

Editorial

Holding up half the sky: the gender agenda remains unresolved

Paula McGee PhD RN RNT MA BA Cert Ed

Editor, *Diversity and Equality in Health and Care*; Professor of Nursing, Faculty of Health, Birmingham City University, Birmingham, UK

Mark RD Johnson MA PhD Dip HE (Warwick)

Editor, *Diversity and Equality in Health and Care*; Professor of Diversity in Health and Social Care, Mary Seacole Research Centre, De Montfort University, Leicester, UK

The month of March marks an annual celebration of women around the world. It began in 1909 as an attempt to demonstrate respect for women and their achievements at a time when, even in the most developed countries, women had few rights or opportunities apart from marriage and childbearing. During the last century women fought for, died for, but ultimately won a number of battles to allow them to vote, to take part in political processes, and to receive equal pay for equal work, among many other issues. Looking back at these achievements, there has been considerable progress. As Britain's Queen celebrates her Diamond Jubilee, there are perhaps more female heads of state than ever before, many of whom, like Ellen Johnson Sirleaf in Liberia, have made great strides towards modernising and resolving the problems of their countries. In the UK, the introduction of the Equal Pay Act in 1970 and the Sex Discrimination Act 5 years later seems like a distant memory. Women who were then young are now nearing retirement age, and their children and grandchildren have grown up in a society where gender equality is no longer questioned. They shake their heads in disbelief at the stories of how things used to be, and their elders feel that they are describing ancient history. From such conversations it is but a small step to believing that the struggle is over.

However, it is not. In fact the struggle for women's human and civil rights is only just beginning in many parts of the world. Across the globe, women still lack equality with men. In societies in which the birth of a daughter is regarded as a calamity, where raising a girl child is likened to tending the garden of another, female fetuses are systematically aborted on an industrial scale that now threatens the populations of parts of India (www.unicef.org/india/media_3285.htm) and China. Modern patterns of migration mean that this gendercide can be exported (www.bbc.co.uk/news/

[health-17136213](http://www.bbc.co.uk/news/health-17136213)). Shortages of women increase their commodification and decrease their humanity. This is graphically illustrated in the Hindi film *Matrubhoomi: A Nation Without Women*, which depicts a village without women. The men buy a woman from another village, who is then chained like an animal and repeatedly raped by every man in the village. Thus in stripping the woman of her humanity the men themselves are dehumanised. The story represents an extreme, but there is already evidence of trade in women as men from the northern Indian states most affected by female gendercide try to find wives, India's very own mail-order brides.

If they survive through birth and infancy, girl children around the world face persistent and entrenched opposition to efforts to improve their lives, particularly in rural areas, which deny them the opportunity to achieve their potential. Lack of access to education, lack of access to healthcare, lack of meaningful participation in the political system, lack of opportunity to earn and control money, and male-dominated systems of land tenure are among the many challenges that they face, most of which can be summed up in one word: poverty. Poverty means that girl children are kept away from school because someone has to spend hours every day fetching and carrying water, growing food (43% of farmers in developing countries are women), collecting fuel and performing all the other tasks that keep a household going (United Nations Womenwatch, 2012). Women's lack of education is directly related to child mortality:

a woman's education is a key factor in determining whether her children will survive past the first five years of life. A child's chances of surviving increase even further when his or her mother has a secondary or higher education.

(United Nations Womenwatch, 2012)

Poverty means that women are likely to die as a result of entirely preventable events in pregnancy and childbirth, particularly if they live in Afghanistan, the Democratic Republic of Congo or Pakistan (www.bbc.co.uk/news/world-south-asia-13773274). Millions of women live in healthcare deserts where there is simply no provision of any kind. Even where services exist, access may be denied because women cannot afford those services (Save the Children, 2011).

Poverty also means that women are vulnerable to what is currently referred to as *food insecurity*, namely shortages in food production and availability, or in other words, hunger. Persistent hunger translates into malnutrition, and it is women who bear the brunt of this. Women who are malnourished are more susceptible to anaemia and other diseases linked to dietary deficiencies, such as rickets, which make extra demands on their energy and which negatively affect their ability to farm (United Nations Womenwatch, 2012). They are also more prone to infections such as tuberculosis, malaria and HIV, and are thus more likely to die prematurely (World Health Organization, 2005). The consequences for their children are dire. Women who are malnourished cannot meet the increased demands that pregnancy makes on their bodies, and thus produce malnourished children who then go on to produce more malnourished children. Without mothers, children become the responsibility of other family members who may themselves be too old, too busy, or too ill or malnourished to care for them properly (see, for example, Wangui, 2009). Millions of children grow up without ever having enough to eat, and in turn produce children who bear the consequences of malnutrition and themselves go on to do the same. It is a self-perpetuating cycle and the results are now very apparent (Save the Children, 2012).

Malnutrition is now recognised as a serious public health problem that particularly concerns women and their children, and which accounts for approximately 33% of all child mortality worldwide every year: 'maternal and child undernutrition is the single leading cause of health loss' (World Health Organization, 2005, p. 8). In addition, and just as important, it causes developmental delay that is both physical and intellectual. Babies and children do not reach their milestones, and become stunted (Save the Children, 2012).

Stunting, or chronic malnutrition, is a result of a child having a poor diet – too few calories or too little nutritious food, or both – for a number of years, or an infection leading to malabsorption of nutrients. The first 1,000 days of life – beginning with conception, through a mother's pregnancy and up until the age of two – is the most critical period in a child's development. Even if a child's diet improves later in life and any health issues are resolved, damage done during this period is largely irreversible.

(Save the Children, 2012, p. 20)

As a result malnourished children are smaller than their well-fed counterparts, are less able intellectually, and will never realise their full potential. Generation follows generation into a downward spiral of loss as the effects of malnutrition are compounded by continuing hunger. The individual loss is tragic, the societal loss unquantifiable, and the economic loss incalculable. Stunted populations with reduced intellectual capacity will struggle to improve their own economic and social circumstances, and are thus more likely to become dependent on or to continue to be dependent on foreign aid, with all the challenges that this brings. More insidiously, stunting fuels prejudice and stereotypes about people being incapable of helping themselves.

Progress in tackling malnutrition has been slow, but one factor stands out as particularly important. There is a clear link between gender inequality and hunger. Where women lack equal status with men, they also lack the resources to which men have access, and are thus locked into poverty. This link is well known, well documented and, in fairness, this is a large-scale problem and some improvements have taken place. Nevertheless, the fact remains that one half of the human race is indifferent to the suffering of the other half, which it sees as less human, less valuable, and less worthy of the most essential prerequisites for a decent life. Women still have to fight every step of the way for everything that men assume to be their sole right and use the iron grip of patriarchy to ensure that it continues to be so. International Women's Day is an annual reminder that there is still a long way to go before all women achieve full human status and enjoy the benefits that this brings.

In this issue

Turning to our own pages, we extend a welcome to our first issue of *Diversity and Equality in Health and Care* for 2012. Observant readers will have noticed the slight change in the title of our journal, which we feel reflects our commitment to providing an arena in which all aspects of diversity can be discussed and respected. In this context we welcome papers on a broad range of topics that includes migration, age, disability, culture, ethnicity, gender and gender orientation, race and ethnicity. Ideally, of course, we would hope that our authors can manage to examine the intersection of these, so that (for example) gender is seen as present even when discussing migration or disability, and so on. Other factors, both distinguishable and hidden, that may cause an individual to be labelled and stigmatised as *different*, are also within our remit. In particular, we are concerned about the ways in which difference affects the equitable pro-

vision of health and care and the ways in which those responsible for providing care can meet their needs. This issue is scheduled for publication in March, during which International Women's Day occurs, we have dedicated our editorial to reflect on the inequalities still experienced by millions of women and the impact of this on the health and well-being of both them and their children.

Our title is not the only change we have planned. Although we have always encouraged authors to consider the implications of their research, and we have highlighted the issues that practitioners face in our 'Practitioner's Blog' section, we now feel that this is the right time to move beyond this into supporting the continuing professional development (CPD) of our readers. Commitment to diversity and equality brings with it a requirement to act. We therefore begin this issue with Carol Baxter's guest editorial, in which she presents an approach to diversity and equality from the perspective of one of Europe's largest employers. On reading this it is clear that the pace of change is very rapid indeed, and those at the forefront of service provision have to undergo continuous updating to keep up with what is happening. This is not only the case as far as managerial changes are concerned, but is also true with regard to the continuing expansion of knowledge and technological development.

Following on from this we present our first feature. We have published a number of articles on diabetes among South Asians, that is, the group of people who originate from India, Pakistan, Bangladesh and Sri Lanka, so it seems fitting to launch our CPD feature with a paper on this topic. Neesha Patel and her colleagues examined standardised questionnaires in the assessment of health beliefs among South Asians. This paper contributes to a burgeoning literature about South Asian people who have diabetes, but it also serves a wider purpose as a reminder that assessment tools can be highly ethnocentric. Given current trends in migration, there is an urgent need for practitioners to be equipped with tools that are suited to the populations that they serve. This paper closes with some useful self-test questions to guide practitioners, and a page listing further resources for readers working with South Asians who have diabetes. We hope that, as this feature develops, it will provide an easily accessible resource for CPD across the field of diversity and equality practice.

Following on from this we move on to our other research papers, all of which focus on some aspect of difference that serves to exclude individuals from mainstream society. Onutobor Omu and Frances Reynolds present our first paper from Kuwait. Like other states in the region, Kuwait is coping with the consequences of a rapid rise in prosperity. Although this is no doubt to be welcomed, it nevertheless creates

a number of concerns which are only now beginning to receive attention from researchers. For example, dependence on an expatriate workforce to provide health-care inevitably highlights differences in culture and the diverse meanings of both *health* and *care*. These issues are examined here through the medium of stroke, a condition that can cause profound disability leading to social isolation, particularly if it is not managed correctly in the early stages. Rehabilitation is crucial if individuals are to regain control of their bodies but, as this paper shows, cultural factors must also be taken into account if quality of life is to be restored. It is not enough to help someone to regain control of their bodily functions. The society in which they live, their customs and values must also be taken into account, and the subtleties involved can be very difficult for outsiders to incorporate into a rehabilitation plan.

Our next research paper focuses on differences in sexual orientation, which, as we have noted elsewhere, tend to excite a great deal of prejudice. Humans seem to be obsessed with sexuality and how it should be expressed, as we have noted before (see, for example, McGee and Johnson, 2006). As with other forms of difference, the prejudiced gaze is exclusively concentrated on what it sees as undesirable. Thus, in this context, the gaze sees only sexual orientation, as though that is the sum total of the individual under scrutiny. There is no consideration of how that difference might relate to non-sexual aspects of living or the possible consequences. Catherine Meads and her colleagues raise pertinent questions about this in their exploration of the current state of knowledge about the relationships between lesbian, gay, bisexual and transgender (LGBT) orientations and factors such as social stratification, health and health inequalities. As they point out, we know very little about the health needs of LGBT people, and we know even less about whether they have unique talents and contributions to make to society. Only by challenging the prejudiced gaze will we ever find out.

Living with a long-term health condition provides the basis of another form of difference, especially when, like sexual orientation, the difference is not visible. Wheelchairs and white sticks immediately advertise the existence of difference and challenge the prejudiced gaze to make some form of adjustment in its expectations. However, hidden differences are more problematic. In our fourth paper, Sue Dyson and her colleagues reveal how young people with sickle cell disorder fare in schools. Schools are strange places. In developed countries, sending large numbers of children to school for much of each day only emerged as the norm when they were no longer wanted anywhere else and technological development created a demand for basic literacy and numeracy skills (Illich, 1971; Holt, 1990). What is now valued as education was not so high on the list of priorities and may not be as useful as many like to think. Even today, schools are

still based around the idea that students should be confined to a particular place, presided over by a small number of adults whose first task is to establish and maintain order rather than to impart knowledge or understanding.

Much depends on the ethos of each school and the attitudes of the adults concerned. Where teachers create an ethos based on respect, have an understanding of sickle cell and are committed to ensuring that all young people can achieve their potential, being different should be no big deal. Unfortunately, this does not happen as often as it should. The ways in which some teachers use their power to make life difficult make familiar and depressing reading irrespective of any particular condition, be it sickle cell, diabetes, epilepsy or asthma. Where the difference is overlaid by additional factors such as race and adolescence, it seems that schools still have a lot of work to do to ensure that young people with long-term health conditions are treated fairly.

Our final paper concerns difference on a much larger scale, in the state of Victoria. Australia has experienced considerable immigration, and remains a preferred destination for many migrants. Consequently, the population reflects a very diverse range of humanity. In Victoria, that diversity represents 150 countries, 180 languages and a sizable number of people for whom English is not a first language. The paper by Gurjeet Gill and Hurriyet Babacan demonstrates that although the Australian state has introduced a Charter of Healthcare Rights, making this work in practice requires organisational commitment, leadership and continuing professional development for staff. We hope that papers such as this will make a contribution to the effort required.

Finally, we plan to continue with our other features. The 'Practitioner's Blog' about cultural and linguistic obstacles in practice highlights the ways in which diversity and equality play out in the day-to-day arena of practice. 'Did you See?' continues to offer opportunities for new writers to critique an article published elsewhere that may be of interest to our readers. 'Knowledgeshare' presents a round-up of useful information about conferences, books and other resources or events. If you would like to contribute to any of these features, please contact the editor concerned.

REFERENCES

- Holt J (1990) *How Children Fail*, 2nd edn. London: Penguin.
- Illich I (1971) *Deschooling Society*. London: Calder and Boyars.
- McGee P and Johnson M (2006) Different, proud and well. *Diversity in Health and Social Care* 3(3):157–60.
- Save the Children (2011) *No Child Born to Die: closing the gaps*. London: Save the Children.
- Save the Children (2012) *A Life Free from Hunger*. London: Save the Children.
- United Nations Womenwatch (2012) *Facts and Figures: rural women and the Millennium Development Goals*. www.un.org/womenwatch/feature/ruralwomen/facts-figures.html
- Wangui E (2009) Livelihood strategies and nutritional status of grandparent caregivers of AIDS orphans in Nyando District, Kenya. *Qualitative Health Research* 19(12):1702–15.
- World Health Organization (2005) *Malnutrition: quantifying the health impact at national and local levels*. Geneva: World Health Organization.