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Gender and public health practice

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Two recent experiences caused me to reflect again on gender equity in public health practice.

I sat around a workshop with a group of public health academics in a middle-income country to look at what might be appropriate 'results' indicators to show that a development assistance project would have made a difference to strengthen public health systems and improve public health practice in rural communities. It was presupposed that public health system capacity can be seen in better monitoring and prevention or detection of major health problems for major target groups. On this basis, possible health concerns to be addressed for rural women could be screening for cervical cancer (as a leading cause of death) or better management of reproductive track infections (a highly prevalent condition). (The prevention of suicide, also a leading cause of death, was a more complex issue to address, and therefore not on the agenda). Several public health experts argued against 'such specific health issues' as cervical cancer and RTIs, and proposed instead monitoring of maternal mortality or provision of antenatal and postnatal care in accordance with national guidelines. One even suggested that if the interest is better screening, then colon cancer might be a good candidate.

A day later, I looked at a framework for chronic disease prevention from a high income country. In the list of 'non-modifiable risk factors' were age, gender, and genetics.

I realised, once again, about the disconnection between gender as a public health category and gender as a social construct. I also contemplated whether there was a more fundamental problem in the education of public health professionals that contributes to the blinders that I had observed.

For many public health professionals, gender is a discrete category for measurement and program targeting purposes. This usually means women. It is an important starting point, since data is often not disaggregated and the differences between men and women (let alone any other categories of gender) are therefore not evident and not addressed. Gender as a social construct, however, would mean that the relationship between men and women would be part of the analysis, beyond an observed difference in health conditions or risks. Suicide prevention, if included in the above program, would necessarily incorporate consideration of gender relations, and would probably reveal such other gender-based issues as intra-familial abuse, the place of alcohol, and household roles. For the Australian Cooperative Research Centre for Aboriginal Health, the public health category and the social construct are coming together when considering why it is that Aboriginal men suffer from chronic disease more, and are not receptive to health promotion interventions. Action research is commencing on 'men's sheds' – safe and accessible spaces that acknowledge the loss of traditional gender roles under colonial occupation, do not pathologize men's ill-health, and promote personal responsibility for action within a framework of group responsibility to the larger community.

How can a better understanding of gender be incorporated into the consciousness and practice of public health professionals? Public health education is currently experiencing growth in many countries and governments, universities, and relevant non-government organisations are examining what should be the core elements of a postgraduate public health degree. The Association for Schools of Public Health in the US has revised core competencies. There are now guidelines in Canada. The Australian Government, with the Australian Network of Academic Public Health Institutions, are currently developing a quality agenda, including a Delphi study on core competencies. Similar work on a public health curriculum is being undertaken in China, while the Bologna process in Europe will also drive greater comparability in the programs. Cultural competency is increasingly recognised across countries as an important graduate attribute for students. Where is gender-sensitivity? Is it a component of cultural competency?

Epidemiology may give us gender as a public health category, while social sciences may help us with understanding power relations between men and women, within varying social and cultural contexts. But the disciplines don't always intersect; indeed, they often battle. Consequently, these different analytical traditions are seldom brought together in an applied manner, to address real life public health issues facing the practitioners. The consequence is that 'women' are often thought of as yet another category of special interest pleading, while those who work on men's health are portrayed as 'let me be a victim, too'.

'Mainstreaming' gender into public health education may not be sufficient. Transformation of public health education beyond discipline boundaries is more likely to be required. This might benefit both public health practice as well as the health of the community.

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