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Gender and Race as Social Determinants of Health

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UKZN INSPIRING GREATNESS

Introduction: Storytelling

- Ukuphuma Kwezintombi (*Girls' Coming Out 'Ball'*), *Uthukela District, KZN*

Case Study 2

- *A black woman born to a poor family in rural Limpopo [compared] to a white man born on the same day in [Camps Bay], Cape Town...the woman is one and a half times more likely to die in the first year of her life. The man, statistically, will live 15 years longer. He will complete 12 years of schooling and probably go to university. She will be lucky to complete one year of schooling. Her children (if she lives long enough) will be stuck in the same place (Oxfam Report, cited by [Sipho Kings](#), Mail and Guardian online, 31 Oct 2014)*

What do we learn from the story? An exemplar

- In Africa (and to my compatriots, this does include South Africa), 75% of all those infected [by HIV], between 15 and 24 years of age, are young women and girls ... the true nightmare intersection of youth and gender... [This is] linked to the **power imbalance between** men and women, [where] matters economic, social, cultural and above all, sexual, doom young women and girls to the much talked about intergenerational sex; transactional sex; sexual violence; early marriage; forced marriages and abductions; and in the context of AIDS, removing girls from school to tend to sick and dying parents; the entire burden of care; [etc]” (Stephen Lewis, 2004)

Individual or group health or ill-health is a symptom of the ways in which we organize our social and economic relations (Barnett and Whiteside, 2004)

Intersecting Identities and Health Inequalities

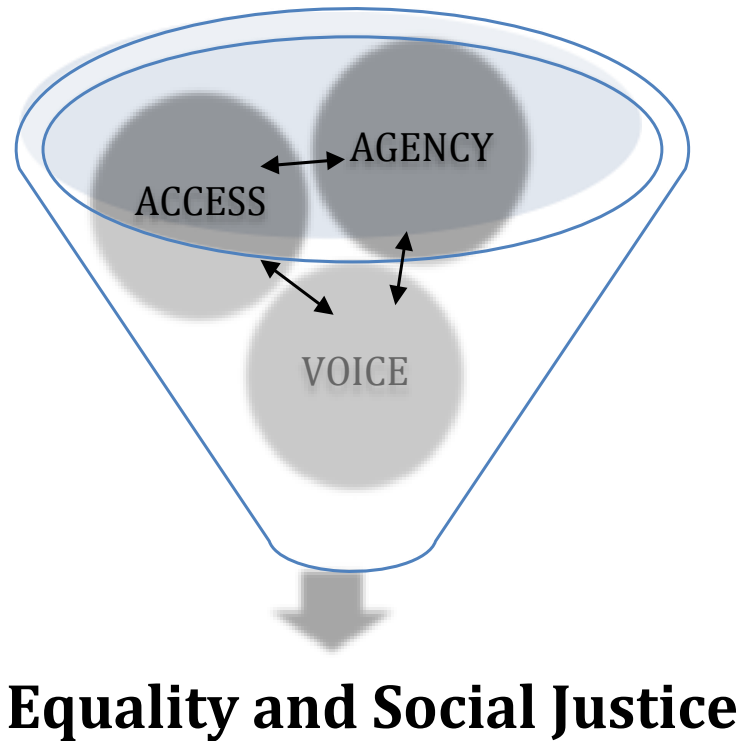
- In South Africa, given the history of apartheid, race intersects gender and other forms of **power relations** (religion, disability, sexual orientation, geographic location, etc) to constitute systems of oppression (see also Lopez and Gadsden, 2016).
- At individual level: These forms of intersecting power relations result in interpersonal violence (gendered, racialised; class based),
- At social group level: symbolic violence/internalised oppression/false consciousness (Marxist) -- oppressed people play a role in their own subordination by internalising. **accepting** and normalising those structures and ideas that are used to subordinate them (Connolly & Healy, 2004).

Identity and Health Inequalities (Cont.)

- At societal/systemic level: structural violence, social structures or social institutions (informed by racism, sexism, ethnocentrism and other forms of oppression) may harm people by preventing them from meeting their basic needs (Galtung)-- individuals and groups with little or no power usually have poor access to services, including health care;
- Example: *Why is HIV prevalence gendered and localised in particular geographic locations and among particular racial and social class groupings?*

How can health research and practice, using an intersectional stance, produce and use knowledge that challenges inequality and aims to effect social change and advance equity [in health care provision]? (Lopez and Gadsden, 2016: 8)

Catalyzing equality in access to services



Three levels of intervention?

- **Transforming institutions (family, community and other social institutions):** Creating equal/inclusive health care environments
- **Changing social norms:** Providing spaces/opportunities for challenging, contesting and changing unequal norms that inform the terms and conditions under which girls/boys, and women/men live and relate
- **Targeting the individual to transform values:**
 - Working with groups in power/oppressor groups (men, white, middle class, heterosexuals, etc) to transform oppressive/discriminatory values that harm the health of the marginalised their own (Sen and Ostlin, 2007:xv);
 - Working with oppressed/marginalised groups (girls/women, poor, LGBTQI; rural inhabitants, etc) to transform internalised oppression
 - Developing lifeskills and enhancing **equal access, agency and voice** in decision-making (Unterhalter et al; 2014)

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