



### *Addressing Essential Structural Dimensions of Gender Inequality*

#### **How do the structural dimensions of gender inequality affect women and men's health?**

All over the world, women as a group have less power and resources in comparison to men as a group. This structural dimension of gender inequality has a tremendous impact on both women's and men's health and longevity.

#### **Structural gender inequality**

The structural dimension of gender inequality refers to the unequal division of power and resources between women and men. These inequalities are assigned through other gendered mechanisms, which are reproduced and maintained at the individual as well as societal level (Okin, 1989). Norms, values and practices give rise to clear distinctions between the sexes and to allocating women as subordinated to men in most important spheres of life, for example, type of education, labour market position, and unpaid duties (Wamala & Lynch, 2002). In many parts of the world, men and boys exercise power over women and girls, making decisions on their behalf, constraining their access to resources and personal agency, and policing their behaviour through socially condoned violence or threat of violence. Even in countries where extreme gender inequality is not evident; women continue to have less influence in economic, political, and other influential institutions than men (Schultz & Mullings, 2006; WGEKN, 2007).

#### **Global fact**

The male versus female dominance in the structural gender aspects of power and resources is a global fact. The Gender Empowerment Measure presented by the United Nations' Development Programme is an index measuring differences between women and men in three basic dimensions: economic participation and decision-making, political participation and decision-making, and power over economic resources, with 1.0 referring to absolute gender equality. Among the countries from which values are reported, about ten exceed a score of 0.8 while more than one-third falls below 0.5 (UNDP, 2010). An illustration from the EU setting is that the average female versus male salary during the last decade has been around 80% (Eurofond, 2010).

#### **Longevity**

There is a rich body of studies which indicate that high degree of influence and participation as well as access to resources improves people's lifetime health (WHO 2010). One gender paradox in health is therefore that women live longer than men despite being subordinated in society (Annandale and Hunt, 2000). The caring role, typically assigned to women, may protect more against life-threatening attitudes and behaviours than the breadwinning role, usually assigned to men (Månsdotter et al. 2006).

#### **Contributors**

Anna Månsdotter, PhD, Karolinska Institutet, Sweden

Isis Marie Aimée Nyampame, MPH, Swedish National Institute of Public Health, Sweden

Charlotte Deogan, MPH, Karolinska Institutet, Sweden

Hanna Wallin, MPH, Karolinska Institutet, Sweden

Ineke Klinge, PhD, Maastricht University, the Netherlands

Carina A. Furnée, PhD, Maastricht University, the Netherlands

María Cristina Quevedo-Gómez, MD, MPH, Maastricht University, the Netherlands

Petra Verdonk, PhD, Maastricht University, the Netherlands

Peggy Maguire, European Institute of Women's Health, Ireland

Kristin Semancik, European Institute of Women's Health, Ireland

#### **Expert Reviewers**

Aagje Ieven, PhD, EuroHealthNet

**The ENGENDER Website**  
<http://engender.eurohealth.ie>

## Existing EU-Level Policy

### Roadmap for Equality Between Men and Women, 2006

Gender equality regarding structural dimensions such as education and income is widely recognized goal within the EU institutions. A recent illustration is the “European Commission’s Roadmap for equality between men and women (2006)”, which outlines six priority areas for EU action on gender equality for the period 2006-2010, including equal economic independence for women and men, equal representation in decision-making, and eradication of all forms of gender-based violence.

### Together for Health: A Strategic Approach for the EU 2008-2013 (White paper)

The reduction of health inequalities is one of the priorities for the overall Health Strategy 2008-2013. A statement on common values and principles in EU healthcare systems, listing the overarching values of universality, access to good quality care, equity and solidarity, is adopted.

### COMMUNICATION FROM THE COMMISSION, EUROPE 2020

#### A strategy for smart, sustainable and inclusive growth

The Strategy is promoting gender equality to increase labour force participation, as a consequence this will increase growth and social cohesion. The Strategy reinforces the importance of promoting new forms of work-life balance, active ageing policies and increasing gender equality as an action for EU to increase the growth smart and sustainable

*“Confronting this [masculinity coded behaviour to retain societal status] may well improve [men’s] physical well-being, but it will necessarily undermine their privileged position and threaten their power and authority in relation to women” Courtenay 2000, p 1397.*

Furthermore, the various norms and structures of gender are intimately interwoven (Harding 1986). A man who does not achieve the masculinity norm of intellectual and monetary resources may, for example, need to compensate his loss of prestige with the masculinity codes of heavy alcohol drinking and other risk taking behaviours (Connell, 1995). According to Courtenay: “Confronting this [masculinity coded behaviour to retain societal status] may well improve [men’s] physical well-being, but it will necessarily undermine their privileged position and threaten their power and authority in relation to women” (2000, p 1397).

#### Health measures

In general women report to a larger extent mental ill-health and have less health-related quality of life than men (WHO, 2001). Obviously, women’s relative lack of power, influence and resources affects health negatively. Further, femininity codes such as caring and cautiousness suit feelings of worries and inferiority, depression and anxiety (Connell, 1995; Hammarström, 2002). The typically female multiple role combination of paid and unpaid labour may also be stressing enough to trigger a variety of adverse health outcomes (Härenstam et al., 2001).

One gender paradox in health is therefore that women live longer than men despite being subordinated in society; another gender paradox is that the benefited group in terms of longevity (women) suffers more in measures of health-related quality of life (Annandale and Hunt, 2000; Härenstam et al., 2001).

Hence, it seems that the undisputable negative impact on longevity from having less power and resources is compensated by other, positive, gender mechanisms for women.

Considering the traditional gender division of parenthood, it could indicate that the caring role (usually assigned to women) protects more against life-threatening attitudes and behaviours, than the breadwinning role (usually assigned to men).

This means, for example, that a man who does not achieve the norm of intellectual and monetary capital may need to compensate his subordination with masculinity codes such as heavy alcohol drinking, taking risks in traffic, and proneness to violence in order to sustaining his societal position (Connell, 1995).

### Good Practice Example 1: Discussing homosexuality among Dutch Moroccans, the Netherlands

This GP aims to increase acceptance of sexual diversity and homosexuality among the Dutch-Moroccan community in five cities giving information, and organizing dialogues with local Lesbian, Gay, Bisexual and Transgender organisations. The taboo regarding homosexuality concerns a number of gendered issues including the proper male and female behaviours and works, religion, social control, and family honour. Consequently, managing change is likely to increase approval of homosexuality as well as of structural gender equality.

## Conclusions from Analysis of Existing Practice

The analysis of the ENGENDER Database identified five main categories of good practices (GPs) pertinent to structural gender inequality: gender and intersectionality approach, paid work and parenthood, women's empowerment, men's health, and men's violence against women.

### **Women's empowerment, men's health, and equality of labour and parenthood**

The GPs aimed at enhancing women's empowerment confirm that these initiatives have been, and continue to be, crucial for a society willing to tackle gender inequalities in power and resources (Kiss, 1998).

Further, the GPs promoting gender equality of paid work and incomes as well as of parenthood and caring duties indicate support for the need to confront both the private and public spheres of life in order to equalise the division of power and resources, and of health and longevity, between women and men (Månsdotter et al., 2006).

The GPs addressing men's risk taking behaviours such as heavy alcohol drinking, violence and homicide are naturally means of extending their healthy life. Additionally, they represent actions carried out to uproot men's dominance in the society, and consequently to improve the health and welfare of women and children (Connell, 1995, Courtenay, 2000).

### **EU and Structural Gender Equality**

Increased equality between women and men is a well-established goal within the EU institutions. A crucial illustration is the European Commission's "Roadmap for equality

between women and men for the years 2006-10, updated with the years 2010-2015. Six priority areas for action are identified: equal economic independence; equal pay for equal work or work of equal value; equality in decision-making; dignity, integrity and an end to gender-based violence; equality in external actions; and, horizontal issues regarding strategies for gender equality (European Commission, 2006, 2010).

### **Men's violence against women**

The GPs addressing of men's violence against women require special attention. This violence represents a main cause of gender inequality, but also a consequence of the unequal relationship between the sexes (Swedish National Council for Crime Prevention, 2010). From a health perspective, men's violence against women is a huge threat to women's health. Not prevented, it is also a heavy toll on the economy. The annual cost in European Union has been estimated to EUR 33 billion (Council of Europe, 2006).

### **An intersectional approach**

Gender interacts with other social markers on health and longevity. The GPs with an intersectional approach is therefore crucial for successfully tackling the combined consequences of discrimination and oppression based on gender, class, ethnicity, sexuality, etc. (Schulz & Mullings, 2006).

*For the in-depth analysis of good practice as well as more examples of good practice from the ENGENDER Project, please see the policy brief annexes, which are available online at: <http://engender.eurohealth.ie>.*

### **Good Practice Example 2: Paternity leave: costs, savings and health gains, Sweden**

This GP examined the reform that permitted Swedish fathers to take parental leave in 1974. It was shown that fathers who took paternity leave had a decreased death risk of 16%, and that the cost-effectiveness of the reform was 8,000 EUR per gained QALY (quality-adjusted life-year). The conclusion was that the right to paternity leave is a desirable reform based on gender equality, public health and economic goals.

### **Good Practice Example 3: The RoSa Library, Belgium**

The current visions and practices of gender equality in all aspects of life are undoubtedly helped by old and new empowerment initiatives of women (Kiss, 1998). This GP contains more than 22 000 books and works on gender and feminism, and a number of extensive archives from the pioneering women's movement.

### **Good Practice Example 4: The Men's Health and Well-being Programme, Ireland**

This GP was established by the Larkin Unemployment Centre in partnership with the Glasgow Celtic Football Club, in Dublin's North inner city. The objectives included assisting men to take control of their own health, providing information in a gender sensitive way, acting as a catalyst to effect positive change, providing new opportunities to engage in recreation and sporting, and building capacity in the community.

### **Good Practice Example 5: Resolution on the 2009-2014 National Programme on Prevention of Family Violence, Slovenia**

This GP represents a strategic document that stipulates the objectives, measures and key policy makers for the prevention and reduction of family violence in the Republic of Slovenia. The fundamental objectives are to connect the measures of various sectors and to ensure efficient activities to reduce family violence at the level of identification and prevention. Definite tasks and activities for the implementation of methods and their deadlines will be translated into action plans, created every two years.

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Månsdotter et al, (2007)

## *Steps for Policy Action*

- 1) Address both private (family) and public (labour market) aspects of life in policy and programmes to enhance gender equality in society and in health**  
Equal pay policy and legislation; Gender-neutral parental leave; Economic incentives which tackle gender-traditional practices
- 2) Design programmes and policies that take into account discrimination based on (class, ethnicity, age, sexuality, etc.) in order to more effectively reduce health inequalities between women and men**  
Identify, and address, multiple social vulnerability for reverse health outcomes
- 3) Support existing efforts and the development of future actions to promote empowerment incentives for women**  
Reminder: the vision of gender equality in all aspects of life is founded on the pioneering women who did not accept being subordinated to men
- 4) Design programmes and policies which prevent risky behaviours serving as masculinity codes – for improving men’s health, and for diminishing the male versus female dominance in power and prestige**  
Restrictions related to alcohol, traffic, violence, etc.; Gender-neutral assumptions regarding women’s and men’s suitability for various life tasks
- 5) Work towards eradication of men’s violence against women, since it constitutes a heavy toll on the society and compromises women’s health, dignity and independence.**  
Reminder: gender-based violence represents a mean to maintain and a consequence from gender inequality in power, influence, and resources

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