Concept Note: GENDER EQUITY AND JUSTICE

Introduction

The aims of the Gender Equity and Justice thematic group in the Alliance for a Healthier World (AHW) are to: (1) describe and mitigate the impact of power, oppression and discrimination on health and well-being, with specific examples focused on reducing gender based violence, promoting empowerment, and creating equitable health systems, to advance sexual and reproductive rights and health across global settings; and (2) ignite JHU administration, faculty, and students to use our diverse expertise and capabilities to develop, implement and evaluate innovative initiatives to advance gender and health equity resulting in more peaceful and prosperous societies, and train the next generation of leaders.

Gender includes the “social roles, social status, culturally established patterns, stereotypes, behaviors and attributes thought to be appropriate and expected for the genders, men and women” (Jewkes, Flood, & Lang, 2015). A person’s gender identity is the way in which that person defines and acts on their gender. Majority and minority gender identities and gender expression are complex and influenced by a range of individual, interpersonal and community factors including biology, age, family beliefs and discourse, peer groups and social definitions. Dominant definitions of male gender include masculinity, which often expects men to protect women and families, to problem-solve and protect female and male honor, to be tough and strong, and to provide financially for the family. In the context of poverty, discrimination, and conflict for example, men endure traumatic experiences related to violence and loss and may face additional stresses related to their masculine gender identity. These stresses may be internal (e.g., self-judgment and stress related to inability to protect and provide for the family, the need to retain a role as family head) and external (e.g., social expectations or perception of masculinity). For women, gender identify includes the expectation that women maintain a household and care for children and other family members, and may be accompanied by societal limitations on rights and access to family and society resources. Thus, women may placate or acquiesce to male authority for safety and survival. Globally, gender and gender-based power disparities are primary drivers of health. Health equity is a multi-dimensional concept concerned with the attainment of good health, the opportunities and capabilities to achieve good health, and fairness of process, and is not simply a matter of equal distribution of health care. Gender is central to health equity, and both gender and health have been highlighted as key components in the advancement and sustainability of economic development and ultimately achieving the Global Sustainable Development Goals by 2030.

Framework for Gender Equity and Justice

To advance our aim of gender and health equity globally we are guided by Intersectionality or Intersectionality theory. Intersectionality refers to the overlapping or intersecting social identities and related systems of power, oppression and discrimination in our global society. This theory allows us to examine the various biological, social and cultural categories, such
as sex, age, gender and gender identity, race/ethnicity, orientation, migration and caste/economic status, that interact on multiple and often simultaneous levels (individual, family, community, institutions and society) to limit gender and health equity. Intersectionality holds that the classical concepts of oppression and discrimination within society – such as sexism, classism, racism, and homophobia do not act independently of each other. Instead, these forms of oppression are interrelated, creating a powerful system of oppression that reflects the intersection of multiple forms of discrimination leading to gender and health inequity (Crenshaw, 1989; Hankivsky et al., 2014)

Priorities in Gender and Health Equality

1. Women’s Empowerment and Prevention of Gender Based Violence (GBV).

Background

Ensuring health across the lifespan and achieving gender equity are central to the Sustainable Development Goals (SDGs). The SDGs recognize the intersecting structural and underlying factors (e.g., poverty, access to education, social and gender norms, property and legal entitlements) that limit sustainable development globally. Women’s empowerment and equality shapes health, particularly reproductive health. Efforts that limit access to family planning and safe abortions highlight the work remaining in women’s empowerment and decision-making, and it’s cascade impact on health for families and communities (Varkey, Mbbs, Kureshi, & Lesnick, 2010). Intimate partner violence (IPV), the most pervasive form of violence against women (VAW), reflects the acceptance of restrictive gender and social norms, and is thus a critical metric of women’s empowerment. Globally, an estimated 1 in 3 women experience violence by a husband/intimate partner in their lifetime, while men are more likely to be assaulted by a stranger or acquaintance than a wife or intimate partner (WHO, 2005). The multiple consequences of GBV are both immediate and long lasting with negative health (e.g. injuries, STI/HIV, depression, chronic pain), economic (e.g. loss of employment, insecure housing) and social (e.g. isolation, stigma) outcomes for the woman, her children, family and community (Campbell, 2002). The victims of GBV are not limited to women alone; modern GBV definitions clarify violence perpetrated based on sex, gender identity, or perceived adherence to socially defined gender norms, and are inclusive of populations who are high risk, marginalized, and even criminalized, such as men who have sex with men (MSM) (USAID and Department of State, 2012).

Gender-based violence reflects gender-based power disparities perpetuated by social, economic and political forces. Risk factors for women’s experience of GBV occur at multiple levels across the lifespan and in many cases include male dominance and control in household and community decision-making, frequent marital conflict, poverty, trauma (e.g. conflict related violence, migration, displacement), heavy alcohol consumption, norms that condone violence to maintain male authority and control women’s behavior (Fleming et al., 2015a; Fleming et al., 2015b; Heise & Kotsadam, 2015; Heise, 1998). Community factors including social norms related to masculinity (e.g., honor, toughness, providing for and protecting the family) and gender inequalities (e.g. limited access to education, health care, property, employment and forced/early marriage) contribute to a social environment that
permits, tolerates, and thus perpetuates GBV (Fleming et al., 2015b; Heise & Kotsadam, 2015).

As noted by Intersectionality theory, these factors interact at multiple levels (individual, family, community, society) to increase or decrease women’s risk for GBV and men’s perpetration of GBV. For example, men may feel societal pressure to use violence in their intimate relationships to reinforce their authority and discipline their female partner. Importantly, when children are exposed to violence, either direct experience or witnessing violence, in the home and/or community, they are at increased risk for future violence perpetration and victimization. For marginalized and criminalized groups such as people who inject drugs (PWID) and female sex workers (FSWs), additional layers of vulnerability such as social isolation and stigma can accumulate to produce risk for violence, and undermine access to justice. These intersections highlight the remaining needs for violence prevention and empowerment that address multiple interactive structural determinants. So too, significant work remains in community engagement and community-partnered endeavors to create sustainable change.

Hopkins brings expertise, experience and innovative approaches to catalyze the next generation of interventions to transform harmful gender and social norms to norms that uphold equity. Creating safer households and communities for women and families, by developing, implementing and evaluating interventions at scale remains a significant priority for women’s empowerment and gender equality globally and holds the promise of improving health at a population level. Our leadership in community-level interventions to transform harmful norms may include:

1. Use of multidisciplinary teams and global partnerships and collaboration to develop a non-coercive and respectful approach to generate and support individual (men, women and children) and community questioning of existing norms, and awareness of alternative norms and practices, with a primary focus on the fulfillment of safety and health through gender equity.
2. Generation of awareness on the part of individuals, community members, service providers and leaders of the multiple harms to health caused by gender inequity and gender based violence (GBV), including giving individuals and communities space to create new norms.
3. Facilitation of values deliberations and dialogues within households and communities, including the destabilization of the existing “norm”.
4. Promotion of collective community actions and public commitments to change norms and practices.
5. Ensuring visibility of community actions and application of supportive services in the community, such as livelihood programs, accessible educational and health care programs, equity in inheritance and property rights, and intolerance for forced/early marriage.
6. Utilization of a process of organized diffusion and translation of research to practice to ensure that the lessons learned and positive actions taken by community members and leaders to advance gender and health equity spreads rapidly from one individual to another and then one community to another, and is sustained.
7. Maintenance of a community environment that enables and supports changes in gender and social norms.

2. Gender-Equitable Health Systems

Background

In both global and domestic settings, health systems are a key interface for women, men and children. Health systems are also a significant source of employment as well as health services, and are typically respected social institutions in a community. Therefore, health systems have both the opportunity and responsibility to take leadership in addressing and changing intersecting structural factors that maintain restrictive and harmful gender and social norms for improved health within communities. Health systems both reflect and shape their context and they are often gender blind in that by definition they ignore the differential needs for women and men. Although, health systems often provide employment for women in the community, thus reducing unemployment and increasing productivity, and resulting in greater economic growth, and improved health and stability for the family. A focus on health systems has also increased attention on overrepresentation of women in marginalized service delivery roles such as community health workers, and the need for training and growth in professional careers, such as vocational nursing to professional nursing/physicians (Percival et al., 2014). Simultaneously, there is a need to not compromise women’s household roles and responsibilities, particularly in societies where women have multiple responsibilities to family and community outside the workplace. Investing in health system employment and growth opportunities for women, therefore offers the potential for a triple return for economies, health and women.

Despite the needs, this field is in its infancy. A consistent definition of gender equitable health systems is lacking, and there is limited guidance from health systems literature and leaders in the field on building or rebuilding systems that respond to gender equity, especially those in post-conflict settings. Gender responsiveness in health systems is limited to addressing sexual violence and maternal and child health (Stockholm International Peace Research Institute, 2014). In conflict-affected settings, there is limited health system focus on gendered needs such as psychosocial support and caregiving for disabled or ill family and community members, as well as family planning and safe abortion (Hill et al., 2013). There is also limited emphasis by health systems on collaboration with other sectors (education, legal, economic development) to build gender equity in society.

Hopkins is uniquely positioned to advance gender-equitable health systems globally. Opportunities include leadership in collaboration to define and support the development, sustainability, and cost-effectiveness of gender equitable health systems, especially in settings where systems are being expanded or rebuilt post humanitarian crisis. Recommended components for gender equitable health systems include (Percival et al., 2014):

1. Health care services that provide quality care and address the priority health care needs of women and men across the life span;
2. Women and men of all ages are able to access and utilize services unimpeded by social, geographic and financial barriers;
3. The system collects relevant, sex disaggregated health information that informs policy and clinical practices;
4. Ensures equitable health outcomes among women and men, and across age groups;
5. Provides equal opportunities and pay for female and male health professionals working within the health system; and
6. Supports women’s full and effective participation and equal opportunities for advancement and leadership at all levels of decision-making.

3. Gender Equity and Justice in Humanitarian Settings

Background

The intersectionality of oppression, power and discrimination and the negative impact on gender and health equity is uniquely evident in humanitarian settings. The displaced population globally continues to grow in parallel with the size of the population displaced by conflict, which is presently estimated at 59.5 million forcibly displaced worldwide, which is the highest levels recorded since the end of World War II (UNHCR, 2015), often resulting in increased vulnerability of women and children who are forced to seek shelter from the conflict or crisis in camps and settlements. Record numbers of displacement were reported in 2013 and 2014 and it appears that 2015 reports will continue with the pattern of increases in the size of population displaced by conflict (UNHCR, 2014). Much of the displacement has been driven by the continued violent conflicts in Afghanistan, Democratic Republic of Congo, Iraq, and Syria among others (UNHCR, 2016). A recent commentary in The Lancet discusses the issue of vulnerability for women and girls, specifically highlighting violence against Syrian female refugees, and cites a catastrophic trend of using sexual violence by armed combatants as a tactic of war, a strategy to humiliate men for not being able to protect their families, create fear and displacement to abandon land/territory and breaking down the family and community support structure when a women/girl is pregnant with a combatant’s child (Parker, 2015). This is not a new issue, GBV and particularly sexual violence have long been understood to be a direct consequence of armed conflict (UNSG, 2006; UNSC, 2009). The impact among refugee and displaced populations varies by region and context, but may include increased risk of HIV and other sexually transmitted infections (STIs), unplanned and unwanted pregnancies as indicated by studies in DR Congo; depression, suicidality, and post-traumatic stress disorder documented throughout Sub-Saharan Africa; as well as short-and long term economic and social sequelae such as extreme poverty, stigma and isolation for individuals, families and communities documented in a variety of geographic locations globally (John-Langba, 2007; Kim et al., 2009; Lehmann, 2002; Sideris, 2003; Spiegel et al., 2007).

Hopkins is a global leader with significant expertise and experience in collaboratively developing, implementing and evaluating innovative programs with refugee and displaced populations. The Hopkins Center for Humanitarian Health is an interdisciplinary group of faculty, staff and students with expertise in advancing innovative economic, gender equity, justice, protection, and health programs in multiple humanitarian settings. The Center is currently working to collaboratively implement gender equity and justice programming with
global partners including UNHCR. For example, implementing and evaluating UNHCR’s guidelines for Prevention and Response in Humanitarian settings are as follows (UNHCR, 2003)

1. Transforming socio-cultural norms, with an emphasis on strengthening leadership of women and girls in designing health, livelihood, education and protection services and security protocols in refugee and displaced persons settlements,
2. Rebuilding family and community structures and support systems to reduce vulnerability and marginalization,
3. Creating conditions to improve accountability systems, including accountability of humanitarian actors and peacekeepers as well as others charged to provide equitable services and security,
4. Designing effective health services and facilities in collaboration with refugee and displaced persons settlement leaders and members that prioritize women and girls equal engagement in decision-making on types of services and safe locations of facilities,
5. Working with formal and traditional health systems to integrate victims voices in addressing confidentiality, services, and safety in refugee and displaced persons settlements,
6. Engaging women and children in peace building and conflict resolution training and efforts at multiple levels; local, regional, national and globally,
7. Prioritizing gender equitable schools and other activities for children to demonstrate the importance of respect and collaboration between girls and boys,
8. Assessment, monitoring, and documentation of diverse forms of violence (e.g. forced sex, early marriage, sex in exchange for safety/protection or food/housing) and health priorities for women, men and children, including mental health, reproductive health, family planning, communicable and non-communicable diseases.

Diverse global guidelines as well as those proposed by UNHCR are recommending involving men as a key strategy for transforming socio-cultural norms and highlight the importance of equal participation by women, men, girls, and boys in planning, implementing, monitoring, and evaluating prevention and response programs. Over the last decade, there has been increasing attention to the fact that men’s roles and relationships to human rights violations in conflict and post-conflict situations include that of perpetrators, victims, witnesses and agents of change, and that male engagement is an essential component of prevention and response programming in humanitarian settings (Barker et al., 2007).
REFERENCES


### Table 1: Gender and Health Equity Research Areas

<table>
<thead>
<tr>
<th>Candidate research theme</th>
<th>JHU faculty or research groups</th>
<th>Potential funders</th>
<th>Advantages of focus on this research theme</th>
<th>Disadvantages of focus on this research theme</th>
<th>Relation to 4 sub-initiatives</th>
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</thead>
<tbody>
<tr>
<td><strong>1.  Women’s Empowerment and Prevention of Gender Based Violence (GBV)</strong></td>
<td>Multidisciplinary (nursing, public health, medicine, behavioral economics, business sociology, human rights, anthropology, psychology, peace building, innovative technologies)</td>
<td>Gates, Global Foundations, USAID, DFID, NIH, CDC, UN Agencies</td>
<td>innovation brings together existing ongoing research and new collaborations across the university to challenge and change existing harmful gender and social norms.</td>
<td>Limited existing rigorous research on empowerment and prevention models in GBV, potential for unintended consequences for women and girls.</td>
<td>#1 Food security #2 Gender Equity #3 Healthy Environments #4 Transformative technologies</td>
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<tr>
<td><strong>2.  Gender-Equitable Health Systems</strong></td>
<td>Multidisciplinary (nursing, public health, medicine, finance/business, sociology, human rights, anthropology, psychology, peace building)</td>
<td>Gates, Global Foundations, USAID, DFID, NIH, CDC, UN Agencies</td>
<td>Innovation brings together existing ongoing research and new collaborations across the university to define gender equitable health systems and establish guidelines/protocols to support responsive health systems</td>
<td>Limited existing evidence to build on and few global collaborations, however, an essential component of rebuilding and strengthening health systems in low-resource and humanitarian settings</td>
<td>#1 Food security #2 Gender Equity #4 Transformative technologies</td>
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<td>3. Gender and Health Equity in Humanitarian Settings</td>
<td>Multidisciplinary (nursing, public health, medicine, behavioral economics, business sociology, human rights, global diplomacy, engineering, anthropology, psychology, peace building, innovative technologies)</td>
<td>Gates Global Foundations USAID DFID NIH CDC UN Agencies</td>
<td>Reinforcing and advance JHU leadership in multidisciplinary research and collaborations with global organizations to support refugee and displaced persons safety, security and health in humanitarian settings. Critical role of engaging men and boys in prevention and response to GBV globally</td>
<td>Limited existing evidence in successful strategies to engage men and boys and few global collaborations, however, an essential component of GBV prevention and response globally and in humanitarian settings</td>
<td>#1 Food Security #2 Gender Equity #3 Healthy Environments #4 Transformative technologies</td>
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