

ENGENDERING INTERNATIONAL HEALTH: THE CHALLENGE OF EQUITY

Lincoln C. Chen
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Introduction

I am delighted to return to this city after an absence of several years. I had forgotten what a beautiful city Stockholm is, especially during this time of the year. The pleasure is heightened by my joining in the celebration of the release of the book, “Engendering International Health: The Challenge of Equity” (MIT Press, 2002), co-edited by Gita Sen, Asha George, and Pirooska Ostlin.

Sweden is a particularly appropriate location for this book release. In 1995-1996, Sida provided the first “seed funding” for the launching of the Global Health Equity Initiative, which has provided an umbrella for this particular book and which has spawned so many health equity activities around the world. Sweden as a society has also been a model of social, health and gender equity. Many Swedish scientists have also been at the forefront of global equity initiatives. In addition to Pirooska who co-edited this volume (and who published another volume on gender and health equity in Sweden), we have been blessed by the leadership of Goran Dahlgren, Finn Diderichsen, and Margaret Whitehead (who is an honorary Swede given her doctoral studies here at Karolinska).

Activities leading to this book were in part linked to a broader Global Health Equity Initiative, led by Tim Evans at the Rockefeller Foundation. Five years ago, several health and social scientists met to discuss the growing “health gaps” around the world. Started with Sida financing, the Initiative gained increasing adherents and participants from many countries (Sweden, UK, US, Bangladesh, Kenya, Chile, and South Africa) and many institutions (Karolinska, Harvard, University of Rome, Kings Fund, BRAC, AMREF, Bellagio). Five working groups were established – gender, ethics, measurement, social determinants, and financing. I think it accurate to say that the policy impact of GHEI has been significant. Governments around the world have prioritized closing the equity gap, and international agencies such as WHO and the World Bank have made health equity a mainstream objective of their policies.

In releasing this important book, I would like to advance three propositions. First, health inequities, especially with regard to gender, are likely to remain one of the premier health challenges of the 21st century. Second, while many disparities are long-standing, new threats to health and gender equity are emerging, in part associated with the process of globalization. And third, new opportunities are also emerging for social action to address inequities in health.

Health Inequities

Our grandparents would never have dreamed of the health progress in the 20th century, when average life expectancy doubled for many privileged people around the world. Many people, however, have been left behind, unable to enjoy these social advances. Disparities in health are evident within all countries, rich or poor, and they are certainly marked among countries, rich and poor. While some fortunate populations achieve life expectancies exceeding 80 years, some populations barely achieve half that level of health. Some African countries have lost a decade or more of their life expectancies, due in part to the AIDS pandemic. The Indepth network of demographic field study groups in Africa reported one site in Guinea Bissau with an average life expectancy of 38 years, where more than half of the children die before reaching age 5.

Disparities in health achievement can be found according to age, race, religion, class, geography, and other characteristics. Among these markers of disparities, gender is one of the most consistent discriminators. I use the term gender here, rather than sex, because the latter is a biological concept while gender is a social construction. Gender describes roles, relationships, and other social constructions, including but not confined to biological differences between the sexes.

To begin with, it is important to draw a distinction between gender equality and gender equity. Equality signals disparities in outcomes, while equity casts a normative lens on inequality to determine whether the observed differences are considered fair or not. Inequality between the sexes would be expected given different biological functions, although these differences may be far less than customarily assumed. But, equity casts a judgment about whether assigned domestic and work roles, and their health consequences, are morally fair or not. Gender inequities in health are important, because severe inequities waste human potential, erodes trust, weakens social institutions, and hampers democratic functioning. Severe inequities are a deprivation of basic human rights.

New Threats and Old Problems

Globalization -- the process of accelerated transnational flows of goods, services, finance, ideas, information, technology, people, and diseases -- are introducing new threats to gender equity. The explosive growth of private markets has raised a set of questions about the relationship between markets and health. Health sector reform, predicated on introducing markets into health systems, has not generated the promise of either efficiency or equity. Increased privatization, imposition of user fees, and decentralization all may have restricted rather than expanded access to basic health services among the poor, both women and men.

The technological transformation associated with globalization has resulted in new techniques that can be either equity enhancing or worsening. One example of the latter are technologies that allow for early sex detection of the fetus. Sex-selective termination of pregnancy has increased in some male-preferred societies, such as India and China. Sex ratios of births should approximate normally 105 males per 100 females. In some countries, these ratios have risen to over 110 (meaning that about 5 percent of

female fetuses have been prematurely terminated). In China, where birth control is strongly encouraged and where male preference is particularly strong, the sex ratio of second or third births can be higher than 120.

Accelerated transnational flows also fuel international disease transmission. AIDS, which affects 40 million HIV positive people, threatens to engulf many societies. There are 25 million HIV positive people in sub-Saharan Africa; India has 4 million and China 1 million, threatening explosive growth in Asia. A host of gender issues is associated with AIDS, including the vulnerability of teenage girl (less boys) in sex relations with older men, power in sexual negotiations and the use of condoms for protection, and debates about intellectual property rights of new drugs. Inequitable access to anti-retroviral drugs against AIDS has been a lightning rod of public discontent of the unfairness in established intellectual property regimes. Cross-border flows also involve people, for example trafficking of women and children, sometimes for commercial sexual purposes. Globalization has also fueled conservative backlash, for example the resurgence of Confucianism that confines women to traditional roles in many parts of Asia. The flow of information has brought forward the previously hidden or buried phenomenon of gender-based domestic violence, which is far more prevalent than previously believed in the world.

Opportunities for Policy and Action

It is important to recognize that gender-based health inequities are not insurmountable. Correcting for gender and health inequities is demonstrably possible. In rural Bangladesh, a good field-based health program by BRAC, a non-governmental organization, was able to demonstrate that the previously higher mortality rate among girls could be erased with a solid social intervention. One needs only to look at Afghanistan to recognize how important governmental policies are in ensuring access (or denial) of basic education for girls.

Health is knowledge-based and socially-driven. The knowledge is not only of new technologies but also people's health knowledge, because people are the ultimate producer of their own good health. Social action involves community-based NGOs, but also consumer movements. The assumption of health responsibility by national governments was one of the most important reasons for the health advances of the last century.

In promoting social action, women should be seen not simply as subjects or objects of gender-equity initiatives, but as agents of social change. In that social change, the role of global institutions is particularly important because of their normative agenda-setting roles. Globalization can enable citizen groups to form alliances and coalitions to advance social causes, of which the gender and health equity initiatives have benefited. Globalization of common values can be used as a base for solidarity in gender and health equity. I am very admiring of this book and the leadership demonstrated by Gita, Asha, and Piroška in forging the common values and social solidarity that will advance the gender and health equity agenda.