken into account it is not surprising that women visit the doctor more often. Furthermore, as Miers (2000) notes women appear to find it easier to discuss their own health and may find it more socially acceptable to do so and Watson (2000) suggests that also important are psychosocial factors such as how men and women evaluate symptoms.

Research suggests that men are reluctant to listen to health promotion messages and to go to the doctor for 'minor' complaints. Men's denial of illness is so strong that even the pain associated with a heart attack may be ignored so that the victim will not be seen as weak or effeminate (Cribb, 2000). Despite this a popular view among many women is that: '[t]o the average man, a bad cold has five-act potential and he will use it to extract every last drop of sympathy' (Watson, 2000: 17). On the other hand there is research that suggests that women are more likely than men to 'suffer in silence'. For example, Jocelyn Cornwell (1984), in her study in Bethnal Green found that women regarded themselves as 'not ill' if they could continue to 'carry on' caring for their home and family.

One response to socially constructed essentialist definitions and explanations of health and illness and sexism in health care (see below) has been the production of books that have been written with the aim of informing individuals about their own bodies and their own health. A Closer Look 12.2 provides some more detail on such publications.

A closer look 12.2

Self-help, books and gender specific services

A number of books providing health information by women for women hit bookstores in North America and the UK in the 1970s (perhaps the most well-known being *Our Bodies Our Selves*, first published by the Boston Women's Health Book Collective in 1973). Although these were written by women and were

A closer look continued

grounded in women's experiences as Hockey (1997) notes these early texts were relevant mostly for white middle-class audiences. It was not until the 1980s that books aimed at black, lesbian, working-class and older women began to appear. There are less books even today specifically concerned with men's health although, as Watson (2000) notes, during the 1990s men's health was an increasing concern within the media with reports on increasing stress and incidences of cancer and declining fertility and reluctance to visit the doctor. The mid-1990s saw the launch of two magazines dedicated to men and health and the first national conference in Britain on men's health (Cribb, 1997). One recent attempt in the UK to encourage men to pay more attention to their health has been the production of a men's health manual modelled on the car manuals produced by Haynes and the introduction of a Men's Health Helpline.

Mental health and psychological well-being

Statistics suggest that about twice as many women than men suffer from a mental disorder. Yet, it is important to note that there are distinctive gender patterns associated with different mental phenomena. For example, anorexia nervosa is a predominantly female condition and women report rates for anxiety, phobias and depression twice as often as men. On the other hand substance use disorders are more common among men than women and diagnoses of schizophrenia, paranoia or mania do not show a gender preference (Doyal, 1995; Busfield, 1996).

So how can we explain these differences? Joan Busfield (1996) argues that men and women respond differently to psychological problems and stressors on their lives. It appears that women are more likely to find supportive 'significant others' to discuss problems with or engage in self-harming behaviour whilst men are more likely to engage in excessive drinking, aggression or violence. This is not to say that women do not sometimes feel aggressive or violent; interestingly though this appears to be most 'newsworthy' when linked to women's hormones which are often portrayed as being unstable, as A Closer Look 12.3 demonstrates.

A closer look 12.3

Violent tendencies

A survey of 400 women with moderate to severe PMS [premenstrual syndrome], carried out by the Natural Health Advisory Service, found that eight out of 10 women feel violent and aggressive for up to two weeks before their period, with 73 per cent claiming their sex drive takes a nose drive.

'PMS has caused great upset in my relationship' says 22-year-old Jemma. 'I have a wonderful, supportive partner, but when I'm premenstrual I don't want him anywhere near me. My perspective on how I feel about him changes completely, it's a horrible feeling.'

If 90 per cent of women suffer to some degree from PMS, then it's also safe to say that a number of families and partners must also feel the strain each month. A survey by website netdoctor.co.uk questioned 1,000 men, with two-thirds admitting they were subjected to irrational behaviour, heated arguments and floods of tears by their premenstrual partners.

Alarmingly, 13 per cent of 15- to 24-year-old men said they'd been physically assaulted by partners with PMS. 'I've seen men who have had to sleep in the car or garden shed because they cannot live with their wives and girlfriends when they are premenstrual' says Stewart.

Source: Christine Morgan 'Beat PMS for good', *Healthy*, March 2006, Issue 42: 11.

It is widely agreed that men in contemporary western societies find it difficult to express their emotions adequately. This failure to express emotions, in addition to the urge to be independent (which itself is encouraged by cultural definitions of masculinity) may significantly affect men's health-related behaviour and their ill/health status (Cribb, 2000). Cribb (2000) adds that part of men's resistance to acknowledging illness may be due to their fear of becoming dependent on women as carers because we know that contrary to the stereotypical view that women are dependent on men (Millett, 1969), it is actually girls and women who are brought up to care for children, husbands and other family members [**Hotlink → Family (Chapter 11)**].

With reference to formal mental health care in the UK for most of the twentieth century women made up

most of the patient population in institution-based care. But in 1991 for the first time, men were in the majority in the population in mental health beds in England and Wales. Since then statistics suggest that women and men have become equal users of these services (Hayes and Prior, 2003). Although neglected in the past, the mental health care needs of men – particularly young men – need to be taken seriously by academics, by health planners and by men themselves (Hayes and Prior, 2003) as A Closer Look 12.4 suggests.

A closer look 12.4

Changing suicide rates

Over the past 15 years, suicide rates in the UK have declined in women yet risen steadily in men. This is particularly noticeable in young males aged 15–24, where the suicide rate has increased by 75 per cent since 1982 (DoH, 1992). Possible explanations for these changes include: the threat of unemployment, the greater independence of women, the reluctance of men to seek help, and men's often inadequate social networks (Cribb, 2000).

Public and private lifestyles and identities

Feminists argue that women's poorer health is explained by the fact that women are socially disadvantaged in terms of education, income and political influence: women have less money than men, less financial security, less desirable employment, and less political and social power (Annandale, 1998). In addition Sarah Payne (1991) adds that women's primary position in the home and secondary position in the labour market indicates both their economic dependence on men and their greater vulnerability to poverty and deprivation. This is important because socio-economic status, however it is measured, is a strong predictor of longevity and of health. As World in Focus 12.1 shows there are worldwide gender inequalities in health.

The main causes of death in women in the western world are breast cancer and cancers of the genito-urinary system whereas men suffer from higher rates of coronary heart disease, lung cancer and chronic obstructive airways disease, accidents, homicides, suicides and until recently AIDS (Hayes and Prior 2003;

World in focus 12.1

World Health Organisation

The Department of Gender, Women and Health (GWH) brings attention to the ways in which biological and social differences between women and men affect health and the steps needed to achieve health equity.

The main focus of GWH is to promote the inclusion of gender perspectives in the work of the WHO by collaborating with other departments and regional and country offices. It aims to increase knowledge of gender issues by conducting selected research, training and advocacy on how socio-cultural factors and discrimination affect health.

Whilst gender affects the health of both men and women, the department places special emphasis on the health consequences of discrimination against women that exist in nearly every culture. Powerful barriers including poverty, unequal power relationships between men and women, and lack of education prevent millions of women around the world from having access to health care and from attaining – and maintaining – the best possible health.

Source: **www.who.int/gender/en/**

Miers, 2000). As World in Focus 12.2 demonstrates the gendered experience of AIDS is changing.

Men are more likely to die of occupationally related illnesses, men engage in more physical risk-taking than women, and accidents and homicides have always been a feature of masculine rather than feminine behaviours. In addition, cigarette smoking has, hitherto, been a major cause of male death (although in the 1990s male and female smoking rates in the UK began to even out and recent reports suggest that more girls than boys are taking up smoking at the beginning of the twenty-first century), men drink more than women, and are more likely to die of alcohol related deaths (including those in motor vehicle accidents). However, men's higher level of exercise participation may counteract some of the health disadvantages apparently resulting from men's less healthy lifestyles (Miers, 2000).

One explanation for such differences, in both medical and lay discourse, is that poor men's health results from their trying to live up to a macho image and lifestyle which is itself dangerous to health. From this perspective much ill-health among men is a consequence of lifestyle. However, as Watson (2000) notes the challenge to change male behaviour and resist stereotypical masculinity is problematic because it presumes that masculinity is a unitary construct and that all men benefit equally from being male in a patriarchal society.

With reference to the relationship between gender, health and the home it seems that marriage is good for physical health and in the UK married people are much lower users than non-married people of health care services. But marriage appears to be more advantageous to the health of men than the health of women. Married men have lower death rates than those who have never married, and married men report better health than single men. Miles (1991) suggests that this may be due to the presence or absence of a significant female partner (carer) who encourages her male partner to seek medical help when they need it and sets the tone for a healthy life. However, being a 'good' wife and mother can actually make women sick. Evidence suggests that women prioritise the needs of other family members allocating them more resources and caring for them to the detriment of their own health, often because this is expected of them (Doyal, 1995; Abbott *et al.*, 2005):

> They [women] are seen as responsible for bringing up healthy children and maintaining the health of their men for the nation. Health visitors, social workers and other professional state employees 'police' the family to ensure that women are carrying out their task adequately.
>
> (Abbott *et al.*, 2005: 196)

Furthermore, the family home can be a dangerous place for many women and children who live in danger of ill-health, even death, as the result of men's emotional, psychological, sexual and physical violence [**Hotlink → Violence and Resistance (Chapter 16)**].

Despite enduring stereotypical views of women as weak and helpless worldwide they remain responsible for large amounts of physical and emotional labour – both unpaid and paid (Coppock *et al.*, 1995; Evans, 1997; Frith and Kitzinger, 1998) [**Hotlink → Work and Leisure (Chapter 14); Hotlink → Family (Chapter 11)**]. However, even though women are now more evident within the workplace research and debate on the

World in focus 12.2

The global picture of aids

According to UNAIDS data, there were about 33.6 million people infected with the AIDS/HIV virus (UN Yearbook, 2000). In 1999 half of the AIDS mortality cases were women: about 12.7 million cases. Data now shows that women are the main victims of the AIDS crisis and the disease is spreading faster among women than men. Contrary to popular belief the majority of AIDS infection is 'through husbands/wives sexual contacts, heterosexual relations, homosexuality, prostitution, blood transfusion, mother to infants through placenta and breast feeding, and through contaminated blood and blood products'.

(Umerah-Udezula, 2001: 1–2)

Figure **12.1** What she needs is a prescription

Source: WEA (1986) *Women and Health*, p. 87. Reproduced with thanks to Angela Martin.

relationship between work and ill-health has focused on male-dominated occupations. It is widely believed that female jobs are neither physically hazardous nor stressful but recent research into nursing and clerical work demonstrates otherwise (Doyal, 1995). This sexist bias in occupational health research is further extended by traditional assumptions of women's weaknesses, reflected in the fact that although a significant amount of research has been conducted to determine whether or not menstruation interferes with women's capacity to work there has been much less interest in how women's work affects their experiences of menstruation (Doyal, 1995). A Critical Look 12.1 provides further examples of how work outside of the home can adversely affect women's health.

A critical look 12.1

Campaign to boost women workers' health

TUC General Secretary . . . said 'Women make up half the workforce. But health and safety standards are still set for the 'average man' and injury compensation is still paid mostly to men' . . . A 1995 report by the Health and Safety Executive suggests women are more likely than men to suffer from a range of injuries:

- They are more likely to suffer from work-related skin diseases than men and often suffer a double dose of exposure to chemicals due to their work in the home.
- Twice as many women suffer from eyestrain, mostly related to VDU work, than men.
- Women are a third more likely to report that they have been physically attacked by a member of the public in their work than men.

Part of the reason for the discrepancies is that women tend to be concentrated in professions that cause certain types of health hazards. For example, hairdressers have a high level of skin problems because of the chemicals involved. Women are also more likely to be working in the caring professions, such as nursing, which bring them into close contact with the public and which are associated with a high level of physical violence.

And they tend to be more exposed than men to repetitive and monotonous work which increase the danger of repetitive strain injury.

The Health and Safety Executive (HSE) says it has concentrated on risks related to specific jobs, rather than gender issues. It adds that men are more likely to suffer some health problems than women. For example, they are more than seven times more likely to suffer from deafness, three times more prone to work-related asthma and bronchitis and more likely to suffer from stress.

Source: BBC News 25 August 1999.

Reproduction and reproductive health

It is commonly assumed that the issue of reproductive health is 'women's business' and arguably for some women this assumption has been instrumental in their control over reproduction. It has also been the cornerstone of many feminist campaigns, which have demanded the right for women to 'control their own bodies' (Petchesky, 1986; Himmelweit, 1988; Kitzinger, 1992). However, the majority of women do not make reproductive choices in isolation from men (Earle and Letherby, 2003) and men both as medics and as partners have significant influence. For example:

> . . . medical dominance in these areas of women's lives means that women are controlled to a large

extent by medical men, and they rely on doctors for advice and information. For example, pregnant women are treated 'as if' something is going to go wrong – women are required to make regular antenatal visits and are virtually forced to have their babies in hospital, where doctors control the management of labour and childbirth . . .

The key point is not that medical intervention has played no role in making pregnancy and childbirth safer, but that doctors have taken over total control of the management of pregnant women, so that women are unable to make informed decisions about their lives . . .

Doctors control the most effective means of birth control – the pill, the coil, the cap, and sterilisation. Women have to seek medical advice to be able to use these methods of controlling their fertility. The 1968 Abortion Reform law made abortion on medical grounds legal and more frequently available, but the decision as to whether a woman can have an abortion is made by doctors. Doctors also control the new reproductive technologies.

(Abbott *et al.*, 2005; 184)

. . . [a] recent example in the UK is the case of Stephen Hone who went to the High Court to stop his pregnant ex-girlfriend having an abortion (*Birmingham Evening Post*, 2001). Relevant also are cases of men instructing medics to maintain life support for their pregnant partners until the baby/ies were capable of surviving outside of the womb (Hartouni, 1997).

(Earle and Letherby, 2003: 4)

In addition, the labelling of an illness or a condition as 'women's business' has serious medical, social and emotional consequences for women as Frank van Balen and Inhorn's (2002: 7–8) comment on infertility (a condition that is often viewed to have its routes in psychological 'disorders' and therefore to be women's rather than men's business) demonstrates:

women worldwide appear to bear the major burden of infertility, in terms of blame for the reproductive failing; personal anxiety, frustration, grief, and fear; marital duress, dissolution, and abandonment; social stigma and community ostracism; and, in some cases, life-threatening medical interventions.

Research clearly highlights that infertility is an emotional as well as a medical experience and the inability to have children when one wants can have serious consequences to a woman's sense of self. For example:

'People can tell by looking at me that I'm handicapped. A failure to womankind . . . I'm like half a woman.' (Tracey)

'There are times when I don't feel like a real woman. I wonder how am I ever going to feel that whole.' (Gloria) (respondents from a research project conducted by Letherby, 1999: 363)

Yet it is important to acknowledge that men's self-esteem is likewise affected:

'I was worried then and now about other people finding out about my infertility. I feel I just couldn't cope with people knowing. I was in the pub once with some friends and there was talk about a male friend getting his wife pregnant and having proved himself. That remark still haunts me. I thought, what are they going to think about me if they find out I have no sperm? What will they say behind my back? I'm not a macho man but I work in an all-male environment where there are lots of crude jokes about sex and related things and I don't want to be the butt of those jokes about a seedless Jaffa*. I don't know what I would have done if someone had said that about me because social reaction bothers me though I know it shouldn't. I'm a married man, but we couldn't have a family because of something I couldn't do and that hurts. I have had to keep quiet about my infertility to protect my self-respect.'

(Matthew, respondent from a study by Mason, 1993: 91–2)

*A Jaffa is a seedless orange

Note how these individuals' concern is linked to conceptions of themselves as adequate women or men.

Stop and think 12.3

Research suggests that women who are unable to have children when they want them are subject to pity from others. Infertile men on the other hand often experience hostile humour from other men (see the account from Matthew above). Why do you think this is?

Whereas in the western world feminists are concerned with women's control over their own reproductive bodies worldwide concerns are sometimes more about maternal and child morbidity and mortality. World in Focus 12.3 demonstrates why.

The inescapable fact is that 20 million women submit to unsafe abortion every year. In some countries, it is the most common cause of maternal death (Figure 12.2).

Figure **12.2** When abortion is banned – many women have a stab at it anyway

Source: Agency: McCanns Manchester. Copywriter: Neil Lancaster. Art Director: Dave Price. Reprinted with permission of Marie Stopes International.

Gendered health care

There is evidence that women have always practised medicine and been involved in healing the sick (e.g. Verslusyen, 1981; Webb, 1986). The 'housewife' role in pre-industrial society encompassed a much wider remit than it does today and was synonymous with healing. Women knew about painkillers, digestive aids and anti-inflammatory agents. The care of infants and women in childbirth was also part of their role. Women healers possessed knowledge not available to men and were highly respected within their communities (Webb, 1986). Between 1300 and 1700, 'medicine' emerged as a male profession and female healers were suppressed although there are different views on why this happened with some writers linking the suppression of female healing to changes associated with the industrial revolution whilst others blame the witch-hunts (for a further discussion see Letherby, 2003b). What is clear is that the development of medicine as a science and a profession is also an example of how the making of knowledge, culture and ideology was an integral part of the development of capitalism (e.g. Smith, 1988). Medical science became 'masculine' science. The establishment of qualified medical guilds was instrumental in the displacement of women healers as was the development of hospitals and when women did become (re)involved in medicine it was as nurses under the regulation of doctors (Garmarnikow, 1978; Hearn, 1982; Hockey, 1993). The medical man-

World in focus 12.3

Maternal and child mortality

- Every day 1,600 women die in pregnancy and childbirth.
- Each year over 60 million women suffer acute complications from pregnancy.
- Around 20 million women sustain debilitating lifelong injuries or infections.
- Complications of pregnancy and delivery are the leading cause of death among reproductive-age women in developing countries.
- Every year, 1.4 million infants are stillborn and 1.5–2.5 million infants die in the first week of life from complications related to their mothers' pregnancy or experienced during delivery.
- 1 million or more children are left motherless each year by women who die from pregnancy-related causes.
- Motherless children are 2 to 10 times more likely to die within two years than children who live with both parents.

Source: Unicef – printed in 'Birth Matters: a special supplement of reproductive health in the developing world', *Guardian* 2004: 5

agement of childbirth, childcare, dying and death changed 'from a structure of control located in a community of untrained women, to one based on a profession of formally trained men' (Oakley, 1979: 18). Although of course we have women doctors now men still predominate, especially in specialisms considered to be high-skill and heroic and nursing remains a female dominated profession that is subservient to the medical profession.

Stop and think 12.4

Mind puzzle: A young boy is involved in a car accident and is taken to the local Accident and Emergency Department. His father travels with him in the ambulance. Once in the hospital the doctor assigned to treat the child approaches his bed, gasps and says 'I cannot treat him'. Why?

Of course it's because the doctor is the child's mother and medics are not supposed to treat family members but because we (often) assume that doctors are male (we often put the word lady or woman to denote a female doctor or indeed a female artist, writer, lecturer and so on) it often takes people a long time to work this puzzle out. Can you explain this?

It has long been argued that diseases and illnesses that proportionately affect men in greater numbers receive more resources than those that affect women more often. Writers now argue that it is not just that 'men's diseases' are taken more seriously but that male patients are too. Doyal (1998) argues that the continuing failure to include women in sufficient numbers either in epidemiological research or in clinical trials has made it difficult to investigate gender differences or to asses the overall significance of gender in the delivery of effective care.

Although men sometimes appear to find it difficult to communicate with health professionals women seem to find it even harder, both because of their socialisation and the stereotypical views that others have of them (Doyal, 1998). One example of sexist treatment is women's experience of breast cancer. Wilkinson and Kitzinger (1994) argue that the cultural emphasis on breasts as objects of male sexual interest and male sexual pleasure is relevant within treatment. They suggest that 'Page 3' mentality [**Hotlink → see Culture and Mass Media (Chapter 18)**] is reproduced in the medical and psychological literature, as well as in the material produced by major cancer charities. Thus, the implicit assumption throughout is that women's breasts are there for men's sexual pleasure with the woman who has a mastectomy described as mutilated or disfigured.

Obviously, it is not only women who are disempowered by the health service. Male members of economically and ethnically marginalised or disadvantaged groups are likely to find it hard too. However, because of their reluctance to access services, white heterosexual middle-aged men – the so–called privileged group – are visible in public health literature but relatively invisible in practice (Watson, 2000). Sexist assumptions then affect the treatment and care available both for women and for men. However, it is important not to assume that individuals are completely passive in health-care encounters as women and men resist and challenge treatment and behaviour that they experience as inappropriate (Coyle, 1999).

It is possible to argue that sexist care reflects sexist policy. As Hayes and Prior (2003) note two of the most important developments in health policy in the UK in the early twentieth century were highly gendered in their impact. The first was a public health programme aimed at improving the health of children which highlighted poor mothering as the cause of children's poor health and the second, the introduction of National Health Insurance for employed people, which excluded most women and all children from the scheme. The National Health Service introduced in 1948, led to a rapid expansion in all areas of health service delivery, including a steady increase in the number of in-patient beds. As previously noted, this expansion had more of an impact on women than on men in that childbirth became medicalised. The 1970s saw the introduction of community care policies, which led to the discharge from hospital of thousands of people with a mental illness or learning disability. This in turn, led to an increasing burden on family carers, most of whom were women which takes us full-circle in our identification of women as the main carers within society.

Different differences

Of course differences of age, class, sexuality, ethnicity and so on are also relevant to our experience of health, illness and health care and all of these intersect with gender. Educational status, car ownership and housing tenure are also significant.

Taking ethnicity as an example, we know that 'race' adversely affects black women's and men's experiences in relation to health (and indeed all other areas of social life). Yet, 'race' is not a coherent category and the lives of those usually classified together under the label 'black' can be very different. Thus, culture, class, religion, nationality, sexuality, age and so on in addition to gender, can all have an impact on women's and men's lives and it is necessary to challenge the homogeneity of experience previously ascribed to women by virtue of being 'black'. For example, as Douglas (1998) notes the health status of black and minority ethnic women in the UK reflects the interaction between their experiences of 'race', gender, class and culture. So, health and well-being are determined in these groups of women by a complex mixture of social and psychological influences and biological and genetic factors. Black women are not an homogeneous group with uniform needs:

> They may be South Asian, Asian, Chinese, Vietnamese, African or African-Caribbean. They may have been born in the UK, may have migrated recently and may be refugees. They may have disabilities, be older, be lesbian. In attempting to examine the need for appropriate health services for black and minority ethnic women the similarities and differences in needs for black women must always be paramount.
>
> (Douglas 1998: 70)

Further as Maynard (1994a) points out individuals do not have to be black to experience racism as attention to the historical and contemporary experience of Jewish and Irish people demonstrates.

In the above example we see the intersection of ethnicity and gender. Now let us consider the intersections of class, occupation, education and gender. Social class continues to be a major factor determining the health of working age men and women but it is important to also acknowledge that whether or not a person is in paid employment is significant in terms of health status. For example a middle-aged man who loses his job is twice as likely to die in the next five years as a man who remains employed. In addition educational qualifications increasingly differentiate health in the working age group, especially among women (Arber and Cooper, 2000). World in Focus 12.4 provides an example of how morbidity rates reflect differential status in Australia.

For our final example focusing on the significance of different differences we return again to AIDS, this time focusing on black gay men's experience of AIDS. As Susan D. Cochran and Vickie M. Mays (2004, originally 1998), argue, focusing specifically on research in the United States of America, prior to the appearance of AIDS in the USA studies on the sexual preferences and behaviours of gay men usually ignored the specific experience of black men. Cochran and Mays (2004) add that following AIDS little has changed. Thus, whilst researchers usually recognise the importance of cultural differences, their approach has been to assume that black gay men would be more like white gay men than black heterosexuals. However, given the differences that have been observed in family structure and sexual patterns between black and white heterosexuals there is no empirical basis upon which to

World in focus 12.4

Health in Australia

Indigenous people, particularly those who have been colonised by members of dominant and powerful western cultures, experience very poor health. Although mortality statistics do not necessarily reflect the whole experience of women's health, the difference in life expectancy for indigenous and non-indigenous women in Australia – 63.8 and 79.9 years respectively – is so large that it cannot be ignored.

Source: Australian Bureau of Statistics (1995), Lee (1998: 10).

assume that black gay men's experience of homosexuality would perfectly mimic that of white gay men. This lack of attention to the differential experience of black and white men may have serious consequences:

> In the absence of a set of questions or framework incorporating important cultural, ethnic and economic realities of Black gay men, interpretations emanating from a White gay male standard may be misleading . . . There may be a reluctance among Black gay and bisexual men to engage in risk reduction behaviours because of the perception by some members of the Black community that AIDS is a 'gay white disease', or a disease of intravenous drug users (Mays and Cochran, 1987). In addition many risk reduction programmes are located within outreach programmes of primarily White gay organizations. These organizations often fail to attract extensive participations by Black gay men . . . Relative risk refers to the importance of AIDS in context with other social realities. For example, poverty, with its own attendant survival risks may outweigh the fear of AIDS in a teenager's decision to engage in male prostitution. Economic privilege, more common in the White gay community, assists in permitting White gay men to focus their energies and concerns on the AIDS epidemic. For Black gay men of lesser economic privilege other pressing realities of life may, to some extent, diffuse such concerns.
>
> (Cochran and Mays, 2004: 541–2)

Conclusion

Overall although there are differences between male and female bodies and male and female patterns of health and illness these patterns are more complicated than biology alone (Doyal, 1995). Whilst we need to acknowledge the significance of biology we need also to look for social explanations of health and illness. It is important then not to rely on sexist stereotypes of 'male' and 'female' patterns of health and illness and to challenge these stereotypes when they permeate routines and experiences and consequences of health care.

Further reading

Ellen Annandale and Kate Hunt (eds) (1999), *Gender Inequalities in Health*, Buckingham, Open University. This book starts with a broad discussion of developments in gender research and moves on to examine 'established wisdom' about gender and health, for example that women are more often sick and men die quicker. The chapters offer a critical examination of gender inequalities in health covering three decades. Mainly about Britain but there are also discussions of the USA and Eastern Europe.

Bernadette C. Hayes and Pauline M. Prior (2003), *Gender and Health Care in the United Kingdom: Exploring the Stereotypes*, Houndsmills: Palgrave Macmillan. This UK book provides a detailed examination of gender differences in the health needs. Key debates explored include the interrelation of age and gender and health; does marital status affect health? amongst others. Full of empirical information.

The Journal of Men's Health and Gender – contents listing available online at **http://www.jmhg.org/**. This journal is international in focus and aims to integrate both professional and lay perspectives and knowledge. A vast number of issues are covered, including genetics, gerontology, mental health, sports medicine and family and primary care amongst others.

Journal of Gender, Culture and Health – this journal covers biobehavioural, developmental, and psychosocial aspects of gender that relate to the health of men and women. It contains both theoretical and experimental articles. Abstracts are available online at: **http://www.ingentaconnect.com/content/klu/joog**

Websites

World Health Organisation – **http://www.who.org**. The WHO is the United Nations' specialised agency for health, established in 1948. The website is an excellent international resource of information and research issues. Type 'gender' into the internal search engine and follow links that interest you.

Department of Health – the UK government site. The link here is for the publications pages, again type 'gender' in the internal search engine and follow the links: **http://www.dh.gov.uk/PublicationsAndStatistics/fs/**

End of chapter activity

1. Re-read Stop and think 12.1. Having read this chapter what arguments can you make for health research that considers gender differences and similarities?

2. Go to the newsagents and look for magazines that focus on health and healthy living. Are the messages for men different from those for women?