Gender as a social determinant of health:

Implications for Australian women's health policy

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1. The recent historical policy context

- First *National Women's Health Policy,* 1989.
- The *National Non English Speaking Background Women's Health Strategy*, 1991.
- 20 years later, a proposed *National Aboriginal and Torres Strait Islander Women's Health Strategy*, 2011, produced by the Australian Women's Health Network.
- Second *National Women's Health Policy* (2010) .
- First *National Male Health Policy* (2010).
- At the same time, over the last 20 or more years, particularly in the 1990s, States and Territories produced policy or strategy to address the health of women and, in some cases, that of men.

2. Gender as a social determinant of health

- The latest wave of policy making in Australian women's health (and male health) foregrounds the term, *gender as a social determinant of health*, in identifying the key issues that government programmes and services – mainly, but not exclusively in health - should address.

- As the WHO's Commission on the Social Determinants of Health (2008) stated in its landmark *Closing the Gap* report, gender was not only one of the social determinants but the main one responsible for producing health inequities throughout the world.

3. My key message

- There is a *politics associated with gender as a social determinant of health* that powerfully influences whether it can advance *feminist interests and projects* in health policy, services and research. This politics imposes barriers to and opportunities for advancement of feminist health interests and projects that must be understood in relation to specific national policy settings and contexts as well as the wider global picture.

4. Critical gender patterns and women's embodiment

- a) There is enduring structural gender inequality that meets and mixes with other major disparities revealing an aggregate picture of most women, by comparison with most men, continuing to face:
- more limited access to the basic social resources; and
- more limited participation in and control over decision making in public and corporate institutions responsible for the distribution of social resources and other services/programmes.

4. Critical gender patterns and women's embodiment

- b) Such a picture is not all of a piece.
- c) Nevertheless, *gender equality* - characterised by women's participation alongside men in all spheres of life (paid and unpaid), at all levels, and able to exercise power and authority to shape policies, develop programs and allocate resources (United Nations Division for the Advancement of Women, 2007) - remains elusive.
- d) Male dominance, though significantly challenged, continues to operate *interpersonally*, in *groups* and in our major *institutions* even when women comprise the majority such as prevails in the health care and education industries.

4. Critical gender patterns and women's embodiment

- e) Gender inequality and male domination of women are enacted in day-to-day practice and experienced as *embodied realities:*
- chronic tiredness and worry,
- depression and anxiety,
- other chronic emotional injuries and conditions (e.g. PTSD, BPD) ,
- serious physical injury, illness and death (esp. from intimate partner abuse/violence, sexual abuse/violence, workplace abuse/violence and some workplace conditions/practices),
- exacerbation of sickness and discomfort associated with reproductive processes (menstruation, pregnancy, menopause), and
- limited physical movement literacy (competence/confidence).

4. Critical gender patterns and women's embodiment

- f) Other significant embodiments arising from gender inequality and male domination of women occur in routine *health care* as injuries, illnesses and premature deaths associated with inadequate and inappropriate:
- administration of pharmaceuticals and surgical procedures in obstetric, gynaecological, cosmetic and mental health treatments of women;
- diagnosis and treatment of major physical disease conditions among women such as CVD and some cancers; and
- health and medical research that focuses on male bodies instead of human bodies.

5. Feminist interests and projects in health

- a) Men do not share with women the experience of the practical embodiment – or the body in day-to-day practice – of the "sexual reproductive distinction", routinely enacted in the *unequal participation and control* by men and women in:
- work and family life,
- public and corporate governance (including management of institutional programmes and services delivery), and
- the distribution of material and symbolic resources – the ones associated with esteem and value.

5. Feminist interests and projects in health

- b) How does it translate into a feminist *health* project? Community-based services, organised and run by women, would:
- be more closely inter-connected and supported by a central feminist health body in order to participate better in State/Territory and national decision making and funding ;
- work in close collaborations or partnerships with other health and welfare agencies employing both women *and* men;
- provide services and programmes for women, but also for children and male partners.

6. The politics of gender as a social determinant of health

- My aim in this short time has been to suggest to you that the idea of gender as a social determinant of health and health inequities, as recently developed and promoted by the WHO, is a major international public health policy incursion. Yet local, context-specific gender politics determine how it may be taken up in policy and funding, imposing barriers to and opportunities for, advancing feminist health interests and projects. I believe the latter remains critical to embedding social justice in all societies but success will depend on how we navigate the politics of gender as a social determinant of health.

Thank you for your time and attention.

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