Chapter 7
Reconceptualising gender in the public health curriculum

In this chapter the findings are interpreted through a discursive poststructuralist perspective, which served as the framework for this study. Poststructuralism focuses on language and the interpretations were based on the premise that curriculum is written and presented in language form. In this way I could demonstrate how gender was constructed in the public health curriculum in sub-Saharan Africa through discourse.

Studies that address gender in the public health curriculum are scarce. In Chapter 1 it was demonstrated that although gender and health is a general public health issue at a global level, the need for addressing it is more acute in sub-Saharan Africa (Simwaka et al, 2005). A synopsis was provided on the following: the huge gender disparities; its impact on the health of men and women; and the subsequent highly gendered burden of disease in sub-Saharan Africa. It was also shown how the public health sector had been slow in recognising and responding to gender as a determinant of health until the shock of increasing rates of HIV/AIDS and sexually transmitted infections set in, particularly in sub-Saharan Africa. (See Section 1.1 and sub-sections.) This study therefore took the position that the issue of gender and the public health response (including public health education) was more prominent in sub-Saharan African when compared to other continents (Simwaka et al, 2005).

Poststructuralist lenses enabled me to view diverse and multiple ways in which gender was constructed rather than try to produce a single unitary view of gender. It also assisted in identifying the dominant and marginalised gender discourses. By doing so, the public health curriculum text could be deconstructed by disrupting taken-for-granted dominant discourses on gender, an action that is not necessarily destructive, as it can lead to reflection and creation of new knowledge on gender (Ornstein & Hunkins,1998). It was also demonstrated how curriculum and the production of gender knowledge is a site of struggle where various subjectivities came into play, either reproducing or contesting various gender discourses, and consequently producing multiple versions of reality and serving as a tool for change. A

poststructuralist perspective, therefore, views the construction of gender as a process rather than a fixed entity. The role of context and lived experiences in shaping the various gender discourses was also presented in the discussion, which showed that mini- local accounts based in wider social systems were also important in the production of gender discourses.

The above summary of the findings is discussed in greater detail in the following sections and some suggestions for reconceptualising gender in the public health curriculum are also provided.

7.1 A poststructuralist perspective of gendered discourses in the public health curriculum

Poststructuralists have a great concern with language and believe that meaning (knowledge) is produced through language. Consequently, they propose that language should be the object of study (Gergen, 1994; Weedon, 1997). My study was based on the belief that knowledge (gender in public health curricula) was discursively produced and conveyed through language and, therefore, we sought to understand how language was used to represent gender in public health curricula. The focus of our discussion would be language and was based on the assumption that reality was always in a text (Burman & Parker, 1993).

In the following sections a summary of the main findings from Chapters 5 and 6 is provided and is then subjected to a higher level of analysis using poststructuralist discursive ‘lenses’, thus reading the findings as poststructuralist text (Cheek, 2000; Lye, 1997).

7.1.1 Gender as a low-priority discourse

Our findings revealed that gender appeared to be a low-priority discourse that was not given a central place in the public health curriculum. When explored through the discourses of ‘areas of specialisation’ (tracks/streams/fields of study), ‘core’ and ‘elective’ courses that were used to arrange the official public health curriculum, it was found that gender (in both explicit and implicit representations) was predominantly more present in the elective courses. However, areas of specialisation and core courses have a more dominant function in the public health curriculum. According to Skelton (2007), offering gender as an elective course means that it

can only be attended by a small percentage of the student group – a self-selected group that this author believes is already aware and committed to issues of social justice anyway.

In the interview texts of our study, gender also emerged as a low-priority discourse as was evident in the language used by the interviewees to explain about the way they taught gender. In their explanations, the participants talked about their teaching of gender in a very casual way that gave the impression that they did not give much thought and seriousness to the subject. One participant acknowledged just *"brushing over"* gender, while another affirmed that they included gender as a *"matter of reflex"*. In fact, one of the participants confessed that gender *"for my thinking, has too low a priority"*. (See Section 6.3.2.2.) This corresponds with Ducklin and Ozga's (2007) view that gender is often "played down" (p.676) in students' educational opportunities. This perception was confirmed by another participant who admitted that gender had been given a low priority, particularly when faced with other competing priorities. Morley (2007) agrees and states that the integration of gender can easily be eclipsed by more urgent economically driven policies such as quality assurance.

The above findings seem to be a reflection of the status of gender in other higher education curricula. Skelton (2007), for example, reports that a course on gender and ethnicity for a Secondary Postgraduate Certificate in Education was optional and was set against several other modules. Ravindran (2006) also reports that many public health programmes offer optional courses on gender. In the analysis of curriculum offerings reported in Section 2.2.2.5, only one school indicated that gender issues were included in their public health curriculum (Thankappan, 2007). In the Health Resources and Services Administration (HRSA) study only one medical school offered suggestions for an actual core curriculum on women's health (HRSA, 2004). In their focus group discussions, some staff indicated that it would be inappropriate and impractical to require inclusion of women's health in the core courses and that fitting in additional required concepts would be problematic, particularly in the light of other required competencies for public health professionals. Verdonk et al's (2008) views are similar to those of Skelton (2007). They explain that when they tried to introduce a gender perspective in the medical curriculum in Holland, there was a lack of political will and they only ended up 'preaching to the converted' – those already involved in gender issues and or willing to resist current dominant ideas within the schools. Skelton (2007) concludes that gender still holds a tenuous and marginal position in the education curriculum.

The interviewed participants in our study also articulated a number of problems and barriers that they felt impeded the teaching of gender, making it appear as a low-priority discourse. They mentioned how gender was a difficult concept to understand and to *"come out"* of some courses, especially those that were disease related. A similar observation is made by Morley (2007) who reports that participants in her study failed to see how gender related to 'hard' sciences. Participants in our study also alluded to the lack of knowledge, resources, commitment and dedicated personnel ('gender champions') as challenges facing them in the teaching of gender. Perhaps this in a way contributed to the fact that there were very few stand-alone courses on gender in our study sample. These problems and barriers seem to mirror those reported elsewhere on attempts to mainstream or integrate gender in various curricula. Key issues in the change process are organisational culture and structure, sufficient resources, political support, faculty interest, attitudes and expertise, student interest and a change agent (HRSA, 2004; Ravindran, 2006; Verdonk et al, 2008).

From a poststructuralist perspective, the above findings indicate that the public health curriculum is a site of political struggle, where choices are made about the inclusion and exclusion of content in the arrangement of the curriculum according to areas of specialisation, core and elective courses. As a political tool, the public health curriculum raises some of the feminist and poststructural questions discussed in Sections 3.3.3.2 and 3.3.4.4: what knowledge counts; the purpose and control of the curriculum; access to the privileged subjects of the curriculum; conditions under which particular discourses come to shape reality; and the selection, organisation, inscription and legitimisation of these discourses in a particular society (Pinar et al, 1995).

Even though we may not have the answers to these questions due to the limited scope of this inquiry, they were important questions to raise. Asking them could aid in the transformation of the social relations of knowledge production, the type of knowledge produced, and the structures that determine how knowledge is disseminated (Pinar et al, 1995). This study focused only on examining gender and its status in the public health curriculum. It did not analyse the status of other important public health topics that may also be competing for inclusion in the curriculum. It is acknowledged that a more comprehensive and sophisticated analysis would be needed to reveal the extent of under-representation of gender issues compared to other burning issues.

7.1.2 Gender as an embedded and implicit discourse

The most dominant ways in which gender was represented in the official public health curriculum was as an embedded and implicit discourse – it was 'submerged' underneath other layers of the curriculum. The concept of 'gender layering' was used to explore this embeddedness. On the surface, it appeared as if gender was not adequately represented, but on further peeling of the 'layers' of the curriculum, aspects of gender were unearthed, which depicted gender in more implicit than explicit terms. Other discourses such as 'women', 'reproductive health' and 'maternal and child health' served as a 'proxy' for gender. In the interviews research participants also confirmed that they addressed gender more implicitly and less directly in the courses they taught. Thus, in both the official curriculum and the operational curriculum (the taught curriculum) a more embedded or implicit approach to teaching gender was the most commonly practised and the one that appeared to be more acceptable.

Only three of the schools had some representation of gender as an explicit domain area of knowledge in its own right in their official curricula, with anecdotal evidence indicating that two of the schools lacked dedicated staff to teach those gender courses. Teaching of gender at a more explicit level appeared to be more problematic, as it requires a 'gender champion' to move the process forward, trained personnel, commitment and other resources in competition with other priorities. This possibly serves as an explanation of why an implicit approach was more common.

Some researchers are not happy with an implicit or embedded approach and instead argue for a more explicit and central place for gender in the curriculum. For example, Ducklin and Ozga (2007) lament that in higher education the educational opportunities for students are hardly addressed directly. They assert that gender should be placed at centre stage and that "without a gender perspective, central issues in curriculum design and delivery and in organizational ethos and culture are missed" (p.677). Skelton (2007) also reports of how a new teacher training programme in the United Kingdom (UK) in the eighties failed to give gender a central place because the designers argued instead that gender should 'permeate' the curriculum, a practice which, according to this author, meant nothing. In our findings only three of the schools of public health represented gender directly as a domain area of knowledge but, even then, it was in the electives and not in the central position of core

courses or areas of specialisation. Skelton (2007) further laments that in the curriculum, gender is often subsumed within the broader concept of 'diversity' rather than being addressed explicitly – a finding that was reflected in the official curriculum documents where gender was also submerged under the broader themes of social determinants of health or maternal and child health.

These findings also seem to be a reflection of debates in wider educational circles on whether gender should be incorporated in curricula as a stand-alone course (for example, Gender and Development) or integrated across the curriculum (Ravindran, 2006). Morley (2007) refers to these two models as the "add on" and the "integrationist" approaches respectively (p.610). According to Ravindran (2006), the advantages of stand-alone courses lie in its practical approach in the face of limited faculty resources in expertise on women's health issues, while its disadvantage is that only a small number of students will be reached each year. The advantage of an integrationist approach is that it reaches a broader audience than electives, but it needs to be centrally coordinated and backed-up with capacity building and support in terms of teaching and assessment materials to assist faculty responsible for teaching. Some of these practical issues that Ravindran (2006) raises are addressed in the following sections.

From a poststructuralist perspective, the above findings seem to have exposed the tensions between teaching gender either explicitly or implicitly and once again indicated how situating gender in the public health curriculum is a controversial discursive social practice (Pinar et al, 1995). The choice of which approach to use lies in the dominant discursive practice that will end up carrying more weight (Cheek, 2000; Weedon, 1997). In the case of our study the dominant practice was the teaching of gender as an implicit and embedded discourse. This choice meant that the production of gender knowledge in the public health curriculum was carried out implicitly, while the explicit representation of gender in the curriculum was constrained, as was apparent from the few explicit gender courses in the official curriculum and as explained by the participants in the interviews. (See also Cheek, 2000; Gavey, 1989; McLaughlin, 2003; Weedon, 1997.) The appropriate balance between explicit and implicit approaches to teaching gender should be an important debate in any public health curriculum revision and is an area for further research.

7.1.3 Dominant and marginalised discourses

Friedman (2006) contends that while dominant discourses make themselves known because they are generated and perpetuated by the dominant forces in society, there are many significant silences and many absences. This section discusses the dominant, marginalised and silent discourses in the public health curriculum.

7.1.3.1 Grand narratives

Several discourses were identified as grand narratives of the public health curriculum and included women's (reproductive and maternal) roles, sexual difference and sex roles differentiation. These three were present as dominant discourses in the official public health curriculum and in the participants' talk in such a manner that they were made to appear natural and had assumed an almost taken for granted status (Gavey, 1997; Pauw, 2009; Shaw & Bailey, 2009; Van Dijk, 2004). The taken-for-grantedness was apparent in the ways in which these discourses were accepted without question and without being problematised, except in very few cases. These 'grand narratives' seemed to have been entrenched and legitimised as gender knowledge in the public health curriculum and in the participants' talk (Ornstein & Hunkins, 1998; Pinar et al, 1995; Usher & Edwards, 1994). Accordingly, Pinar et al (1995) argue that through discursive practices, language is used to persuade us to conceive of curriculum in particular ways, with the dominant group imposing its values on the less dominant group.

The way in which "gender naming" (Kabira & Masinjila,1997, p.17) occurred reinforced the position of the 'women' discourse as the most dominant in the public health curriculum, where women were referred to relatively more times than other gendered categories. This could contribute to an entrenchment of the view that gender is about women.

The discourse on women was supported by another strong discourse on women's reproductive and maternal roles (Section 5.3.2.1), which also appeared to be entrenching the common view of women in terms of their reproductive and maternal roles (Health Canada, 2000), without due regard to their overall well being and other social factors that influenced their health (AGI, 2002; Raymond, 1993). The reverse could also be true. A predominant focus on women and their reproductive and maternal roles may also serve to reinforce traditional roles of men as being distinct from these roles, thereby sidelining men's involvement in reproductive

health. The discourse on sexual differences (Section 6.1.1.1) appeared to magnify and perpetuate the differences between men and women, while underplaying other markers of differences between women and between men, such as class, ethnicity, age and sexuality (Alvesson & Billing, 1997; Butler, 1990; Gavey, 1997). In the interview transcripts, the discourse on sex role differentiation was based on sexual differences (Section 6.1.2.) Where gender as a social construct is derived from this difference and men and women are stratified into static roles based on their sex, the paradox of the sex/gender system is reinforced and is often regarded as the main cause of gender inequality (Kabeer, 1994). The potential effect of such a construction is the confusion and conflation of sex as gender and gender as sex that is so predominant in the biomedical paradigm. This confusion and conflation has led to calls by gender experts to make a clear distinction between sex and gender in order for both of them to be adequately addressed in public health (Doyal, 2004b; EngenderHealth, 2000; PAHO, 2002; WHO, 1998; WHO 2006a). Trigiani (1999) captures some of the potential pitfalls and limitations of the sex role discourse narrated by our participants: its rigidity; a failure to recognise that traits deemed 'masculine' by a particular society are valued more highly than those labelled 'feminine'; a lack of explanation for why and how certain characteristics become attached to men or women; the assumption that gender forms the core of a person's identity; and the failure to acknowledge the role of agency in constructing gender roles. (See also Section 6.1.2.)

Another prominent discourse supporting the women discourse was the discourse on women and work. This discourse permeated the official public health curriculum right across the areas of specialisation, the core and elective courses. Most of the participants who were interviewed seemed to have accepted the discourse on gender/women and work (sex roles) without question. (See also Section 6.1.2.)

7.1.3.2 Marginalised and silent discourses

According to Cheek (2000), dominant discourses constrain the production of knowledge in that they allow for certain ways of thinking about reality while excluding others and, accordingly, texts should be interrogated to uncover the unspoken and unstated assumptions within them. Burr (1995) captures this more succinctly by stating:

> To give anything an identity, to say what it is, is necessarily also to say what it is not. In this sense, presence contains absence. That is, to say that a quality is present depends upon implying what is absent. (p.107)

It was therefore imperative that we also pay special attention to those discourses on gender that appeared to be marginalised or even excluded in the public health curriculum, as these could add value to the understanding of gender and health issues. The marginalised discourses in the public health curriculum were the discourses on men, sexuality and sexual orientation, and power relations. The silent discourse was that of gender identity.

a) Men's health

The category 'men' was not very prominent – almost to the extent of being invisible, as one interview study participant reiterated: *"The males are just outside… they also belong to gender issues"*. Our findings showed that indeed there was little mention of men and their health in the official curricula of one school that had implemented a gender-mainstreaming (GM) programme, but only after this intervention, interview study participants from this school started to advocate for the inclusion of the study of masculinities in their curricula. One argued for the consideration of *"male gender constructs"*, while another one called for *"men to be brought more into the discussion"*.

Given the foregoing, it is important to consider making more visible the discourse on gender as 'men' in public health curricula and programmes. This, according to Doyal (2001), would make it possible to help men to promote their own health, as well as offering important opportunities for educating men to take more responsibility for their own health and that of their partners. In addition, attention to masculinities would enable the development of strategies that seek to introduce and illuminate alternative images for men in an effort to contest and resist dominant constructions of masculinity (Iverson, 2006).

Arguing from another angle, Knudsen (2003) posits that man, as gender, is neutral and that this gender neutrality keeps masculinity and patriarchy invisible in textbooks. Kuzmic (2000) comments that "to leave masculinity unstudied, to proceed as if it were not a form of gender, is to leave it naturalised, and thus to render it less permeable to change" (p.112). Knudsen (2003) is of the view that by making women visible, men are made even less visible but more central. This author adds that it is precisely this invisibility of men and masculinity that serves to perpetuate ideological messages and perspectives that mask patriarchy.

b) Gender and power relations

The phrase *"power relations"* in relation to gender appeared twice in official course descriptions, once in a compulsory course in an area of specialisation and once in an elective – *"how health issues intersect with power relations in different cultural contexts"* (School 2500). In terms of 'gender' at least, feminists have argued that what needs centralising in professional development courses are power dynamics and differentials (Skelton, 2007). Questions of power are crucial because social gender relations are kept in place by prevailing power structures. Most of the visible power has to do with decision making and the ability to force others to do what the power holder prescribes (Kabira & Masinjila, 1997). Kabira and Masinjila (1997) encourage analyses to identify the source of power, as these would lead to determining questions of authority and legitimacy. Subtle forms of power that may not have immediate coercive visibility should also be analysed, as they might in the long run play a crucial part in the unfolding of events.

c) Sexuality and sexual health

The public health curricula advanced the view of gender as male and female and were silent on other gender identities such as transgender and intersex people. By implication, it also advanced heterosexual orientations and was silent on other sexual orientations such as homosexual and lesbian sexual orientations. Ferfolja (2007) contends that discriminatory educational systems often silence and marginalise those who do not conform to the dominant gender and (hetero)sexual discourses that operate in broader society. Indeed, education institutions constitute, reinforce, and perpetuate these heterosexist discourses and are at least partially responsible for the production and reproduction of sexual inequalities. School cultures produce heterosexual subjects through practices of normalisation and punishment where those located in dominant discursive locations of heterosexuality are 'rewarded' and celebrated. Conversely, those who transgress the 'acceptable' standards of (hetero)normality may be 'punished' through overt and covert harassment, stigmatisation, ostracism, exclusion and silence. Silences authenticate particular discourses and herald others as illegitimate (Ferfolja, 2007).

7.1.4 Knowledge and power

According to Nightingale and Cromby (1999), discourse reflects prevailing structures of social and power relationships. As they often lie deeper than what is evident, it is not easy to recognise these power dynamics on the surface. From our discussion so far, it is possible to surmise some of the subtle power relations that have aided in shaping the public health curriculum.

In the first instance, gender was found to be a low-priority discourse without a central place in the areas of specialisation and core courses but, instead, was more prominent in the elective courses. Believing that the construction of the public health curriculum is a discursive practice, and that the curriculum developers were faced with certain choices to make, we concluded that the choice to have gender more in the electives could have been a result of power relations prevailing at the time. Secondly, the same conclusion could be made with regard to the teaching of gender as an implicit rather than as an explicit discourse. Where there is political will, resources, personnel, et cetera could be mobilised for the teaching of gender in a more explicit way. Finally, the existence of dominant discourses and marginalised discourses points to power relations at play, since the dominant discourses support and perpetuate existing power relations (Gavey, 1998). According to Pinar et al (1995), issues of curricular inclusion or exclusion are largely political issues. The dominant discourses in this inquiry were mainly lodged within a biomedical paradigm. (See also Section 7.1.6.1.) Verdonk et al (2008) and Risberg et al (2006) argue that a dominant biomedical tradition and the disciplinary and traditional organisation of curricula are strong barriers for gender-mainstreaming.

7.1.5 Contexts shaping the construction of gender

Weedon (1997) emphasises the role of context in shaping knowledge within poststructuralist thought and adds that our subjectivity is the product of society, culture and historical contexts in which we live. We found this confirmed in our analysis, particularly at the level of the two case studies where we had an opportunity to investigate contextual aspects of the two schools in further depth. The different contexts of the two cases studies (described in Appendix 1) largely shaped the gender approach taken in each school – one a gender-mainstreaming (GM) approach and the other a gender-equity approach. It was also evident that the academic discourses had a big impact on shaping some of the gender discourses espoused by the

participants. For example, we found that in School 1600 the technical GM training had largely influenced the participants' constructions of gender in terms of sex roles – which appeared as a unitary truth. In comparison, in School 2500 the gender discourses were acquired more by default and produced more nuanced notions of gender based on real life experiences that should help to realise the goal of gender equality. Other contexts that aided in shaping gender discourses were social contexts (culture and religion), historical periods (the women's movement) and the diverse lived experiences of the participants in different contexts. (See Sections 6.2 and subsections.) These contexts could be seen as part of the forces that shape the hidden curriculum in public health, which, according to Morley (2007), is difficult to capture and eradicate. As discussed in Section 3.3.2, the hidden curriculum often has a deeper and more durable impact (Posner, 1995) and deals with the tacit ways in which knowledge and behaviour get constructed outside the usual course materials and formally scheduled lessons (Pinar et al, 1995). In this regard, Bennet (2002a) suggests that universities need to acknowledge the complex world of social reproductive labour of their scholars and teachers.

There were only a few schools that attempted to place gender within wider social, cultural, economic and political contexts in the official curriculum documents and, in most descriptions, gender was constructed as an innate fixed entity devoid of any context. The different contexts that shaped gender in the two case studies and the lived experiences of the interview participants were key in contributing to the multiple realities on gender, reflecting the poststructuralist contention about the role of context in creating knowledge.

7.1.6 Multiple realities in gendered discourses

Gergen (1997) maintains that discourses grow from the language used within a certain culture. In line with poststructuralist thought, the aim of this inquiry was not to come up with a unifying and singular understanding of gender (Gavey, 1998). Based on the ontological poststructuralist assumption that reality is socially constructed and multiple (Michael, 1999), the inquiry aimed at gaining insight into the language that was used to construct diverse discourses on gender in the public health curricula. The discourses uncovered in our analysis were: sexual differences (nature); reproductive and motherhood roles of women (nurture); sex role differentiation (culture); gender embedded in broader social systems (context); and gender as lived experience. Even though some of these discourses seemed to be contradictory to poststructuralist tenets, by its very nature, poststructuralism embraces plurality and is

tolerant to difference in the belief that this will open up space for alternative ways of knowing, thus bringing about change.

From these findings we concluded that gender was not a fixed entity. It is a site of struggle over meaning and knowledge production – gender means different things to different people in different contexts and, therefore, multiple meanings are inevitable. The multiple discourses on gender were also a manifestation of the way in which gender permeated our concepts of knowledge and our way of knowing.

A summary of the emerging gendered discourses is provided in Figure 7-1 and shows that firstly, gender was constructed as a fixed, stable category, 'gender'; and secondly, that gender was viewed as a varied category, 'genders'.

7.1.6.1 The 'Gender' discourses

In Figure 7-1 the discourses that I refer to as 'Gender', appeared to depict fixed, stable, and homogeneous categories of gender. These included the discourse on gender as sexual difference (nature), the reproductive and motherhood roles of women (nurture), and the discourse on gender as sex role differentiation (culture). These discourses were largely situated in a biomedical paradigm. The 'women' discourse was particularly prominent in the official curriculum and the sex role discourse in the transcribed interview text. The sexual difference discourse permeated both texts.

When gender is viewed as 'gender', it portrays images of an essentialist, innate entity based on biological differences between men and women (Alsop et al, 2002). For public health, the focus becomes biological aspects of diagnosis, treatment and prevention, with an emphasis on biological or sex differences as explanatory factors for well-being and illness (Sims & Butter, 2002). In our inquiry, gender as biological sex was the most dominant approach. This confirms IJsselmuiden et al's (2007) finding that public health curricula in Africa are mainly biomedical. It has, however, also been argued elsewhere that systematic disparities between women's and men's health do not only derive from biological sex traits, but also from the different positions that women and men occupy in society (PAHO, 2002; WHO, 2006a). According to Lebel (2003), emphasis on a biomedical approach has the potential for excluding the range of social, political and economic aspects related to health.

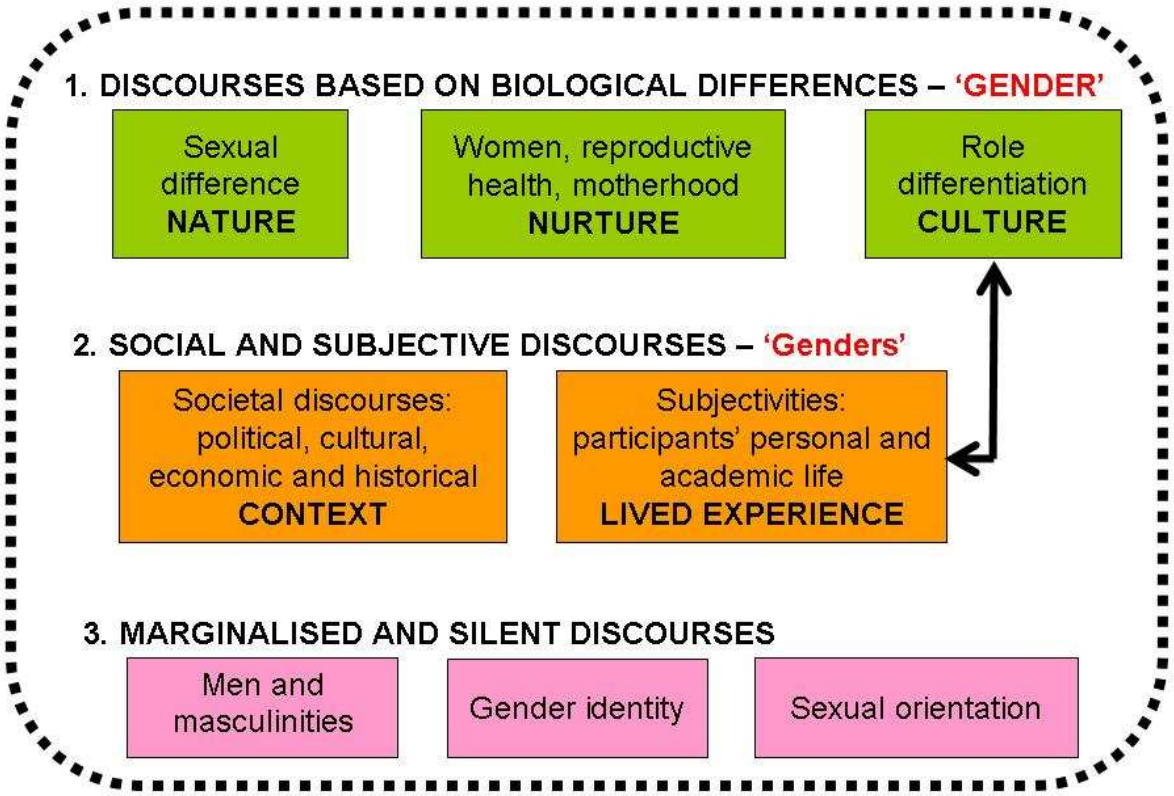

Figure 7-1. Emerging gendered discourses

7.1.6.2 The 'genders' discourses

The 'genders' discourses were based on an understanding of gender as a social aspect of reality located within different political, cultural, economic and historical contexts and as a subjective experience depicted in the narratives of the participants (lived experience). Subjectivity is a central theme in poststructuralist thinking, as it serves as a site of struggle and has the potential of bringing about change through resistance and embracing new realities (Weedon, 1997). In the participants' narratives we saw how their subjectivities were opened up when talking about gender to expose multiple realities that they either embraced or resisted and challenged. For example, there were participants who questioned the view of gender as women. There was a participant who problematised the whole idea of sex roles and how these *"put women in certain places"*. And there was a participant who resisted being *"looked down upon"* by a boy, while at the same time she embraced her religious teachings on gender equality without question.

Finally, there was the participant who lamented her multiple gender roles and how her dual burden impacted on her upward mobility within the workplace. Tamale and Oloka-Onyango (2005) describe how women academics carry a dual burden that requires them to pursue both their academic obligations, while meeting traditional obligations such as childcare, household management and care of the elderly. This burden directly affects women's freedom to operate and articulate issues in the academy. Morley (2007) also lends weight to these sentiments by arguing that gendered power relations symbolically and materially construct and regulate women's everyday experiences of higher education and that gendered differences are relayed and reinforced both formally (e.g. preparing for classes, reports and assignments) and informally via social practices (e.g. sharing of toilets, fetching children from school and going to the market). In this way, Weedon (1997) posits that a subjective poststructuralist perspective has an emancipatory and empowering potential as it has the potential to open up different and new ways of thinking that can bring about change. (See also Hodgson & Standish, 2009; Youdell, 2006.) Klages (2003) concludes that in this regard poststructuralism favours mini-narratives, stories that explain small practices, local events and rejects large-scale universal concepts – the grand narratives.

The interview participants' narratives led us to a valuable conclusion – that gender is a lived experience, that experiences differ from person to person and that gender is, therefore, a fluid rather than a static notion. This was not so clear in the official curriculum documents. Viewing gender as 'genders' has the potential to open up spaces for public health to interrogate social factors such as political, economic and cultural determinants of health, thus producing multiple ways of understanding gender and health. (See Doyal, 2004b; Hoffman, 1997; PAHO, 2002; WHO, 1998; WHO, 2006a.)

7.2 Curriculum as gender text

Curriculum as gender text appeared in two formats: the technical curriculum and the hidden curriculum. They are described in the following sections.

7.2.1 The technical curriculum

Chapter 5 discussed the highly structured public health curriculum in which gender was located. While it was not clear from the curriculum documents which methods were used to

teach gender, the curriculum descriptions seemed to reflect a traditional curriculum that is passed on in a linear fashion. However, there were a few schools that tried to place gender in a wider context by alluding to gender in terms of social, cultural, economic and political factors. In addition, based on the narratives of the interviewed participants who had undergone gender-mainstreaming training (School 1600), the training appeared to have been too technical to the extent that some of them could not explain the gender terminology and could not apply it to their teaching. In the official curriculum documents gender seemed to appear as a technical term – a fixed entity. It was mainly in the interviews with the participants that we were able to capture the wider social contexts in which gender was constructed.

Many authors have taken up issues with a technical GM approach. Lyons et al (2004) contend that GM continues to elude accurate definition because of bureaucratic jargon that conflates policy and practice. Beall (1998) points out that there is still much confusion about what a policy of mainstreaming means in practice. Kanji (2003) confirms that much work has been carried out on the *technical* and operational side, particularly in training, analytical and planning tools guidelines. But Cos-Montiel (2004) feels that these have not been enough to bring about changes in rules, resources and power structures. From these arguments, Verdonk et al (2008) and Risberg et al (2006) also report that it is difficult to mainstream gender in a highly structured traditional type of curriculum. (See also Section 2.1.9.3.)

7.2.2 The hidden curriculum

The preceding section on the technical curriculum brings to the fore the features of a hidden curriculum and its effects on students. The hidden curriculum comprises unintended outcomes that arise out of organisational and structural factors in the learning process (Hafferty, 1998; Tekian, 2009). (See also Section 3.3.2.) Whereas it may have been the intention of School 1600 to bring about a better understanding of gender among its staff, the GM strategy resulted in its own hidden curriculum. The teaching intended by the mainstreaming training did not take place because of the technicist and materialist way in which the university policies and the training were approached. GM remained an academic discourse that did not have much impact on what was actually happening in the classroom. The interview participants' narratives about their experiences of this hidden curriculum in the classroom were captured in Section 6.3.2.

Karlsson (2010) also reports similar findings on the mainstreaming approach adopted by a provincial education department in South Africa, which was also technical in approach and did not necessarily lead to the intended outcome of transforming gender relations. These types of findings on the hidden curriculum have led Morley (2007) to argue that the technique of GM has stripped gender of any radical or political potential, and in this way, has diluted or neutralised gender as a political tool. Charlesworth (2005) sums all this up by declaring that "gender has been defanged" (p.16), while the African Gender Institute calls for the reinsertion of politics, as well as a transformation agenda, into Gender and Women's Studies (AGI, 2002). (See also Section 2.1.9.3.)

From a poststructuralist perspective, the hidden curriculum reflected in the participants' talk on how they taught gender seemed to paint a picture of various subjective positions that they experienced as they were confronted with teaching gender in the public health curriculum. These included inadequacy, inexperience, lack of interest and other logistical difficulties. (See Section 6.3.2.) However, viewed from a poststructuralist perspective these subjectivities (and the hidden curriculum) are not in themselves a 'bad thing' as, according to Weedon (1997), opening up subjectivities could lead to change. For example, the discursive issues the participants raised about the teaching of gender may sound negative, but they could be used in a constructive way to improve the way gender is perceived and taught in higher education public health programmes.

Another way in which the hidden curriculum came to the fore was through the unintended consequences of constructing knowledge in ways that were not intended by the curriculum; for example, the grand narratives (Section 7.1.3.1) and the perpetuation of gender as a fixed entity (Section 7.1.6.1). Other findings from this study also have profound implications with regard to the unintended outcomes of education of which curriculum planners and designers should be mindful. Firstly the assumption that gender is a male/female binary category could lead to the exclusion from health services and programmes those who do not fit into this category, such as transgender and intersex people. Secondly, the dominant construction of gender as sexual difference in the public health curriculum could lead to the view that only biological factors are the determinants of ill health, which has the potential of exclusion or marginalisation of other social, political and economic determinants of health from consideration. Thirdly, the dominant focus on gender as 'women' could lead to the marginalisation of men and their health in the public health curriculum. There was also a

strong focus on women's reproductive and maternal roles, which could result in a preference for the provision of health services and programmes for women of reproductive age to the exclusion of other groups such as women of non-reproductive age and men. Fourthly, it appeared as if some members of staff did not have the right skills, knowledge and confidence to teach gender because of the way they had been taught in a technical way. This opens up an opportunity to redesign gender-sensitisation programmes with a focus on 'understanding' gender rather than a focus on technical 'jargon'. Finally, if schools are serious about incorporating gender in their curriculum, adequate resources and personnel need to be committed to it.

7.3 Reconceptualising gender in the curriculum

As I come to this section, I am aware of the caution advised by Hodgson and Standish (2009) and Nudzor (2009) about making policy recommendations in research. They argue that conventional educational research is only concerned with reaching a conclusion that can be translated into a policy outcome. According to Hodgson and Standish (2009), this practice tends to "fix the account and the subject within it" (p.309), thereby constraining and limiting change and action. Hodgson and Standish (2009), along with Nudzor (2009), suggest that poststructuralist researchers should not view policy as a fixed entity but rather as a process and a site of struggle leading to various forms of subjectivities and resistance. These then open up alternative and new ways of thinking about educational practice and, in this way, educational policies and practices could be changed.

My suggested recommendations will be viewed within the framework of a reconceptualised gendered public health curriculum, which, according to Pinar et al (1995), is in line with poststructuralist thought. (See also Section 3.3.3 and subsections.) Based on the findings that the public health curriculum was highly structured and reproduced and reinforced mainly fixed constructions of gender, I would like to offer suggestions for a reconceptualised gendered public health curriculum by looking at the curriculum through a different lens – by moving away from the technicalities of the curriculum to understanding the curriculum as a process and not a product.

7.3.1 Moving from a single objective reality to discursive practices

In public health curriculum development there needs to be greater recognition of the multiple, unstable and gendered subjectivities, as well as a questioning of the constructed dominant gender discourses located mainly in sexual difference discourse that limits other perceived options and experiences. This could be achieved by moving away from method-centred to participatory constructivist teaching, where knowledge is constructed with the students and their views taken into consideration and where plurality and difference is tolerated. In this way diverse voices would be accommodated. According to Usher and Edwards (1994), a tolerance for plurality and difference provides alternative discourses, which could be appropriated for a critical examination of the theory and practice of education. Consequently, the social relations in which knowledge is produced and the type of knowledge produced could be transformed.

In this process, the hidden curriculum that may constrain the achievement of gender equality in public health programmes would be unearthed and brought to the fore and could be used for transforming gender relations in these programmes. In addition, exposing students to diverse ways in which gender is understood could serve as a starting point for addressing these plural understandings in wider society.

7.3.2 Contextualising gender knowledge

There were only a few schools that attempted to place gender within broader social, cultural, economic and political contexts in the official curriculum documents and, in most descriptions, gender was constructed as an innate fixed entity that was devoid of any context. The different contexts that shaped gender in the two case studies and the lived experiences of the interview participants helped to reinforce the poststructuralist contention about the role of context in creating knowledge. (See Section 7.1.5.)

It is proposed that the public health curriculum on gender place more emphasis on the social, cultural, economic, historical and political contexts in which gender is constructed and experienced. These insights could assist public health students to tackle society's complex and varied health problems that are similarly embedded in very complex and varied settings. Adapting to different contexts means being comfortable with many different ideas about

gender and its meanings and also highlights the structures that determine how gender knowledge is disseminated. In this regard, there is need for more diverse models of teaching that would enable public health students to adapt to the varied and complex contexts. Milward (2007), for example, suggests the use of problem-solving methods that could engage with lived experience in people's personal and work lives. IJsselmuiden et al (2007) again promote the view of training public health professionals to work within all levels of society.

Contextualising knowledge could also be made possible through the enactment of a multidisciplinary and interdisciplinary public health curriculum, as advanced by Sim et al (2007).

7.3.3 Reflexive methodologies in the teaching of gender

Chin and Russo (1997) emphasise that when developing lesson plans for our courses, one should reflect on how our values and perspectives influence our understanding and thinking and how our views differ from those of others. Such reflections would move us away from focusing on linear and traditional perspectives on gender towards uncovering the more hidden meanings of gender that could only be found in the hidden and null curricula.

It is suggested that the teaching of gender in the public health curriculum start from people's everyday experiences of lived social relations in order to understand people's constructions of gender rather than imposing gender concepts in the abstract. Reflection on people's own constructions helps in making personal connections to personal experience and focusing on the process of learning. Therefore, training methods need to focus more consistently on the life experiences of participants and to create adequate spaces for a process of reflection.

7.3.4 Building of alliances and partnerships

It was evident from the official curriculum documents and the transcribed interview texts that the teaching of gender explicitly was problematic due to lack of dedicated personnel, resources and adequate knowledge on gender. It is proposed that alliances, collaborations and networks between actors working on gender equality be sought, nurtured and maintained in order to generate new gender knowledge, share information and resources and encourage each

other. In this way the social relations of knowledge production on gender could be transformed.

7.3.5 Moving from technical concerns with curriculum to understanding the curriculum

It is envisioned that moving the public health curriculum from narrow and static views on gender to understanding gender could be achieved by moving from a focus on gender terminologies to the discursive and by including consideration for varied and complex contexts. This change could lead to the kind of reflection that leads to action, with many partners making a contribution to gender knowledge. According to Pinar et al (1995), such a curriculum would transform the social relations of knowledge production, the type of knowledge produced, and the structures that determine how knowledge is disseminated.

7.3.6 Broadening the scope of investigation

One of the limitations pointed out in Section 4.5 was the exclusion of students' experience of a gendered curriculum in this study. Further research is needed on how students construct gender and what contexts shape these constructions. In this regard the role of the hidden curriculum could be of importance.

Another limitation of this study was that only anglophone countries in sub-Saharan Africa were included in the study. It would be interesting to investigate and compare gendered constructions from francophone and lusophone African perspectives.

7.3.7 Further research on gender in the curriculum

The findings of this study, supported by various literature sources, pointed to some tension between explicit and implicit gender discourses in the public health curriculum. Further research is needed into these constructions and to find useful ways to accommodate this tension in the curriculum.

Our findings also revealed that gender was presented predominantly in the elective courses than in the areas of specialisation and core courses. Some researchers have also complained that in the educational curriculum, gender is never given a central place (Ducklin & Ozga,

2007; Skelton, 2007). This raises the question: should gender be at the core of the public health curriculum?

If the public health curriculum indeed has to go through a process of reconceptualisation, and if gender has to be reconceptualised in the curriculum, then we need to come up with more innovative methods of teaching that view both curriculum and gender as contested constructs arising out of discursive practices. This would expand the view of teaching gender in the public health curriculum from a narrow view that focuses on content to the broader views proposed in Sections 7.3.1 to 7.3.3.

7.4 My personal deconstruction of poststructuralism

I have tried to clarify the contribution of poststructuralism to this inquiry. Through this prism, it was possible to understand the diverse and multiple ways in which gender was represented in the public health curriculum. It enabled us to identify dominant and marginalised discourses, which led to the 'deconstruction' of traditional and narrow ways of viewing the curriculum in relation to gender, and replacing them with a multiplicity of perspectives. Through the personal narratives of the participants, their subjectivities were 'opened' up to produce multiple and varied gendered discourses. The importance of context and history in shaping the various gender discourses demonstrated that wider social systems were also important in the production of gender discourses. Consequently, a poststructuralist perspective in this study enabled new ways of understanding the public health curriculum in relation to gender. Indeed, as Hodgson and Standish (2009) contend, poststructuralism has an emancipatory and empowering potential – the potential to open up different and new ways of thinking about research and social practices.

However, even as I was acutely aware of this emancipatory and empowering potential of using a poststructuralist perspective, I felt some tensions and contradictions with some of the views that it advances. In the first place, I felt uncomfortable working within a poststructuralist framework and yet presenting my work in a very structured way into different sections – but I took comfort in knowing that this was done to guide the reader and make it easier for them to navigate through the terrain of my thesis.

Secondly, I felt some tension and contradiction between gender as a product of discourse and gender as a stark reality – a lived experience in the material world. Poststructuralism attributes the socio-economic material conditions of men and women to the discourse itself and has been severely criticised for this. (See Section 3.1.5.) In order to deal with this tension and contradiction, I took the stance of some poststructuralist theorists like Youdell (2006) who acknowledge that knowledge is not only produced within a social and historical context, but also within a personal life history context, and one that includes embodiment and materiality. This was confirmed by the narratives of some of the interviewed participants, which led me to the conclusion that gender was a lived experience.

Thirdly, the position of poststructuralism that gender is discursively produced to me meant that men and women had no agency over their circumstances. Contrary to this view, like Friedman (2006), I found conscious, living actors who appropriated, resisted and redefined gender.

Finally, I was not comfortable with the poststructuralist refusal to pronounce on policy issues in a very definitive way – but rather to remain abstract and not specific (Arnot & Fennell, 2008; Humes & Bryce, 2003) without offering any concrete solutions that would bring about change on gender in the public health curriculum.

7.5 Beyond a poststructuralist interpretation of the public health curriculum

Friedman (2006) argues that poststructuralism has its limits and that continued discourse deconstruction will not help us move beyond its limitations. I would like to offer my position on how we could move beyond poststructuralism in order to overcome some of its potential pitfalls. Firstly, I would like to suggest that in order to go beyond the emphasis on gender as discursively produced, we need to acknowledge the stark realities of the material conditions in which people live. The ‘discursive’ and the ‘reality’ could be combined to produce more ‘wholesome’ gender knowledge. This was achieved in this study, when the narratives of the interviewed participants revealed their daily struggles and realities of their lived experiences as gendered bodies.

Secondly, based on the stark realities in which people live out their daily lives we need to move beyond the abstract and be more courageous and bold to come up with more specific policies and interventions that could help in improving their material conditions. There is a need to articulate issues more concretely and firmly rather than leave them 'hanging'. Therefore, on the one hand, the 'discursive' would enable us to understand the multiple ways in which gender is constructed in the public health curriculum. On the other hand, moving beyond this to the 'reality' would enable the public health curriculum to come up with clear concepts and content that could result in concrete interventions that would help to address the realities on the ground. Consequently, my suggestion is for the co-existence of the 'discursive' and the 'reality.'

Thirdly, in moving beyond the 'discursive' we need to acknowledge that men and women have some agency in constructing their gendered identities and experiences and, therefore, the need to take into consideration what they have to say about their circumstances. This could discourage top-down public health interventions and instead encourage public health to come up with bottom-up participatory interventions, policies and programmes that take into consideration the stark realities lived by people and that view people as co-partners in development – thereby making way for the influence of local agency in the development process (Erevelles, 2005; Friedman, 2006).

Finally, the focus of poststructuralists on the knowledge-power nexus may sometimes lead to the unearthing of what can only be seen – the dominant discourses and how power relations come to shape these discourses. Friedman (2006) contends that:

> With a focus on discourse and its deconstruction, post-structuralists are limited in their scope of analysis because the only discourse amenable to deconstruction is that which makes itself known; and in most cases the discourse that makes itself known is that which is generated and perpetuated by the dominant forces in society. (p.205)

This author adds that this type of analysis contains many significant silences and many absences. In my study, I found that the hidden curriculum, where gender is constructed 'behind the scenes,' is not easy to make known publicly. This means that the discourses produced by the hidden curriculum could easily go unnoticed, unproblematised and assumed to be part of the norm, unless they are interrogated. This made us conclude that the hidden curriculum is an important space where gender is constructed by appropriation, resistance and

re-construction. I therefore suggest that while not downplaying dominant gender discourses, we need to go beyond these to look at the hidden gender curriculum that does not readily make itself known. This could help to unlock the knowledge-power nexus and in this way, gender knowledge could be incorporated into the public health curriculum with constructive, rather than only deconstructive aims in mind (Erevelles, 2005; Friedman, 2006).

7.6 Epilogue: The *bricolage*

This journey has been long, tedious and complex – but exciting. It was complex because of the multiple constructs (gender, discourse, curriculum, public health) and their inter-relationships – all of which had to somehow function within a poststructuralist framework. It became exciting as I began to see each construct fall into place and as the relationships between the constructs began to become clearer. Therefore, as I come to the end of this long journey, I feel like a *bricoleur* who constructed a *bricolage* from a diverse range of resources, which happened to be in my immediate environment and surrounding.

According to Carl (1997), "bricolage describes the process of the bricoleur who works with symbolic and material resources from his/her personal experiences, and membership in social communities and larger cultural contexts. Resources are defined broadly as stories, concepts, perceptions, memories, and so forth, by which persons make their world coherent" (p.12) and they are appropriated from the *bricoleur's* surrounding environments.

The *bricoleur* goes about her work by making do with what is there and with what she encounters (Sehring, 2009). She assembles her resources in a creative and improvisational manner by connecting seemingly isolated fragments with other apparently isolated fragments (Carl, 1997; Weinstein & Weinstein, 1993) and by continually making and re-making her artefacts, and figuring out the structure along the way (Carl, 1997). In this way, the *bricoleur* is considered adept at performing a large number of diverse tasks, which could lead to new institutional [re]arrangements (Sehring, 2009).

As a *bricoleur*, I used the resources that were within my immediate surrounding to come up with my *bricolage*. These resources were the public health curriculum (what I did) and gender, which I taught (what I knew). As I searched for a theoretical framework within which to locate these two constructs I turned to another available resource also in my immediate

surrounding – the library, and through a literature search, I 'stumbled' across discourse analysis and poststructuralism, which I also appropriated as further resources for my work. Therefore, my everyday life experiences served as the context and content of my *bricolage* (Carl, 1997). (See also a description of my positionality in Section 1.1.2.)

As I started using these resources for this inquiry, I really had no idea how these fragmented elements could come together, and further, I was not sure how well public health would merge with a discursive poststructuralist framework – they seemed such 'strange bed-fellows' to me. Therefore, starting off with no particular structure in mind, I 'tinkered' with, (re)assembled and 'cobbled' these fragmented discursive resources until the *bricolage* in Figure 7-2 emerged, which brought out more meaning to the recombined fragments. As can be seen from the *bricolage*, it evolved and emerged from fragmented pieces found in the immediate surrounding of the researcher to create a coherent, composite *bricolage*.

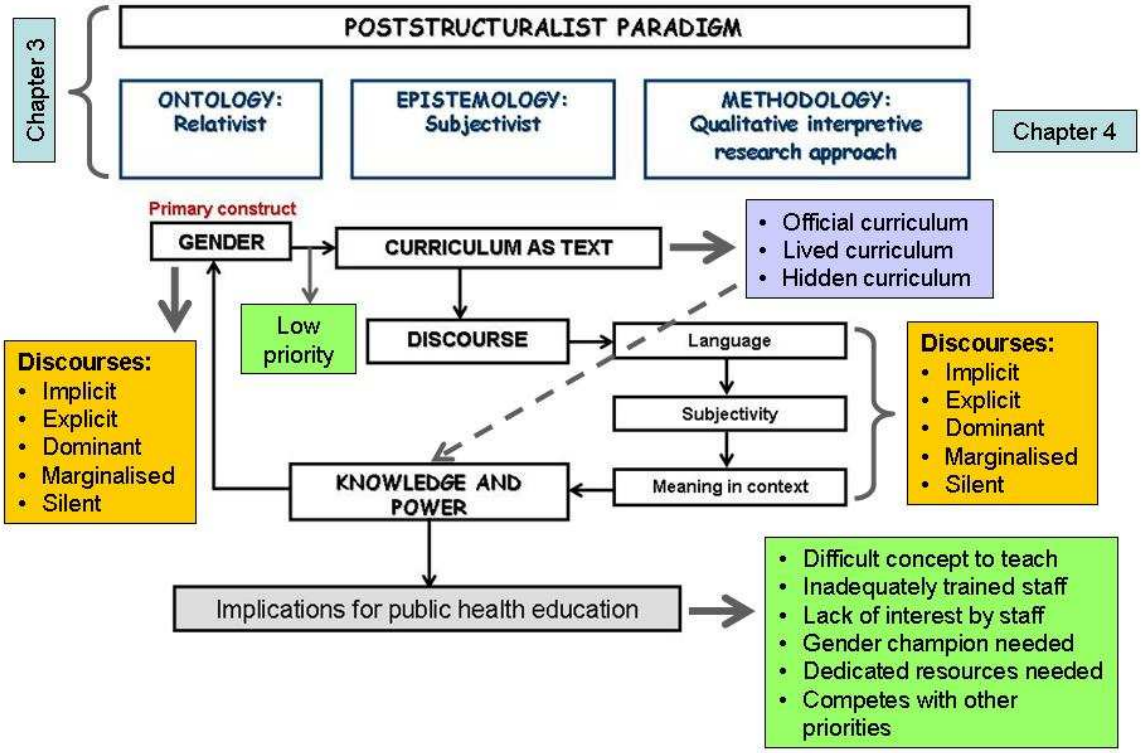

Figure 7-2: The *bricolage*

The *bricolage* also shows the different disciplinary fields and knowledge bases from which the different fragments emerged: public health, gender studies, curriculum studies, social sciences (discourse analysis and a poststructuralist perspective), thus portraying multi-perspective images and the complex relationships between them. Kincheloe (2003) contends

that *bricoleurs* seek multiple perspectives to reflect the numerous relationships and connections that link various forms of knowledge together, not to provide the truth about reality. Kellner (1995) is also of the view that the more interpretive perspectives one can bring to bear on the object of study, the more comprehensive and stronger one's reading may be.

According to Louridas (1999), "a pluralistic approach, in which various heterogeneous and polysemous factors are integrated, is bricolage" (p.17). Accordingly, looking at the world through different lenses is central to the *bricoleur's* task.

Like Pohn (2007), I too feel like an amateur *bricoleur*, and as I conclude, I echo her words that this "work is open and not finished" (p.4) – others may draw on it, to either deconstruct or reconstruct it. I close with the words of Goodchild (2002) and Romanyshyn (2002) quoted by Pohn (2007, p.4) that "this [is] my best effort for now", and "for the moment that's enough".