Sex, gender, and health: the need for a new approach

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The past two decades have seen considerable activism by women to improve the quality of their health and health care. Recently men too have begun to draw attention to the negative implications of "maleness" for their health. There is an increasing danger that these campaigns could be drawn into conflict with each other as they compete for public sympathy and scarce resources. If conflict is to be avoided there needs to be a much clearer understanding of the impact of both sex and gender on health. This can then provide the foundation for gender sensitive policies that take seriously the needs of both women and men.

Sex and health: the biology of risk

The differences between male and female reproductive systems have always been an important consideration in healthcare delivery. This reflects the crucial role of high quality family planning and obstetric services in enabling women to realise their potential for health. Despite recent progress, around half a million women continue to die each year as a direct consequence of pregnancy and childbirth, and more than 10 times that number are seriously disabled.[1] It is the centrality of these issues in women's lives that has led many to adopt the concept of sexual and reproductive rights as a major campaigning issue.

Many countries have developed new services in response to the "platform of action" devised at the 1994 International Population and Development Conference in Cairo. Given the greater vulnerability of women to reproductive health hazards it is not surprising that these programmes have concentrated mostly on their needs. However, more attention is now being focused on men as the HIV/AIDS epidemic has highlighted the risks of sexually transmitted diseases for both partners. This has made it possible to help men to promote their own health but has also offered important opportunities for educating them to take more responsibility for the health of their partners.[2 3]

There has also been a growing recognition that the biological differences between the sexes extend beyond the reproductive. A wide range of genetic, hormonal, and metabolic influences play a part in shaping distinctive male and female patterns of morbidity and mortality. Sex specific diseases such as cancers of the cervix and prostate are the most obvious examples. However, there is also growing evidence of sex differences in the incidence, symptoms, and prognosis of many other health problems including HIV/AIDS, tropical infectious diseases, tuberculosis, autoimmune problems, and coronary heart disease.[4 5] One of the most important of these sex differences is the greater biological propensity of men to develop heart disease early in life.

If health services are to meet the needs of both women and men then all these sex differences need to be taken seriously in the planning and delivery of care. But biological influences are only part of the complex of factors shaping the health of women and men.

Summary points

Men are now following the example of women in drawing attention to the links between gender, health, and health care

The health of both sexes is influenced by biological factors including, but not confined to, their reproductive characteristics

Socially constructed gender characteristics are also important in shaping the capacity of both women and men to realise their potential for health

Gender inequalities in access to health promoting resources have damaging effects on women's wellbeing

Men face particular problems because of the relation between masculine identities and risk taking

Greater sensitivity to sex and gender is needed in medical research, service delivery, and wider social policies

Socially constructed gender differences are also important in determining whether individuals can realise their potential for a long and healthy life.[6]

Hazards of female gender

An extensive literature documents the relation between gender divisions and women's health.[7] Researchers have explored a wide range of social, economic, and cultural factors, showing their links with physical and mental wellbeing. This analysis has focused mainly on the gender inequalities that continue to characterise so many of the relationships between women and men. As a recent report has documented, there are no societies in which women are treated as equals with men, and this inevitably affects women's health.[8]

Gender inequalities in income and wealth make women especially vulnerable to poverty. In some parts of the world this makes it difficult for them to acquire the necessities for health, especially during the reproductive years when family needs are greatest. Social norms about the divisions of responsibility mean that many women have very heavy burdens of work, especially those who combine employment with domestic duties, pregnancy, and childrearing. Within the household women often receive little support, and too many are abused by other family members. A recent study has estimated that 19% of the total disease burden carried by women aged 15-44 in developed countries is the result of domestic violence and rape.[9] Anxiety and depression are reported more often by

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women than by men in most parts of the world, yet there is no evidence that women are constitutionally more susceptible to such problems.[10 11]

As well as affecting their health, gender inequalities may also limit women's access to services. Around the world many millions of women continue to be deprived of basic health care as a result of poverty and discrimination. In Britain the removal of these financial obstacles was one of the main achievements of the NHS. However, there is still evidence that women are treated by some doctors as less valuable than men. This can lead to demeaning attitudes as well as the unequal allocation of clinical resources.[12 13] This gender bias is especially evident in the context of medical research, where studies have shown that women have too often been excluded from studies for inappropriate reasons.[14]

Male gender: a mixed blessing?

Until recently very little attention had been paid to the impact of gender on men's health. This is now changing as the links between masculinity and wellbeing begin to emerge.[15 16] At first glance maleness might seem to be straightforwardly health promoting since it offers privileged access to a range of valuable resources. However, closer examination reveals a more complex picture. Though the shape of masculinity may vary between communities, the development and maintenance of a heterosexual male identity usually requires the taking of risks that are seriously hazardous to health.[17–19]

The most obvious examples of such risks come from the world of paid work. In most societies the traditional role of provider has put men at greater risk of dying prematurely from occupational accidents.[20] Though the gender distribution of the labour force is now changing, men from the poorest communities still do the most dangerous jobs. Alongside these potential risks in the workplace, many men also feel compelled to engage in risky behaviour in order to "prove" their masculinity. As a result, they are more likely than women to be murdered or to die in a car crash or dangerous sporting activities.[21] In most societies they are also more likely than women to drink to excess and smoke, which in turn increases their biological predisposition to early heart disease and related problems. They also seem to be more likely than women to desire unsafe sex. Again, many of these hazards are likely to be more common among men in the poorest communities.[16]

INSIGHT

Showing off—or proving his masculinity?

The implications of masculinity for mental health are also receiving increasing attention. It has been argued that "growing up male" renders many men unable to realise what might be their emotional potential.[15] The need to be seen as "hard," for example, may prevent them from exploring the caring side of their nature. An unwillingness to admit weakness may prevent many men from taking health promotion messages seriously and from consulting a doctor when problems arise.[22 23] Indeed, illness itself may be especially feared because of its capacity to reduce men to what one recent study has called "marginalised masculinity."[24] Thus many men have to grapple with internal constraints to get optimal value from the health services available to them.

Putting sex and gender on the health care agenda

This brief analysis has highlighted the complex links between biological sex, social gender, and health. In one sense it is clearly an oversimplification since there are marked similarities in the healthcare needs of women and men as well as major differences between different groups of women and different groups of men. However, this does not mean that issues of maleness and femaleness are not important. If health services are to be equitable and efficient greater sensitivity will be needed to sex and gender concerns. This will need to be reflected in research, in patterns of service delivery, and in wider social and economic policies.

If the gender bias in medical research is to be eliminated measures will need to be taken to ensure that study designs include sex and gender as key variables whenever appropriate. In the short term this would promote equity through filling the gaps that currently exist in our knowledge of women's health. In the longer term it would improve the overall quality of medical science and would therefore benefit men too.

To improve access to services women may need to have better transport and child care arrangements. For men (and many women) there may be a need to provide more services in the workplace or in community locations. Across the range of healthcare settings it is essential that women and men are both treated with respect. Women should not be humiliated by sexist behaviour, for example, or be damaged by discriminatory practices.[12 13] Men, on the other hand, should not be expected to live up to stereotypical conceptions of heterosexuality and masculinity. Clinicians need to recognise the psychological difficulties that male patients may bring to the medical encounter and the challenges that illness may pose to their sense of their own identity.

Health promotion policies in particular need to be gender sensitive if their messages are to be heard. Too many campaigns are addressed to women in their role as the carers of others while ignoring their own wellbeing.[25] Men too often feel that health is women's business and that health promotion messages are not addressed to them. HIV/AIDS campaigns have simultaneously exhorted women and men to "use a

condom" without recognising the very real differences in power and status that structure most sexual encounters. If this is to change, campaigns need to be designed in ways that encourage both women and men to look after themselves and each other.

Finally, we need to examine the potential of wider social and economic policies for promoting gender equity in health, and here the issues are especially complex. On the one hand, the further development of antidiscriminatory policies could clearly be valuable in tackling the economic and social inequalities that continue to affect women's health. On the other hand, changes in patterns of social security provision or employment conditions would make it easier for men to develop the "female" side of themselves. Greater flexibility of working hours, for example, as well as more generous provision of parental leave could make it easier for men to bridge the gap between work and home. Carefully designed educational initiatives could also be used to reshape the gender relations of the next generation.

These changes in public policy could play a part in promoting gender equity in health.[26] However, they would still leave some of the most fundamental problems untouched. So long as masculinity continues to be defined in ways that are hazardous to health too many men will continue to experience preventable diseases and even death. At the same time, too many women will continue to be damaged by the actions of male partners who are following the scripts of masculinity. Changes of this kind will not be easy to achieve since they will involve a redefinition of some of the most intimate areas of human life. But unless they are tackled, gender inequalities will continue to be one of the factors limiting the capacity of both women and men to realise their potential for health.

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Is a tattoo the answer?

My 83 year old grandmother wants a tattoo. She feels it would help reduce one of her great fears. She worries that if she collapsed someone would try to resuscitate her; she therefore wants "Do not resuscitate" tattooed on her chest. She is not ill, she is not depressed, she simply feels that she has had a good life and is ready to leave it whenever nature decides to end her time. She wants no fuss, no money spent. She worries about losing her independence, about getting dementia; a sudden collapse would be her perfect death, so why waste the opportunity?

A tattoo might seem a bit drastic, but we have considered alternatives. She always carries her living will with her, but would paramedics arriving to find an elderly lady unconscious and in ventricular fibrillation look in her bag before applying the paddles? A pendant with an engraving is another possibility, but, again, would anyone look? A Medic Alert bracelet was another idea. I telephoned, but Medic Alert is not allowed to engrave medical directives. They could engrave that that the wearer has a living will, and keep a copy, which they could fax or read out to the paramedics if they telephoned; it seems a bit unlikely.

Would anyone really take notice of a tattoo? Perhaps in an emergency medical staff would at least consider their course of action and make an urgent search for more information about the patient's wishes. Maybe not, but I cannot think of any better alternatives to guarantee my grandmother's wishes are upheld.

I have tried to convince her that the collapse in the street scenario is quite unlikely in her situation, and the odds on a successful resuscitation are not great anyway. If she became ill and was at home or in hospital there would be time to make her wishes clear. However, her anxiety persists.

Is her concern justified? The thing she dreads is possible; I cannot tell her it would not happen. It would be impractical and largely unacceptable for emergency medical staff to delay resuscitation while they tried to find out a person's wishes. I do not know if her fears are common, there seems to be little research on the matter. What literature I could find seems to be centred on resuscitation decisions in hospital or for those with chronic disease. But she is not alone: the woman pictured in Minerva of 7 July (*BMJ* 2001;323:58) who had "Do not resuscitate" tattooed on her chest wall must have had the same worry. We presume she considered alternative ways to reduce her fears but found them unsatisfactory. For her, a tattoo was the answer.

So my grandmother is working on her tattoo design, and next time I visit she wants me to take her to a tattoo parlour. She knows the potential risks, she knows it will hurt, but she will feel better. How can I refuse?

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