Why it must be a feminist global health agenda

VIEWPOINT: WHY IT MUST BE A FEMINIST GLOBAL HEALTH AGENDA

Authors

Sara E Davies,[1] Sophie Harman,[2] Prof Rashida Manjoo,[3] Maria Tanyag,[4] Clare Wenham [5]

Abstract

Global health advocates recognise that gender is an issue in the field. This piece outlines how feminist research can advance gender equality in global health. This viewpoint has three aims. First, highlight some of the central findings of feminist research. Second, show how feminist research can be applied to the issues the women and global health movement is currently grappling. Third, make recommendations for a more inclusive feminist global health agenda. We focus on four themes in feminist research: 1. Feminist leadership is more than addressing gender quotas; 2. Gender diversity and intersectionality; 3. Hidden Burden of Care; and 4. Feminist method and knowledge production. Critical engagement with these four themes is integral to achieve gender equality at every level of global health.

Key Messages

- Feminist research is vital to move the women in global health agenda forward.
- Feminist leadership requires more than gender quotas: it requires formal and informal cultural change within institutions across global health governance. Quotas are important, but so too is reform towards feminist institutions and conditions.
- Inequalities exist across sex but also class, education, geography, income, race, physical and mental ability. Gender advocacy must promote inclusive participation and data collection to identify where discrimination and barriers to inclusion exist.

[1] Griffith University, sara.davies@griffith.edu.au. Sara Davies is an Australian Research Council Future Fellow (FF130101040) and Associate Professor in the School of Government and International Relations.

[2] Queen Mary University of London, s.harman@qmul.ac.uk. Sophie Harman is a Reader in International Politics.

[3] University of Cape Town, Rashida.Manjoo@uct.ac.za. Rashida Manjoo is a Professor in the Faculty of Law, and former United Nations Special Rapporteur on Violence against Women, its Causes and Consequences.

[4] Monash University, maria.tanyag@monash.edu. Maria Tanyag is a Research Fellow at the Monash Gender, Peace and Security Centre.

[5] London School of Economics and Political Science, c.wenham@lse.ac.uk. Clare Wenham is an Assistant Professor of Global Health Policy, Department of Health Policy

- Global health is dependent on gender bias. Women predominantly occupy unpaid roles as caregivers and health workers: this needs to be recognised and the labour paid.
- Gender inequality is often informal and private: we need diverse methods of research and research collaboration to expose, recognise, and address the informal and hidden ways in which inequality takes place.
- Critical dialogue must be matched by gendered allocation of resources, support for women's champions, and institutional reform to facilitate research and programs that secure progressive gender rights in global health governance, leadership and everyday practices.

Main research article

We need to re-think the interconnection between women, gender and global health. Beyond increased physical risk factors, women are disadvantaged structurally; over-represented in informal care roles; and under-represented in leadership, decision-making and senior research roles (1). Global health policy and programs are often blind to women's needs being different to men's (gender equity) and women's unequal position in society (gender equality), rendering women 'conspicuously invisible' (2) (3). In response, initiatives such as Women in Global Health have established a target of 50/50 representation in global health leadership by 2030 (4). Tedros Adhanom Ghebreyesus has called for gender 'balance' in senior management roles at the World Health Organisation (WHO), including its regional and country offices. However, as we outline below, addressing women's representation in the workplace (i.e. quotas) is not the same as promoting gender inclusive and gender mainstreaming practices (5).

In this viewpoint, we call for a feminist research agenda in global health. Feminist research challenges structural and social power inequalities within patriarchal societies that produce inequalities which disadvantage women (6) (7). Feminist research and methodology has particular relevance in addressing some of the key issues the women and global health movement is currently grappling with - 'substantive' representation, organized political movement, the (role of the) welfare state, intersectionality, and sexuality (8). These feminist

insights inform four recommendations for global health: 1. Feminist leadership requires more than gender quotas: it requires formal and informal cultural change within institutions across global health governance; 2. Gender inequality cannot be addressed without tackling race and socio-economic inequality: global health must be intersectional across research, programme delivery and implementation; 3. Global health is dependent on women in unpaid care roles: this needs to be recognised, calculated and the labour paid; and 4. Gender inequality is often informal: we need diverse methods of research to expose, recognise, and address the informal and hidden ways in which inequality takes place. These four recommendations are fundamental to achieving women's representation and gender inclusive practices at every level of science, medicine and global health.

1. Feminist leadership is more than addressing gender quotas

Quotas are an important beginning to address historic inequality and lack of representation of women in the public sphere, but it will not address hierarchy or shift power relations to the extent required (9). Feminist research has shown that emphasis on women's representation – the 'inclusion project' (10) - will not on its own overturn unequal structures, address rights abuses, or ensure gender sensitive policies (11). Women are not inherently feminist or advocates for gender inclusive programming i.e. consideration of how policies may affect men and women's lives differently or may reproduce gender stereotypes (gender mainstreaming). Similarly, men are not essentially anti-feminist or against gender mainstreaming. Feminist scholarship shows that change comes not only from formal processes, such as employment law, positive discrimination, and effective return to work initiatives. Change happens by addressing informal sites of hierarchy and exclusion, e.g. holding meetings outside core hours, what is valued as 'quality' work (12). Finally, change requires a shift in perception so that those addressing gender and racial inequality are seen as progressive rather than trouble-makers (14).

The women and global health agenda has begun by tracking the number of women in leadership positions in academic and global health organizations and identifying the gender representation gap (3) (15) (16). Quotas are important, but to achieve gender equality requires substantive institutional change that recognises and is responsive to the formal and informal ways inequality occurs. This includes institutional commitment to implement

formal changes (gender training for all staff, flexible working, spousal visa policies) and informal practices (such as recognising informal roles within the workplace e.g. who takes the notes, whose ideas are heard, who drives the cars in the field). Institutional culture change is difficult and burdensome, and therefore requires everyone, not just female leaders.

2. **Gender diversity and intersectionality**

Women are not a homogenous group (17). Gender intersects with additional drivers of inequality and social determinants of health such as - age, geographic location, sexuality, class, religion, ethnicity, citizenship, and disability (18) (19) (20) (21) (22) (23) (25) – that act as barriers to participating in global health and accessing healthcare. For example, race and gender intersect in understanding how and why maternal and neonatal mortality is significantly greater among black women in USA (26). Globally, socio-economic status, race, and gender intersect to restrict affordable and equitable access to health care services for minority and indigenous women who may fear these services due to a history of forced sterilisations and experimental health welfare programs (27). Finally, gender and socio-cultural factors intersect as drivers of violence against women where the World Health Organization (WHO) Multi-Country Study on Women's Health and Domestic Violence has shown a strong relationship between poverty, physical insecurity, and gender discrimination (28).

Therefore, a feminist global health agenda must be intersectional. We must mainstream intersectionality through research design (data sets which map intersectional inequalities), programme delivery (tailoring delivery to specific needs of different populations) and monitoring and evaluation (end of project assessments to see which populations benefited and were disadvantaged by an intervention). An intersectional approach requires attention to who is present and who is able to speak in global health research, programmes and decision making.

3. Hidden burden of care

Feminist research has shown that women disproportionately provide the invisible care and domestic labour in households and communities (28). Providing informal care and labour has a negative impact on women's health and well-being (20). Often these same women are faced with multiple burdens of care, but do not necessarily benefit from or receive care themselves. Income and gender hierarchy often present structural barriers to access healthcare (28) (29). An additional challenge is the social gender norms which are ascribed to different forms of health labour (30). For instance, community health work, which is at the frontline of health service delivery, remains voluntary and undermined by poor working conditions in many parts of the world. Philanthropic foundations, donor states, and recipient states have long benefitted from unpaid labour; a gendered political economy lens advises us to ask who benefits and who is missing from funded health initiatives. Global health institutions must recognise the gendered nature of unpaid care roles; calculate the 'unpaid healthcare labour wage' (31) provided by carers and community health care workers; and, crucially, pay for this labour.

4. Feminist Method

Global health research, derived from public health and the biomedical sciences, recognises positivist methods as the gold standard. Positivist methods are important in identifying and analysing participation, membership quotas, and voting cleavages within health systems data, but do not capture the whole picture of the gender division of labour and social-economic vulnerability. Engaging feminist methodologies such as ethnography, participant observation, participatory action learning/research and story-telling, encourages research partnerships with minority and marginalised populations (32) (33). It can also expose false assumptions in traditional data collection methods, such as the 'male-headed' household or 'female-headed' household variable to classify the 'worker' (34). Men may be present but not work; women may work but not be formally employed or paid a wage. A feminist lens demands more from the standard classifications of available data and asks what do those terms mean in that particular social and economic context, which is vital for understanding program implementation and delivery.

We need to include feminist methods in global health research to expose the formal and informal ways in which gender inequality is manifest in health care access and delivery (35). We need to look for the silences and pockets of exclusion in order to ensure representation, inclusivity and reflexivity within research and program delivery. This means actively considering whose voices are missing and what barriers to participation exist, and the methods we use to reveal these.

Works Cited

1. Talib Z, Barry M. Women leaders in global health. The Lancet Global Health. 2017; 5(6): p. e565-e566.
2. Harman S. Ebola, gender and conspicuously invisible women in global health governance. Third World Quarterly. 2016; 37(3): p. 524-541.
3. Hawkes S, Buse K, Kapilashrami A. Gender blind? An analysis of global public-private partnerships for health. Globalization and health. 2017; 13(26).
4. Women in Global Health. Women in Global Health. [Online].; 2017 [cited 2018 January 30th. Available from: http://www.womeningh.org/.
5. Tamale S. When Hens Begin to Crow: Gender and Parliamentary Politics in Uganda. Boulder: CO: Westview Press; 1999.
6. MacKinnon C. Toward a feminist theory of the state Cambridge: Harvard University Press; 1989.
7. McIntosh M. The State and the Oppression of Women. In Kuhn A, Wolpe A. Feminism and Materialism. London: Routledge; 1978. p. 255–289.
8. Waylen G, Celis K, Kantola J, Weldon L. Waylen G, Celis K, Kantola J, Weldon L, editors. The Oxford handbook of gender and politics Oxford: Oxford University Press; 2013.
9. Waylen G. A Seat at the Table - is it enough? Gender, Multi party negotiations and institutional design in South Africa and Northern Ireland. Politics & Gender. 2014; 10(4): p. 495-523.
10. Squires J. Gender in Political Theory Cambridge: Polity; 1999.
11. Tadros M. Introduction: Quotas – Add Women and Stir? IDS Bulletin. 2010; 41: p. 1-10.
12. True J, Mintrom M. Transnational Networks and Policy Diffusion: The Case of Gender Mainstreaming. International Studies Quarterly. 2001; 45: p. 27-57.
13. Mohanty C. Comment: Sister-Administrators in the Neoliberal Academy: reflections of a feminist of colour. In Fryberg S, Martinez E. The Truly Diverse Faculty: new dialogues in

American Higher Education. New York: Palgrave; 2014. p. 193-200.

14. Global Health 50/50. 'The Global Health 50/50 Report: How gender-responsive are the world's most influential global health organisations? London: UCL; 2018.

15. Data2X. Data2X. [Online]. Available from: https://www.data2x.org/.

16. Crenshaw K. Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics. University of Chicago Legal Forum. 1989.

17. Correa S. Population and Reproductive Rights: Feminist Perspectives from the South London: Zed Books; 1994.

18. Cook R, Cusack S. Gender Stereotyping: Transnational Legal Perspectives Philadelphia: University of Pennsylvania Press.; 2010.

19. Doyal L. What Makes Women Sick: Gender and the Political Economy of Health London: MacMillan; 1995.

20. Mohindra K, Labonte R, Spitzer D. The global financial crisis: whither women's health? Critical Public Health. 2011 21; 3: p. 273-287.

21. Desai M. The messy relationship between feminisms and globalizations. Gender and Society. 2007; 21(6): p. 797-803.

22. Carty L, Mohanty C. Mapping transnational feminist engagements: neoliberalism and the politics of solidarity. In W BRaH. The Oxford Handbook of Transnational Feminist Movements. Oxford: Oxford University Press; 2015. p. 82-115.

23. Marmot M. Social Deteminant of Health Inequalities. The Lancet. 2005; 365(9464): p. 1099-104.

24. Villarosa L. New York Times Magazine. [Online].; 2018. Available from: https://www.nytimes.com/2018/04/11/magazine/black-mothers-babies-death-maternal-mortality.html.

25. Sherwood J. Colonisation – It's bad for your health: The context of Aboriginal health. Contemporary Nurse. 2014; 46(1): p. 28-40.

26. Elson D. Social Reproduction in the Global Crisis: Rapid Recovery or Long-Lasting Depletion? In Utting PRSaVB. The Global Crisis and Transformative Social Change. Basingstoke: Palgrave Macmillan; 2012. p. 63-80.

27. Brickell K, Chant S. The unbearable heaviness of being": reflections on female altruism in Cambodia, Philippines, The Gambia and Costa Rica. Progress in Development Studies. 2010; 10(2): p. 145–159.

28. George A. Nurses, community health workers, and home carers: gendered human resources compensating for skewed health systems. Global Public Health. 2008; 3(S1): p. 75-89.

29. Ferrant G, Pesando LM, Nowacka K. Unpaid Care Work: The missing link in the analysis of gender gaps in labour outcomes. ; 2014.

30. Caretta M, Riano Y. Feminist participatory methodologies in geography: creating spaces of inclusion. Qualitative Research. 2016; 16(3): p. 258-66.

31. Kapoor P. Between Fact and Fiction: Can There Be a Postcolonial Feminist Ethnography?. Women's Studies International Forum. 2017; 60: p. 58–68.

32. Tickner JA. Feminism meets International Relations: some methodological issues. In Ackerly , Stern , True J. Feminist Methodologies for International Relations. Cambridge: Cambridge University Press; 2006. p. p. 38.

33. Fonow M, Cook J. Feminist methodology: new applications in the academy and public policy. Signs. 2005; 30(4): p. 2211-2236.