

**MODULE** **3**

**THE ORIGIN OF  
HEALTH NEEDS**



## THE ORIGIN OF HEALTH NEEDS

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### OVERVIEW: MODULE THREE

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<b>Objective</b>	<ul style="list-style-type: none"> <li>● To understand how the interrelationship between biological, psychological and social factors generates specific health needs for women and men.</li> <li>● To undertake a gender analysis based on this understanding so that interventions respond equitably to the health care needs of both sexes.</li> </ul>
<b>Core Message</b>	To promote gender equity in health, it is important to identify specific health needs for each sex in order to respond to each.
<b>Expected Outcome</b>	The participants will be able to identify gender differences in health situations, conditions and problems.
<b>Methodology</b>	Lecturette Buzz Groups Small Group Work/Plenary Report Back Plenary Discussion
<b>Materials</b>	<p>OHT No. 3.a/b/c Circles: Biology of Men and Women; Gender Constructions; Needs in Health</p> <p>OHT No. 4: Equity and need</p> <p>OHT No. 5: Origin of Male and Female Differences in Health/Illness Profiles</p> <p>OHT No. 6: HIV/AIDS and Biological Characteristics</p> <p>Handout No. 11: Copy of OHT No. 3 a/b/c</p> <p>Handout No. 12: Origin of Male and Female Differences in Health Profiles</p> <p>Flipchart No. 12: Group Task</p>
<b>Components</b>	<p>3.1 Differences in Health/Illness Profiles Between Women and Men</p> <p>3.2 An Example of the Influence of Sex and Gender in the Health Profiles of Men and Women</p>
<b>Time</b>	<p>3.1 40 minutes</p> <p>3.2 30 minutes</p> <p>Total: 70 minutes</p>
<b>Preparation</b>	<ul style="list-style-type: none"> <li>■ Photocopy Handout No. 11-12</li> <li>■ Prepare Flipchart No. 12</li> </ul>

## DIFFERENCES IN HEALTH/ ILLNESS PROFILES OF WOMEN AND MEN

<b>Method:</b>	Lecturette Buzz Groups Plenary Discussion
<b>Materials:</b>	OHT No. 3.a/b/c: Interactions OHT No. 4: Equity and Need OHT No. 5: Origin of male and female differences in health Handout No. 11: Copy of OHT No. 3 a. b. c. Handout No. 12: Origin of Male/Female Differences
<b>Time:</b>	<u>40 minutes</u>
<b>Preparations:</b>	Photocopy Handout Nos. 11 and 12

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### PROCESS

- The facilitator opens the discussion by saying:  
We all know that there are differences between men and women with regard to their physical and mental health. However, traditionally, the health sciences, particularly the medical profession, have focused on what they considered to be strictly biological differences between the sexes.
- Facilitator presents OHT No. 3.a, with biological circle.  
Facilitator continues, placing OHT No. 3.b directly over OHT No. 3.a:

However, men and women also play different roles in different societies, and because of that they develop different skills and abilities. These roles, skills and abilities are valued differently, and it is usually those associated with masculine spheres that receive greater social recognition and are valued more highly than those associated with feminine spheres. This differential value has direct implications for the degree to which men and women have access to and control of resources. Collectively, these sexually assigned roles and responsibilities and the abilities, values and access to and control of resources that arise from them, give rise to gender inequities.

- Facilitator points to labels on the outside of the circle: (Culture/race/class)

It is important to note that these gender constructions are strongly influenced by culture, by socio-economic level and by age, and these all must be taken collectively into account when examining how gender influences health and health work.

- Facilitator places OHT No. 3.c directly over OHT No. 3.a and 3.b:

If men and women are biologically different and, in different cultures, socioeconomic groups and generations, are shaped by different gender constructions, then we can also assume that men and women have different needs in health which must be understood so as to respond in an equitable and efficient manner to them.

- Facilitator distributes copies of Handout No. 11 (copy of OHT No. 3 a, b, c). Points out that to attain equity in health it is necessary to identify and respond to different health situations, conditions and problems pertaining to each sex. Facilitator shows OHT No. 4, which defines equity and need.

*Text of OHT No. 4*

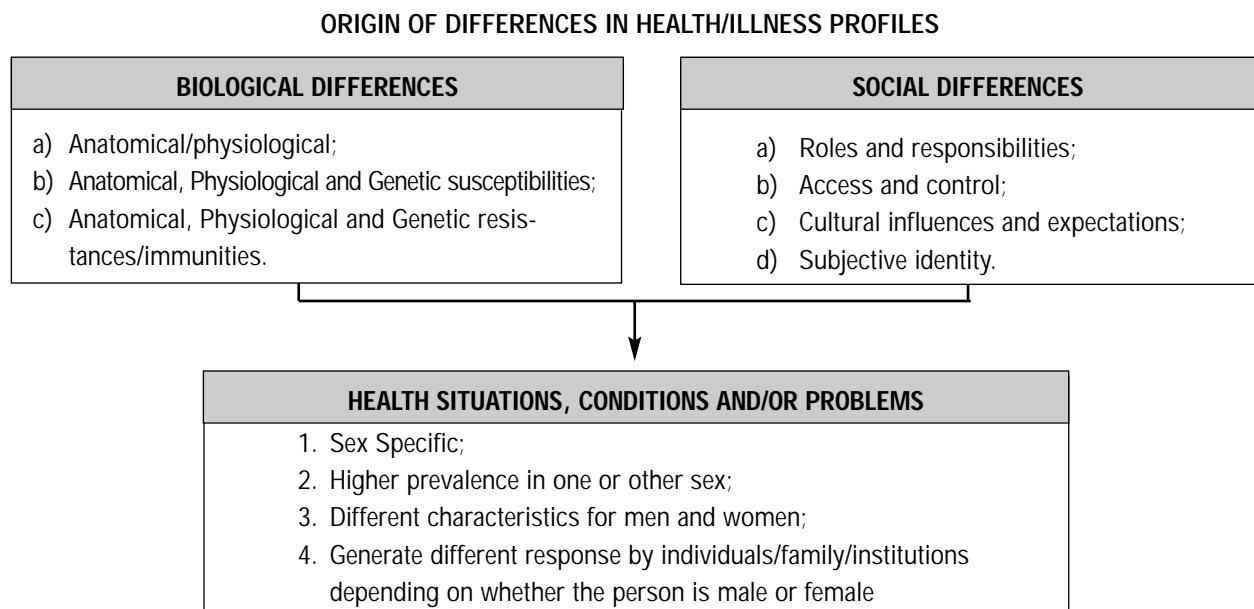
EQUITY AND NEED
<ul style="list-style-type: none"> <li>To attain equity in health, it is important to recognize that different groups have different needs that must be identified so as to adequately address them.</li> </ul>

The gender perspective enables greater equity in interventions in health and increases the effectiveness of these actions.

- The facilitator shows OHT No. 5: Origin of Male and Female Differences in Health Profiles, and notes that we can further understand the interaction of biological and social factors on health by examining specific health situations or problems.

Explains that this OHT shows the origin of the differences in health/ disease patterns between men and women.

*Text of OHT No. 5/Handout No.12*



- Covering the lower box of OHT No. 5, the facilitator displays the two charts in the upper part of the slide (biological and psycho/social differences), goes through them and explains:
  - Differences in health profiles between the sexes are based on an interaction between biological determinants and gender constructions.
- The facilitator then uncovers the lower box and asks participants for examples of these health situations/conditions/problems, and writes their contributions on a flipchart as they are called out.
- Facilitator adds any that are significant and missed by participants.

### SOME EXAMPLES:

#### i. Sex Specific: Situations, conditions or problems exclusive to each sex:

- ♀ Pregnancy (in adolescence); Cervical cancer; Menopause; Maternal mortality; Prolapse of the uterus; Abortion (which can have consequences such as anemia, infections of the reproductive tract, prolapse of the uterus and urinary incontinence).
- ♂ Prostate cancer; hemophilia

#### ii. Different Prevalence: Situations, conditions or problems with different rates of prevalence in men or in women:

- ♀ Anemia due to iron deficiency, linked to women's loss of iron during menstruation, pregnancy and lactation and exacerbated by cultural practices that privilege men in intrahousehold distribution of iron-rich food; osteoporosis (8 times more in ♀ than in ♂), associated not only with biological factors but also with lifestyles; diabetes, hypertension and obesity, conditions which are more frequent in women than in men, and also in lower income groups; depression (two to three times more frequent in ♀ than in ♂ in all phases of life, related to personality types and experiences connected with types of socialization and differential opportunities for ♂ and ♀); sexual violence in childhood, adolescence and adulthood; excessive mortality due to cancer during adult age (associated less with the lethal nature of cancers in women than with limited access to medical technologies for early detection and treatment of cancers in their initial stages); varicose veins; urinary incontinence; arthritis; autoimmune disorders.
- ♀ Cirrhosis, associated with alcohol abuse; Schizophrenia; Lung cancer, associated with tobacco consumption; excessive mortality from violence, homicide and accidents (evident from the first year of life, associated with stereotyped masculine attitudes and behaviors such as aggression, risk-taking, excessive consumption of alcohol); Silicosis, associated with mining work; Hernias; Color-blindness

(20 times more in ♂ than in ♀); Coronary artery diseases which are biggest killers during years men are engaged in labor force; greater incidence of dyslexia, hyperactivity and stuttering.

**iii. Different Characteristics: Situations, conditions or problems which have different characteristics for men or for women:**

- Risk for shistosomiasis is greater for those women who come into more frequent contact with contaminated water, to wash clothes, for example;
- Sexually transmitted diseases (STDs) are "asymptomatic" for longer periods in women and have more severe consequences in women such as sterility and even death, in cases of pelvic inflammation;
- Nutritional deficiencies can cause maternal deaths in childbirth;
- Alcoholism and tobacco consumption have different health consequences for women, particularly during pregnancy;
- Sexual violence for women can cause unwanted pregnancy and STDs;
- Malaria during pregnancy is an important cause of maternal mortality, spontaneous abortion and stillbirths; particularly during pregnancy, malaria contributes significantly to the development of chronic anemia;
- Death with weapons (suicide or homicide) is more characteristic of men than of women;
- Women tend to be to a greater extent than men, victims of violent crimes perpetrated by intimate partners;
- In our societies, sexual "impotence" has more negative repercussions when it involves a man, than does sexual "frigidity" when it involves a woman. This is due to the great importance which is given to male sexual prowess which in many societies, is what defines "being a man." Being unable to perform sexually implies not being a "real man;"
- Lack of access to quality water supply affects women more than men because in many societies they are the main users of water and it is also they, and their children, who must fetch and carry water.

**NOTE:** In this section, one might also include sex differences in the perception of symptoms and in help-seeking behavior. In many societies, for example:

- ♂ only go to health services when an illness is in advanced stages;
- ♀ do not seek care from STD clinics because of social stigma that is associated with women that have an STD.

- Facilitator points out: The last category (iv) is clearly gender based, i.e., important structural barriers to access to the resources and benefits of the health system derive from the roles that men and women play in society and the relations that arise from the value assigned to these roles.

### iv. Responses by Individuals/Family/Institutions: Situations, conditions, or problems with different responses from the health sector in particular or society in general:

- Cardiovascular problems: the notion persists that these are typical men's diseases; as a result, symptoms are not recognized in women. Data indicate that cardiovascular diseases are one of the main causes of death, in some population groups the major causes of death, among women older than 49 years.
- Disfigurement for Leishmaniasis, schistosomiasis, leprosy, onchocerciasis generates greater rejection by society if the sufferer is female, given the connection between physical beauty and women's worth.
- Ratios of 1 to 300 for masculine/feminine sterilizations (despite the fact that vasectomy is a simpler, more economical and less invasive procedure than sterilization for women).
- Domestic violence toward woman is judged differently from public violence against strangers and there is a greater degree of social tolerance for violence towards women from their male partners than there is for other types of social violence. This tolerance is reflected in legislation on family violence in almost every country.
- The exclusion of women from clinical studies of pathologies affecting both sexes; consequently, therapies based on these studies may not be reliable for application to women, and may be hazardous for the female population. The consideration of the male body as the standard for clinical studies acts to limit the number of studies that focus on women's reproductive and non-reproductive health, and obfuscates the impact of certain medications or treatment at different stages of their life cycle.
- There has been low priority assigned to research of pathologies and treatments exclusively or primarily affecting women.
- Focus of family planning services on women have excluded men, with the result that men have limited access to such services. In addition, given the gender relations within a family, decisions about contraception need to include men, otherwise women can be prevented from using them by their partners/husbands.
- Differences by sex in the quality of care in health services: research in the United States of America, Canada, Australia, Sweden and some countries in Latin America shows that the quality of care received differs between men and women, and that this difference is inequitable for women (waiting time, over-medication, humiliating treatment).

- Facilitator asks participants to quickly form groups of three and undertake the following brief task:

**Buzz Group Task:** What situations/conditions/problems in the categories are influenced or affected by gender?

**Example:** Although maternal mortality results from women's biological capacity to give birth, the fact that women die in childbirth from preventable causes is clearly influenced by the value society in general and the health sector in particular places on women.

In processing the responses, the facilitator points out/sums up:

- Most of these, even though they are biologically specific to one sex or the other, and appear to be "gender neutral (to have no social or gender connotation) do so in terms of how and when they are reported and treated by the health system, and how persons presenting the symptoms of disease are treated by society.
- *It is important to begin the analysis from the perspective that all health issues have a gender base and challenge participants to look for what the gender implications are for each.*

**Plenary Group discussion:** Ask participants for examples of health conditions and lead a discussion to show the gender implications.

**Some additional examples:**

- a) The fact that diabetes is more prevalent among women is derived from biology. However, because of women's nurturing role they are more likely to ensure that diabetic men in their families are fed right. Research indicates that women who have diabetes are less likely to feel comfortable with providing themselves with special food and adequate medical attention.
  - b) School-aged boys may be overdiagnosed as hyperactive in comparison to their female counterparts because of developmental differences between the sexes and the way these differences are addressed by the school system.
- Facilitator emphasizes in summing up:
    - Differences and disadvantages in the field of the health are manifested not only in the way health and disease are distributed in a population but also in the way health is promoted, disease is prevented and controlled, patients are cared for, and in the models adopted for structuring health and social security systems.
    - Without fully appreciating the implications and impact of gender roles and relations, health practitioners will fail in their treatment of certain groups and individuals, and health planners will inadequately serve the total population.

## AN EXAMPLE OF THE INFLUENCE OF SEX AND GENDER IN THE HEALTH PROFILES OF MEN AND WOMEN

<b>Method:</b>	Lecturette Small Group Work/Report Back
<b>Materials:</b>	OHT No. 6 Flipchart No. 12: Group Task on HIV/AIDS
<b>Time:</b>	<u>30 minutes</u>
<b>Preparation:</b>	Prepare Flipchart No. 12

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### PROCESS

- The facilitator emphasizes the fact that bio-psycho-social differences in health profiles for men and women naturally lead to differences in their respective response needs to particular conditions, situations, or problems.
- The facilitator addresses the group and says:

Now that we have reviewed the differences in health profiles of men and women, for which sex disaggregated data is essential, let's look at how a gender perspective can anticipate the likelihood of a man or woman becoming ill and dying from a specific disease.

Example of HIV/AIDS:

- It is currently more prevalent among men. However, incidence of HIV is rising much more rapidly among women. Today, worldwide, women constitute 75 percent of the new cases of infection.

Why? Gender analysis help provide reasons for this. It can also provide us with guidelines for designing interventions that respond adequately to health needs that are specific to men and women.

There are:

- different risk factors for the sexes
- different degrees of severity of consequences
- different responses from women and men, the health sector in particular or society in general

- Facilitator shows OHT No. 6, which summarizes what will be presented below.

Text of OHT No. 6

HIV/AIDS: BIOLOGICAL CHARACTERISTICS
<p>Women More Vulnerable because:</p> <ul style="list-style-type: none"> <li>● Semen Highly Infectious</li> <li>● Vaginal Mucous Membrane More Vulnerable</li> <li>● Semen Remains in Vaginal Tract</li> <li>● Age Factor: ↑ under 18; ↑ after menopause</li> <li>● STD - HIV/AIDS link: ↑ Incidence for Women</li> </ul>

- Facilitator presents information on each factor, one by one. Asks participants to expand on each factor, correcting/expanding as needed.

RESPONSES:

Women are more vulnerable than men to HIV infection through heterosexual relations; studies show that women are two to four times more likely than men to be infected in this way. There are several explanations for this, including:

- *Semen Highly Infectious*: HIV needs live cells in order to be transmitted. The body fluids richest in cells are the most infectious. As a result, semen is more infectious because it has greater cellular content than vaginal fluids;
- *Vaginal Mucous Membrane More Vulnerable*: The epithelial quality of the vaginal mucous membrane is more vulnerable to infections than the penis;
- *Semen Remains in Vaginal Tract*: Semen remains in the vaginal or rectal tract for a longer period than do vaginal fluids on the penis; as a result, women's exposure time to the virus is greater in heterosexual relations;
- *Age Factor: ↑ under 18; ↑ After Menopause*: Age is an independent factor that increases susceptibility to HIV of women under 18 years and in the post-menopausal stage. This is because the vaginal mucous membrane in young women does not acquire a cellular density that acts as

an effective barrier until after 18 years of age; after menopause, the vaginal mucous membrane becomes thinner and weaker and is more vulnerable to HIV.

- *STD - HIV/AIDS link:* ↑ *Incidence for Women:* Women suffer more than men from sexually transmitted diseases which increases the risk of HIV infection through heterosexual relations. In many cases STDs are asymptomatic in women, which impedes early detection and timely treatment.

**Gender Perspective:** However, biology alone does not explain rapid rise in women. Although there are important biological differences between women and men with respect to susceptibility to HIV, these biological differences do not explain the fact that women now constitute 75 percent of the new cases of infection. We have to consider the interaction between psychosocial and biological factors: a gender perspective allows us to understand how women, in addition to their biological risk for HIV, are psychosocially at greater risk than men because of those gender constructions characteristic to many societies.

- **Small Group Work:** The facilitator divides participants into four (different) groups and displays flipchart with group task.

Flipchart No. 12:

TASK
<p>1) Identify situations in which SOCIAL GENDER CONSTRUCTS INCREASE THE RISK OF CONTRACTING HIV FOR ONE SEX OR THE OTHER.</p> <p>2) Include concrete experiences/observations of own societies/cultures/lives that provide evidence for 1).</p>

Possible responses:

- *Social tolerance of male promiscuity:* the deep-seated idea that men have more urgent sexual needs by "nature," means that women as a group, and society in general, find it "forgivable" for these needs to be fulfilled indiscriminately;
- *Social assignment of greater value to what is masculine and the positive social support for female passivity and self-denial:* women internalize from the time they are very young the idea that it is "natural" for the man to be "worth more" and thus women, less. In many cultures, the qualities of the ideal woman include resignation, passivity and dependence. The psychological construct of feminine sexuality inhibits many women from questioning men in any area and particularly in the area of sexuality;

- *Lack of open communication on sexuality among partners:* a problem for many women is that, inhibited from inquiring about the sexual habits of their partners, they assume that they are faithful and, as a result, are not aware that they are at risk of contracting HIV and other STDs. In other cases, psychological denial mechanisms are also involved;
- *Male rejection of the condom:* rejection occurs more frequently in sexual relations of the man with his stable partner (use of the condom is associated with relations with prostitutes). In addition, the definition of masculinity is built around the idea of "taking risks" which implies that a "real man," will take a risk rather than take precautions. Also, women often reject condom use among their partners, because they associate its use with promiscuous sexual relations or prostitutes;
- *Female psychic construct based on economic and social subordination:* women may be aware of their vulnerability but may tend, because of gender constructions, to lack an internal locus of control that would enable them to reduce or eliminate the risk of their sexual relations. Men who do not want to use condoms generally will not do so, and women will not risk their relationship or male economic support, nor will they face the violence of a confrontation that this type of situation can cause. National AIDS Control Programs often assume that the strategies of prevention are equal for men and women, an assumption that is not reflected in reality, for example, in the control over the use of condoms;
- *Women have not been taken into account by the scientific community when carrying out clinical research on HIV/AIDS:* with the exception of prostitutes, women have been ignored for many years in efforts to prevent transmission of HIV and in research on AIDS. This is probably due to the fact that there was a much greater proportion of men than women affected in the countries that led international biomedical research. Accordingly, for years the natural history of HIV was defined and studied in men, without taking into account the fact that women are at greater risk for HIV/AIDS for the reasons we have seen here;
- *Prohibitions on access to sex education and contraceptives, including condoms:* among the multiple obstacles to the condom, there are religious prohibitions imposed by churches and the most conservative sectors of society; the male argument is based on the loss of sensitivity to sexual pleasure and the association of condom use with STDs and casual relations; in addition, there is a lack of adequate sex education and a lack of access to contraceptives and condoms, often justified with the argument that sex education promotes promiscuity in youth;
- *Age of Sexual Partners:* men have sexual relations with younger and younger women, particularly virgins, because of the belief that younger women are less likely to have contracted the virus. This is spreading the virus among increasingly younger women and girls.
- *Lack of health services for women with STDs or HIV which take into account gender-based needs:* generally, the health sector has not developed a satisfactory response for women suffering from STDs; this is one of the factors that significantly increases their biological susceptibility to HIV. Although women suspect that they may have STDs, they do not seek care because of the social stigma that the situation entails;

## COMPONENT 3.2

- *Sexual violence*: sexual violence against women, both public and domestic, increases the risk that women will contract STDs and HIV;
  - *Fidelity and virginity*: both characteristics are considered culturally very valuable for women. In this context, women do not easily share their sexual history with their sexual partners, putting the couple at risk.
- Report Back: Groups report back, one group at a time, with responses to Task No. 1 and one response to Task No. 2. Facilitator fills in any factors (above) that might have been missed.