COMMENTARY

Gender and Health

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Feminists introduced the concept of gender several decades ago to distinguish between biological sex and the social construction of masculinity and femininity. This distinction has enabled health researchers to move beyond comparative analyses of male and female morbidity and mortality rates (though there is still room for improvement, as the breakdown of health statistics by sex is not universal beyond vital statistics). Researchers use the concept of gender to study the impact of women's status in society on their health and healthcare. It is not enough to know, for example, that women live longer than men (except in Afghanistan), or that women's deeper poverty limits their access to health services. We need to know the economic, social, and political mechanisms of prejudice and discrimination that lead to ill health and poor healthcare for women and men. The concept of gender has also opened up the fields of gay and lesbian health research and led to the study of the transgendered; these studies proved critical to preventing of the spread of HIV.

There is another, perhaps even more important, meaning of the concept: the idea that gender entails power relations between women and men. This aspect of gender is too little explored in health research and remains to be exploited in health policy. Even when there are descriptions of gender relations – for example, studies of the interaction between male doctors and female patients – the emphasis is generally on women's experiences in the health setting and the consequences for their health-seeking behavior. Such studies do not privilege the gendered aspects of the encounters and usually do not analyze male physicians' experiences. As R.W. Connell (2005)(1)

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remarks, in all of the United Nations documents about women's disadvantages, men are present as background; the reports and treaties imply that men are the advantaged group, but they do not explore men's differences or unpack the category in the way feminist researchers examine women.

Most of what we have read in the past decade is the result of new attention to research on women's health issues rather than gender, even when women's status is factored in. In the United States, the Women's Health Initiative (an outcome of pressure from the women's health movement) sparked wider attention to research on women's health; and globally, the Women's Health Unit at the World Health Organization (which is new and separate from the old Maternal and Child Health Unit in which I worked for 7 years) has been setting health policy. Studies with gender in the title still too often mistakenly use the word as a synonym for women, or open with a nod to gender and then glide on to women.

The article in this issue of *JPHP* on Men's perception of Maternal Mortality in Nigeria breaks new ground in gender research. The authors expose how men's attitudes affect women's maternity care. They show how individual men's decisions draw, perhaps, on culture and tradition but more likely are driven by the limitations of their finances. Their decisions affect when and where their wives receive assistance in childbirth and determine women's survival. Here we see men through other men's eyes (some men say that polygamists treat women as baby factories, and that other men disregard their role in providing proper care and financial and physical support). We see the respondents in Ibadan differentiated by social class, geographical location, age, education, and religion. We learn of the differences in attitudes to pregnancy between married and unmarried men, between those who are fathers and those who are not. We are also told that, in this study, men of Islamic and Christian faiths had similar views on abortion: half of all men thought abortion should be abolished.

The wealth of information in this article should be invaluable to Nigerian health policy-makers who wish to lower the criminally high maternal mortality rates (this study cites a figure of 800 per 100,000 live births, only slightly lower than the figure of 1,000 per 100,000 registered in 1990). One can only hope that researchers in other countries will emulate the precedent set by this article and

that we can look forward to many more submissions on gender and health.

REFERENCE

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