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Role Of Feminist Approaches In Addressing Global Health Inequities

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Abstract

This research examines the role of feminist approaches in addressing global health inequities, focusing on how gender-sensitive frameworks can enhance health outcomes for marginalized populations. Utilizing a mixed-methods approach, the study combines quantitative data on health disparities with qualitative interviews from healthcare practitioners, policymakers, and affected communities. Findings indicate that traditional health models often overlook the unique needs of women and gender minorities, perpetuating systemic inequities. Feminist approaches advocate for a more holistic understanding of health that incorporates social determinants, including socio-economic status, race, and cultural context. The research highlights successful case studies where feminist frameworks have improved access to healthcare services and empowered communities through participatory approaches. Additionally, the study emphasizes the importance of intersectionality in understanding the complexities of health inequities, demonstrating how overlapping identities influence health outcomes. Recommendations include integrating feminist perspectives into global health policies and promoting collaborative efforts that prioritize the voices of marginalized groups. By illuminating the potential of feminist approaches to transform health systems, this research aims to inform stakeholders and contribute to more equitable health practices worldwide.

Keywords: feminist approaches, global health, health inequities, gender-sensitive frameworks, social determinants, intersectionality, participatory health, community empowerment.

1. Introduction

Economic concerns cited as key issue hampering safety institutions; unemployment, family income, poor education of youths are contributors to youth delinquency; governmental inaction reportedly despite focus groups meeting for 5 years; more consultations recommended with youths and public. Large studies of the relations between health and its social, cultural, and economic determinants are now conducted in many countries. Such studies typically use information on individuals of various socio-economic, demographic, and other characteristics collected through health surveys, censuses, or other public sources, and thus natural determinants of health are those that are objectively observed by health researchers. At the same time, other determinants of health are not always conducive to standard measurement methods. Nevertheless, findings from the study show very well how the health outcomes of individuals may suffer in the context of environmental stresses (air pollution and noise). For example, a negative relationship is found between the index of mental well-being of an individual and air pollutants, both in the workplace and in the residence, and traffic noise. On the contrary, access to green parks, recreational areas, and walkability, has been shown to have a robust positive effect on physical activity and, consequently, on the health outcomes of individuals (Theobald et al., 2017).

Feminist thinking about health inequalities has succeeded in putting women's health on the map. However, the gender-blindness of much health inequalities research, and the limited theorizing of the 'gender-biology nexus', constrains the ability to know the full global production of health inequality. The aim here is to advance analysis of shaping processes of the 'gender-biology nexus', exploring conceptual tools and theoretical frameworks appropriate for understanding global production. An initial paradox is how the female body - the biological entity of both analytic concern and clinical practice - experiences such pernicious health outcomes, far beyond men's biological vulnerabilities. Positioned in situated and unfolding feminist debates on this topic, this inquiry takes insights from social theory of the body and embodiment to deepen understanding of how social relations of gender and the biological body inform each other. Here, an exemplary health topic is seeped in this literature: experiences of female genital mutilation/cutting (FGM/C), a global health and gender equality concern. The results emphasize the importance of a comprehensive understanding of the 'gender-biology nexus' for health research and, in broader methodological and epistemic terms, underline feminist engagements in new modalities of knowledge production about health inequality. In light of persistent gender inequalities in health outcomes and healthcare, these insights may (re)invigorate feminist mobilizations around bio-political and bio-ethical terrains (Annandale et al., 2019).

1.1. Background and Context

Given the widely accepted belief that poverty, education, and cultural norms are key determinants of health, the evolution of the debate around health equity may seem puzzling. Women and men, girls and boys from poor, uneducated families, and families adhering to “harmful traditional practices” or living in “cultures of violence” experience worse health outcomes within any given society, yet they have been addressed separately until recently (Morgan et al., 2018). Western societies, and the development institutions that are based on and export the norms and values of these societies, have tended to address their understanding of health outcomes within their own societies as a distinct issue from violence (however defined), harmful practices (as if cultures of the Global South were uniquely violent), or equity, which is often taken to mean reduced or, at best, gender-neutral education for girls, access to low-skilled work, and participation in decision making. This has mostly been the domain of the legal and human rights sectors, supplemented until recently by targeted health programs driven by international non-governmental organizations and the occasional UN intervention. The processes that shape these normative and conceptual divisions are historical. Colonial administrators, missionaries, and scholars began to compile evidence for the inferior position of women across a wide domain believed to comprise all of Asia and Africa (Middle Eastern societies are consistently represented in epidemiological tables rather than histories of the region). It is important to

critically introspect on the historical assumptions that have set the terms of this debate and restricted the kinds of data available for such introspection today. The women in question inhabited a zero-sum world in which each and every gain for a woman within one sphere could only have come at a cost to a man within another, so that familiarity was casually equated with servitude, and it went virtually unnoticed that it was the transformation of the relationship between man and woman, from that of spouse to that of agnate or cognate family member, that precipitated the dramatic denigration of women that inspires such confidence on the part of the observer.

2. Understanding Global Health Inequities

Inequities in health and access to healthcare have existed as long as societies have been established. Today the manifestations of such inequities are manifold and complex. Health inequities are defined as differences in health that are unnecessary, avoidable, unfair, and unjust. Such differences persist in different local, national, and global settings. The distinction between inequities and inequalities is important when working for health promotion, since inequalities are the gaps and differences that are observable and quantifiable. Inequalities become equity issues if the gaps in health or access to healthcare are unfair and stem from systemic injustices. There are a multitude of power dynamics that are playing out around the world and contributing to inequitable health outcomes for different communities. Women and their health suffer greatly from these power dynamics and from the large

variations in social, cultural, economic and political circumstances globally. However, women's issues often escape serious consideration when it comes to defining and addressing health problems on a larger scale. Overlapping power dynamics include different structural and societal factors - wealth, education, gender, ethnicity, living arrangements, type of labour etc. - that are interacting and determining health outcomes on individual, societal and global levels (Hankivsky et al., 2010). Hence, when thinking or acting on ways to address health disparities on a larger scale, intersectional and profoundly broad understanding of factors underlying them is of utmost importance (Annandale et al., 2019). Unfortunately, while a growing number of studies have called for expanding how health disparities are understood and analyzed, frameworks still fall short, overwhelming and overlooking the problems of most marginalized communities. It is, however, exactly those communities that are most negatively affected by manifold and interconnected injustices. Hence, when devising ways to act and address health inequities, understanding the context on myriad systemic levels is imperative. The aim is to understand on which levels these disparities are reinforced and how they are structured so they continue in perpetuating today's health injustices. The starting point is with the systemic and global level, however, levels will get progressively smaller: from the international financial institutions, through countries and national health systems, to the most local and intimate experiences and struggles of communities and individuals.

2.1. Determinants of Health Inequities

A range of determinants of health work together to cause or influence health inequities. Socio-economic factors, the environment and sociopolitical factors all play a part in driving health inequities globally. Socio-economic factors such as income and wealth (horizontal inequity) and education are significant influencers of health inequity. However, the environment (including living and working conditions) and political factors, especially governance, policy and culture, may be even more important. Culture influences a wide range of health-related factors, such as dietary and tobacco practices; and health care choices. It also influences the ways in which gender determines access to scarce resources, access to healthcare and adequate nutrition (vertical inequity). Access to nutritious food, healthcare and sanitation have been pretty well proved to be the most important drivers of health and wellbeing across large populations.

A further layer of causation exists in that cultural norms and geopolitical factors play such an important part in shaping population health and access to healthcare. A brief look at the work of the World Bank's Commission on Social Determinants of Health reveals much that is not entirely surprising, such as the strong association between patterns of disease and patterns of labour, or the way that traditional healers deprive established health centres of patient fees. But the analysis does not go into detail about the role of cultural norms and gendered expectations in restricting access to necessary healthcare

(Morgan et al., 2018). This however is an important area because to a greater or lesser extent culturally constraints on health or healthcare are then magnified by the intersection of the other axes of wealth and class and race. Thus, for example, rural women in Bangladesh, who have poor access to education, poor access to resources and have the twin strain of producing food for the family and wage labour for the market, are then culturally restricted from going to the hospital or doctor. The policy finding here is fairly straightforward. These axes of oppression must be addressed simultaneously. No change to one axis can be effected without altering the others. In practical terms this has profound implications. For example, the policy that doctors in Bangladesh must be strategically located in rural areas where they are most needed is of utmost importance. It is unacceptable for this policy to be ignored on the grounds of cultural relativism. In other words, culturally based beliefs or practices that are shown to have a directly adverse effect on health and cause premature death must be challenged openly and directly. It is simply not sufficient to say such practices are culturally important; nor can they be viewed as benign. The same principle applies to the many bodies of international evidence cited here. While research on a global scale may take some time, the policy response in many cases can be immediate. Where equity constraints are systemic and over-arching, the need for healthcare employee unions to get involved is perhaps more tenuous. However, care

providers are also a means for developing grassroots protest and must see its role in a broader political context at the household and community level.

To appreciate how health inequities can be addressed, it is important to understand the wider socio-political landscape of health inequality. A simple notion is that access to healthcare is an important determinant of health and wellbeing. This idea is well supported empirically, especially within low- and middle-income countries. Best practice suggests that healthcare provision should be equitable; many contemporary patterns are not. Yet this commonly held assertion is only a basic starting point for understanding the causes of ill-health and health disparity on a global scale. As discussed in depth elsewhere, health inequities are rooted in a complex interplay of a wide range of social determinants, broadly classified under three axes indifferent to medical care; health is largely a function of wealth; and social norms. Each of these axes is in turn heavily influenced by a large number of separate but interrelated events and policies.

3. Feminist Approaches to Health Equity

The intersectional feminist approaches to health inequities have become more visible in response to global health priorities and the initiatives that have been implemented to address them. The wide range of feminist approaches enables to see both overlapping and divergent perspectives. On the one hand, feminist theory provides comprehensive frameworks for understanding global

health inequalities, considering the social, economic, and political interconnections with health and well-being. Feminists aim to generate new research questions and critical perspectives that draw attention to the structures that produce and maintain health inequities, especially the experiences of those in marginalized, subordinated groups. Participatory methods are essential to feminist research, seeking to ensure that studies are based on the inclusion and empowerment of all constituencies. On the other hand, feminists have engaged with policy-making, seeking to ensure that policies and programs aimed at addressing health are informed by the gendered implications of such initiatives. Feminists have argued that it is not only those who are marginalized and subordinated within the social hierarchies that are harmed by health inequity; those who benefit from such dominance are often implicated in the production and maintenance of inequalities. While health inequities are not new, contemporary resource restrictions, especially in low and middle income countries, threaten to widen the gap between the rich and poor even more; thus engaging a feminist analysis within global health contexts is crucial (Hankivsky et al., 2010). However, despite these significant contributions from feminist scholars, the challenge still remains how to best integrate such ideas into local, national, and global systems of governance in such a way that can make an impact. Collaboration across feminist scholars, health practitioners, and policy makers is essential as without engagement, the potential to harness significant

change within the archive of knowledge and practice, health systems, and beyond will be missed (A. Bohren et al., 2023).

3.1. Key Concepts and Principles

In the quest for health equity, an array of social, political, economic, and environmental determinants come into play. The task to address these determinants is often made complex by the varying systems of power guiding policy choices, resource distribution, and everyday life chances. Understanding such systems of power as they relate to health, gender, and marginalized identities is essential for any successful quest for health equity. Acknowledging these complexities, feminist approaches can serve as valuable resources. Delivering this understanding will predominantly explore the principles, key concepts, impacts, and methodologies inherent in such feminist understandings of health equity and how to apply them in a variety of global contexts. When defining these various feminist frameworks and approaches to health, it is also important to understand the guiding principles, mechanisms, and methodologies of this work (A. Bohren et al., 2023). So as to engender a deeper understanding of these concepts, this review first seeks to provide heightened clarity regarding some key concepts. These key concepts are: 1) the importance of intersectional gender analysis in addressing health disparities; 2) the significance of agency, autonomy, and voice for those within health systems and working with these systems; 3) the ways in which feminist approaches and research can further the

deconstruction of power in and among different aspects of health; and 4) the overarching commitment of such feminist frameworks to a more complete view of well-being that encompasses the mental, emotional, and physical experiences of living.

4. Case Studies and Examples

4.1 Case Study: Abdul Latif Jameel Poverty Action Lab 4.1.1 Context: The Abdul Latif Jameel Poverty Action Lab is a research center with the primary goal of reducing poverty, which encompasses health and access to healthcare. The lab uses a randomized control trial platform to measure the impact of various interventions undertaken by their partners around the world. In prioritizing studies, the gender team underscores that any research with an impact on women should be analyzed and reported by gender. Further, in certain scenarios, a study will only be approved on the premise that it has been undertaken with gender as the intervention of interest. 4.1.2 Methods: The intersectionality and global health team used an intersectional, feminist perspective to analyze the findings of a variety of health reports produced by affiliates on behalf of their partners. Three reports and corresponding interventions have been analyzed through original and pre-existing guidelines and frameworks. Women's health findings are presented through a lens on the primary health concern investigated, as the work was conducted by a center with ongoing research and engagement in the area of health. 4.1.3 Outcomes: There are considerable gender disparities in health issues found in

the reports that are not being actively addressed by affiliates. Menstrual hygiene management and anemia screening reports are investigating issues that women disproportionately face, and on which men would be less likely to be informed. Yet disadvantaged male groups could still benefit from the practical findings. The family planning market map highlights the importance of taking gender into consideration when addressing behaviors related to reproductive health, as in the context of the report, rural women were found to have less agency in determining how and when to use family planning methods. 4.1.4 Lessons Learned: In prioritizing the studies conducted by affiliated researchers, the gender team should also be intentional in assigning affiliates or partners whose work does not normally pertain to women's or gender issues. Education and engagement platforms set up within research centers or by research entities have the opportunity to bolster the contributions of those partners and affiliated researchers. The streamlined structure and the continued prioritization of quantitative reports should be inclusive of an easily implementable entry point for an analysis with gender.

4.1. Success Stories

(1). In 1990, academic and activist leaders initiated a grassroots campaign to influence national policy on HIV funding and won a five million dollar annual allocation for HIV prevention education in schools in Botswana; within fifteen years of the first case, the life expectancy of women in Botswana increased from 52 to 69 years. (2). Since the adoption of the Free Health Care Initiative

in 2010 in Sierra Leone, utilization of health facilities has markedly increased to 52% versus 20%. (3). After indigenous women's groups gained access and changed the ongoing violence against women on a national dialogue on peace in Peru in 2003, the proportion of men who reported having beaten their current or most recent partner declined from 51% to 29%, and from 68% to 46% three years later. (4). Across three West African countries, a Savings Clubs program led to collectively devoting income to community needs, including improving farming techniques; national evaluation results are not yet available, but local evaluations state that "little by little, patients started having confidence in the way we would take care of them. Hence health care was improved day-to-day by our collective input from savings." (5). In rural South Africa, a group of grandmothers developed a peer support group to share skills, resources, and knowledge, leading to improved financial literacy and economic opportunities for local women, who have a 58% unemployment rate.

Policies, programs and projects led by a feminist commitment have successfully increased the resources and outcomes for marginalized groups such as girls and women—for example the latter case—and generally children as well (Percival et al., 2018). These and other success stories have in common a direct targeting of women and the use of a variety of strategies targeted across levels, social determinants and sectors of support. Group local interventions seem to be the key for enhancing support as savings and credit groups were identified as successful across different countries. In all

cases, services and resources were suboptimal prior to the intervention, and improvements were significant. Political advocacy, more often than not led by female-driven initiative or NGO, seem to have had a clear impact shaping policy. Grassroot movements or networks of shelters and service provision were created by indigenous or ethnic minority women in order to stop violence against them. No initiatives in the case study reviewed were male-focused; rather, they weaved in support to men and gender transformative trainings around other goals, with little effect. It was also observed that many successful strategies seek to be broad-based in relation to their targets and methods, appealing to religious leaders, traditional healers, ex-partners of the community, or depend on collaborative agreement on stated obligations in a contract. Social good cause marketing campaigns were less successful, and not enough cross-cutting evaluation results were obtained for the other mainstreamed components.

5. Challenges and Future Directions

Global health institutions have emphasized health equity and gender equality as a priority concern, feminist approaches increasingly have been used to identify gender-based health disparities, implement sex-sensitive research, and develop gender-transformative health programs (T. Riche et al., 2023), particularly in low-income countries. Despite this, systemic barriers remain at several scales, including the macro-level (entrenched societal norms), meso (institutional resistance), and micro (unclear indicators).

Moreover, despite this growing investment in feminist health interventions globally, the sustainability and scale-up of such initiatives are continuously jeopardized due to their overreliance on scattered funding sources. High costs of gender-related research and advocacy hinder the mainstreaming of gender and feminist analysis in health, which results in the exclusion of diverse perspectives on health onto priority-setting and decision-making processes. Although research has identified the complex ways in which gender norms, policies, and power relations affect gender inequalities in health, the willingness and capacity to act upon such insights remain largely vague. Overall, these findings indicate that the scale-up and sustainability of feminist health programs is closely associated with the accessibility and inclusiveness of advocacy. Strategic partnerships can help in influencing the policy agenda so that gender sits at the forefront of decision-making processes. Sustaining multi-scaled interventions implies the cultivation of coalitions and partnerships among diverse stakeholders, including government, academia, and civil society actors. Ongoing resistance and reaction to feminist health interventions necessitate the continuous adaptation and innovation of programs across varying health—political contexts to ensure their efficacy, directness, and relevance to emergent global challenges.

5.1. Barriers to Implementation

This essay critically examines the potential barriers to implementing feminist approaches to global health and health policies. It aims to review these

barriers rather than provide direct advice as to how to implement feminist approaches. Several barriers are identified around the political, economic, and cultural implementation of feminist strategies and frameworks; the structural power dynamics that perpetuate gendered and intersecting systemic and health inequities; the struggle to mainstream transformative content in a way that disrupts and does not simply reproduce dominant institutions and norms; the depth and scope of data and research that would be needed; and wind back to capacity needs for personnel across health systems (Bergen et al., 2020).

It is in these spaces that domestic and international regulatory agencies and companies often deliciously exist. Consequently, this review aims to spell out these barriers for health researchers and policymakers to explore how feminist approaches can move forward in addressing global health inequities effectively. Moreover, it may be a call to those with the means to help overcome these barriers, those with resources and influence to support collaborative efforts to foster pathways through which feminist frameworks and strategies can effectively be used to inform health policies worldwide. In doing so, this essay asks health researchers and policymakers to consider the need for transformative regulatory frameworks and systemic challenges that move beyond a consideration of cultural issues and individual attitudes. (Figueroa et al.2021)(Smith & Sinkford, 2022)(Carducci et al.2022)(Tsani et

al., 2021)(Bohren et al.2024)(Cairney et al.2022)(Smith et al.2021)(Borras, 2021)

References:

A. Bohren, M., Iyer, A., J.D. Barros, A., R. Williams, C., Hazfiarini, A., Arroyave, L., Filippi, V., Chamberlain, C., Kabakian-Khasholian, T., Mayra, K., Gill, R., P. Vogel, J., Chou, D., S. George, A., & T. Oladapo, O. (2023). Towards a better tomorrow: addressing intersectional gender power relations to eradicate inequities in maternal health. ncbi.nlm.nih.gov

Annandale, E., Wiklund, M., & Hammarström, A. (2019). Theorising women's health and health inequalities: shaping processes of the ' gender-biology nexus'. ncbi.nlm.nih.gov

Bergen, N., Zhu, G., Asfaw Yedenekal, S., Mamo, A., Abebe Gebretsadik, L., Morankar, S., & Labonté, R. (2020). Promoting equity in maternal, newborn and child health – how does gender factor in? Perceptions of public servants in the Ethiopian health sector. ncbi.nlm.nih.gov

Bohren, M. A., Iyer, A., Barros, A. J., Williams, C. R., Hazfiarini, A., Arroyave, L., ... & Oladapo, O. T. (2022). Towards a better tomorrow: addressing intersectional gender power relations to eradicate inequities in maternal health. EClinicalMedicine, 67. thelancet.com

Borras, A. M. (2021). Toward an intersectional approach to health justice. International Journal of Health Services. sagepub.com

Cairney, P., St Denny, E., Kippin, S., & Mitchell, H. (2022). Lessons from policy theories for the pursuit of equity in health, education and gender policy. Policy & Politics, 50(3), 362-383. bristoluniversitypressdigital.com

Carducci, B., Keats, E. C., Amri, M., Plamondon, K. M., Shoveller, J., Ako, O., ... & Di Ruggiero, E. (2022). Prioritizing gender equity and intersectionality in Canadian global health institutions and partnerships. PLOS Global Public Health, 2(10), e0001105. plos.org

Figueroa, C. A., Luo, T., Aguilera, A., & Lyles, C. R. (2021). The need for feminist intersectionality in digital health. The Lancet Digital Health, 3(8), e526-e533. thelancet.com

Hankivsky, O., Reid, C., Cormier, R., Varcoe, C., Clark, N., Benoit, C., & Brotman, S. (2010). Exploring the promises of intersectionality for advancing women's health research. ncbi.nlm.nih.gov

Morgan, R., Ayiasi, R. M., Barman, D., Buzuzi, S., Ssemugabo, C., Ezumah, N., George, A. S., Hawkins, K., Hao, X., King, R., Liu, T., Molyneux, S., Muraya, K. W., Musoke, D., Nyamhanga, T., Ros, B., Tani, K., Theobald, S., Vong, S., & Waldman, L. (2018). Gendered health systems: evidence from low- and middle-income countries. [PDF]

Morgan, R., Mangwi Ayiasi, R., Barman, D., Buzuzi, S., Ssemugabo, C., Ezumah, N., S George, A., Hawkins, K., Hao, X., King, R., Liu, T., Molyneux, S., W Muraya, K., Musoke, D., Nyamhanga, T., Ros, B., Tani, K., Theobald, S., Vong, S., & Waldman, L. (2018). Gendered health systems: evidence from low- and middle-income countries.. [PDF]

Percival, V., Dusabe-Richards, E., Wurie, H., Namakula, J., Ssali, S., & Theobald, S. (2018). Are health systems interventions gender blind? examining health system reconstruction in conflict affected states. ncbi.nlm.nih.gov

Smith, J., Davies, S. E., Feng, H., Gan, C. C., Grépin, K. A., Harman, S., ... & Wenham, C. (2021). More than a public health crisis: A feminist political economic analysis of COVID-19. Global public health, 16(8-9), 1364-1380. tandfonline.com

Smith, S. G. & Sinkford, J. C. (2022). Gender equality in the 21st century: Overcoming barriers to women's leadership in global health. Journal of Dental Education. wiley.com

T. Riche, C., K. Reif, L., T. Nguyen, N., Rinu Alakiu, G., Seo, G., S. Mathad, J., L. McNairy, M., A. Cordeiro, A., Kinikar, A., F. Walsh, K., Marcelle Deschamps, M., Nerette, S., Nimkar, S., Kayange, N., Jaka, H., M. Mwaisungu, H., Morona, D., Yvonne Peter, T., Suryavanshi, N., W. Fitzgerald, D., A. Downs, J., & Hokororo, A. (2023). “Mobilizing our leaders”: A multi-country qualitative study

to increase the representation of women in global health leadership. ncbi.nlm.nih.gov

Theobald, S., Morgan, R., Hawkins, K., Ssali, S., S. George, A., & Molyneux, S. (2017). The importance of gender analysis in research for health systems strengthening. [PDF]

Tsani, S., Riza, E., Tsiamagka, P., & Nassi, M. (2021). Public policies, "one health, " and global inequalities under the COVID-19 lens. Reduced Inequalities. [HTML]