

A discourse analysis of gender in the public health curriculum in sub-Saharan Africa

by

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Declaration

I hereby declare that the thesis, which I hereby submit for the degree Doctor of Philosophy in Public Health at the University of Pretoria, is my own work and has not previously been submitted by me for a degree at another university.

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Dedication

This thesis is dedicated to my loving daughters:

Sandra

Sherryl

Amanda

Zahara

And serves as an inspiration for them to pursue their education to the highest level possible

Abstract

Gender inequalities are still widely pervasive and deeply institutionalised, particularly in Africa, where the burden of disease is highly gendered. The public health sector has been slow in responding to and addressing gender as a determinant of health. The purpose of this inquiry was to gain a deeper insight into the different ways in which gender was represented in the public health curriculum in sub-Saharan Africa.

A qualitative inquiry was undertaken on gender in the curriculum in nine autonomous schools of public health in sub-Saharan Africa. Official curriculum documents were analysed and in-depth interviews were held with fourteen staff members of two schools that served as case studies. A content analysis of the data was carried out, followed by discourse analysis. A poststructuralist theoretical framework was used as the ‘lens’ for interpreting the findings.

Most of the official curricula were ‘layered’, with gender not appearing on the surface. Gender was represented mainly as an implicit discourse and appeared explicitly in only one core course and a few elective modules. The overwhelmingly dominant discourse in the official curricula was the ‘woman’ discourse, with a strong emphasis on the reproductive and maternal roles of women, while discourses on men, sexuality and power relations seemed to be marginalised.

Gender discourses that emerged from the in-depth interviews with participants were lodged in biological, social and academic discourses on gender. The dominant discourses revolved around sexual difference and role differences based on sex. Participants drew on societal discourses (family, culture and religion), academic discourses and their lived experiences to explain their understandings of gender. Their narratives on the teaching of gender showed that gender was not taught or received a low priority and that it was insufficiently addressed in the public health curriculum. Barriers to teaching gender were: lack of knowledge, resources and commitment; resistance; and competing priorities.

From this study it emerged that curriculum and the production of gender knowledge are sites of struggle that result in multiple understandings of gender that are manifest in dominant and marginalised discourses. Prevailing institutional power relations mirror dominant societal and

political discourses that have a fundamental effect on curriculum decisions and resource allocations. This interplay between dominant discourses and power relations, underpinned by a strong biomedical paradigm, could explain the positioning of gender as an implicit representation in the curriculum, with a more explicit focus on gender in the elective modules than in the compulsory or core courses. Being implicitly represented, gender does not compete with other priorities for additional resources.

It is recommended that the public health curriculum be reconceptualised by: accommodating multiple understandings of gender; questioning constructed dominant gender discourses; considering broader, varied and complex social, cultural, economic, historical and political contexts in which gender is constructed and experienced; and moving from curriculum technicalities to understanding the curriculum as a process and not a product.

Keywords: gender; public health; curriculum; higher education; sub-Saharan Africa; discourse analysis; poststructuralist framework; reconceptualisation

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List of abbreviations and acronyms

ADB	Asian Development Bank
AGI	Africa Gender Institute
AIDS	Acquired Immunodeficiency Syndrome
AORN	Association of periOperative Registered Nurses
APHRC	African Population and Health Research Center
ASPH	Association of Schools of Public Health
BA	Bachelor of Arts
BSc	Bachelor of Science
CHE	Council for Higher Education (South Africa)
CODESRIA	Council for the Development of Social Science Research in Africa
DoE	Department of Education (South Africa)
DPH	Diploma in Public Health
EFA	Education for All
FCI	Family Care International
GAD	Gender and Development
GET	Gender, Education and Training Project
GHETS	Global Health through Education, Training and Service
GM	Gender Mainstreaming
GWS Africa	Gender and Women Studies for the Transformation of Africa
HFA	Health for All
HIV	Human Immunodeficiency Virus
HRSA	Health Resources and Services Administration
ICPD	International Conference on Population and Development
IDS	Institute for Development Studies (Sussex, Brighton)
IIED	International Institute for Environment and Development
IOM	Institute of Medicine
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MPH	Master of Public Health
MSc	Master of Science
NEPAD	New Partnership for Africa's Development
NGO	Non-governmental Organisation

NQF	National Qualifications Framework (South Africa)
OR	Operative Registered Nurses
PAHO	Pan American Health Organization
PhD	Doctor of Philosophy
PMTCT	Prevention of Mother to Child Transmission
PSYSSA	Psychological Society of South Africa
SAQA	South African Qualifications Authority
SCTIMST	Sree Chitra Tirunal Institute for Medical Sciences and Technology
SOPH	School of Public Health
STIs	Sexually Transmitted Infections
TUFH	Towards Unity for Health
UK	United Kingdom
UN	United Nations
UNAIDS	United Nations AIDS Organization
UNESCO	United Nations Education and Scientific Organization
UNICEF	United Nations Children's Fund
US	United States
WGS	Women and Gender Studies
WHO	World Health Organization
WHO-AFRO	World Health Organization Africa Region
WID	Women in Development

Chapter 1

Introduction

Over the last three decades gender has been placed on the international agenda of many conferences and meetings, but it appears to be an unfinished agenda. This thesis reports on a study of gender in the public health curriculum in schools of public health in sub-Saharan Africa. In this chapter I provide a background on why there has been a special focus on gender, how gender wound its way onto the public health education agenda and how my personal experience as a researcher and lecturer on gender and health has contributed to the choice of topic. The exposition of the problem and the research questions are followed by a short description of the research design. The chapter ends with a brief reference to the significance of the study and the organisation of the thesis.

1.1 A focus on gender

The notion of gender seems to be a complex and elusive concept and many authors acknowledge the variety and multiplicity of understandings that exist within gender theory (Alsop et al, 2002; Unterhalter, 2005; Billing, 2009). Conceptualisations of gender can be viewed along a spectrum (Corinna, 1998), ranging from a view of gender as an essence based on biological differences between men and women, to those in-between men and women (Chiweshe, 2010; Lorber, 2006), to social constructionist perspectives that view gender as a socially constructed concept (Alsop et al, 2002), to fluid conceptions of gender as consisting of multiple identities (Grebowicz, 2007).

Some of the major contentions surrounding the concept of gender are its conflation with the term 'sex' or the emphasis placed by some authors and groups on women only. According to the World Health Organization,

The word gender is used to describe the characteristics, roles and responsibilities of women and men, boys and girls, which are socially constructed. Gender is related to how we are perceived and expected to think and act as women and men because of the way society is organized, not because of our biological differences. (WHO, 1998, p.14)

The purpose of this study was not produce a singular definition of gender, but rather, to explore the different ways in which we make sense of being male or female – “we are concerned with the myriad of things which it can be to be male or female and thereby with the processes by which we become gendered ourselves” (Alsop et al, 2004, p.3). According to Unterhalter (2005), different meanings entail different actions and this thesis also examines the meanings and implications of the different ways in which gender is conceptualized. These differences are examined in Chapter 3.

The discussion will start with a short overview of the way in which the concept of gender has found its way onto the agenda of international conventions and declarations, particularly in the period between 1993 and 2000. The strong focus on women could be explained by the fact that gender disparities seemed to disadvantage women disproportionately. Firstly, the international community officially called for the elimination of gender discrimination and violence against women at the World Conference on Human Rights in Vienna in 1993 (Countdown2015, 2004c; Hausmann et al, 2006). This appeal was followed by the International Conference on Population and Development (ICPD) in 1994, which emphasised gender equality and equity, empowerment of women and women’s freedom to make reproductive choices – aspects that were viewed as important for sustainable development (Countdown2015, 2004c). Following on the heels of the ICPD in 1995 was the Beijing Conference on Women (Hausmann et al, 2006). Through the Beijing Platform for Action (1995), a framework was set out for understanding the negative impact of gender inequalities on individuals and on the wider society (UN, 2002). At the turn of the new decade, a set of goals known as the Millennium Development Goals (MDGs) was developed during the United Nations Millennium Summit in 2000. Key among these goals was the recognition that the promotion of gender equality and the empowerment of women were critical to sustainable development (UN, 2002; WHO, 2003).

However, despite all these concerted efforts to place gender at the centre stage of development, evaluation reports indicated that very little gains had been made in the achievement of gender equality (Coen et al, 2004; Countdown2015, 2004a; FCI et al, 2004; UN, 2002). In the words of Family Care International (FCI) et al, “[t]he decade’s performance, to put it bluntly, has been disappointing” (FCI et al, 2004, p.5). Besides, men’s involvement in gender issues and concerns was still very limited (EngenderHealth, 2000; Nadeau & Bankole, 2004).

In Africa there are huge gender disparities at a general level which, according to the New Partnership for Africa's Development (NEPAD), are created and reinforced by negative trends in the economy and by underdevelopment, leading to high levels of female poverty and thus unequal access to and control of resources. In addition, the legal structures to address these gender imbalances in Africa are not strong enough (NEPAD, 2002). However, a deeper analysis by Longwe (2002) of NEPAD's strategies for Africa's development indicates a failure by NEPAD to address structural and institutionalised gender discrimination, as well as a discrepancy between policy and practice. Pauw (2009) also points out this contradiction between policy and practice in South Africa. She claims that despite South Africa's "... progressive gender policy, women's positions remain tenuous and vulnerable in many ways as seen in the high incidence of violence against women, sexual harassment and women's specific vulnerability to and rates of HIV infection" (p.3). This gap between policy and implementation of gender policies has also been decried elsewhere (Countdown2015, 2004b; FCI et al, 2004).

1.1.1 Gender and health

Globally, there are arguments in the literature that the dynamics of gender in health seem to be of profound importance and yet they seem to have been overlooked (PAHO, 2005). For example, there are suggestions that the health sector (including medicine and public health) has been rather slow in recognising and accepting the importance of gender as a determinant of health and health status. In addition, gender has not been taken seriously, nor has it been adequately addressed by this sector when compared to other disciplines (Doyal, 2004a; Doyal, 2005; Hartigan, 1999; Health Canada, 2000; Hoffman, 1997; Klugman, 2004; Simms & Butter, 2002; WHO, 2002). There are furthermore suggestions that the health sector has been jolted into action to begin taking gender seriously only during the last decade and a half, mainly as a result of the ICPD, the Beijing Conference and increasing rates of HIV/AIDS and sexually transmitted infections (STIs) (Countdown2015, 2004b; Jobson & Wyckoff-Wheeler, 2002; Klugman, 2004). According to Simms and Butter (2002), a major reason for this "belated acknowledgement" (p.1) is reportedly the fact that the health sector has for a long time focused on the biological aspects of diagnosis, treatment and prevention, with an emphasis on biological or sex differences as explanatory factors for well-being and illness (WHO, 1998), to the exclusion of more social approaches to public health in which gender is included (Hartigan, 1999; Klugman, 2004; Simms & Butter, 2002; Wong, 2003).

As a result of the above arguments, there seems to be a concerted campaign for the inclusion of gender as an important determinant of health status in public health programmes, policies, curricula and research. For example, widespread calls have been made for the following:

- The inclusion of gender into all health programmes and policies (Doyal, 2004a; Doyal, 2005);
- A more critical reflection upon the influence of gender on institutional structures and scientific and technical paradigms (Hartigan, 1999);
- An increase in health professionals' awareness of the role of gender norms, values and inequality in perpetuating disease, disability and death, and the promotion of societal change with a view to eliminating gender as a barrier to good health (Health Canada, 2000; WHO, 2006a);
- The incorporation of gender concerns in medical education curricula and research (Wong, 2003);
- The recognition of the importance of partnership between women and men, as well as the crucial need to reach out to men with services and education that would enable them to share in the responsibility for reproductive health (EngenderHealth, 2000); and
- An approach to women's health that goes beyond a narrow focus on their reproductive, maternal and child care roles, to include a much broader approach that focuses on other areas of health (Doyal, 2004b; Health Canada, 2000; UNICEF, 2009).

Various reasons have been put forward for the promotion of gender as a determinant of health. Firstly, the Pan American Health Organization (PAHO) and the World Health Organization (WHO) argue 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, 1998; WHO, 2006a). This positioning has the potential of creating inequalities, which could create, maintain or exacerbate dissimilar and often inequitable patterns of exposure to risk factors that endanger health. Additionally, these inequalities could also affect the access to and control over resources and services that promote and protect health (Phillips, 2005; WHO, 2010). Secondly, Doyal (2004b) cautions that excluding sex and gender as key variables in studies are likely to produce incomplete or misleading findings, leading to limited effectiveness and efficiency in public health and medical practice. She argues that this could contribute to perpetuating existing inequalities

between women and men. Thirdly, Hoffman (1997) reiterates that the lack of acceptance of the importance of gender in health could have a significant negative impact not only on women's health, but also on health services, research and the education of health professionals. Finally, it has been argued that the concept of gender has always been misunderstood by being equated firstly to sex and then to women-only issues (Engender-Health, 2000; WHO, 1998). This misunderstanding has supposedly resulted in a focus on reproductive health and women's maternal roles – a focus that has also been reinforced by international treaties and declarations such as Health for All (HFA) and the MDGs (King et al, 2006). Health Canada (2000) maintains that an exclusive focus on reproductive health serves to exclude women of non-reproductive age and of men, thus continuing to perpetuate gender inequality. (See also Greig et al, 2000; Health Canada 2000; Lorber, 1997; Phillips, 2005; UNICEF, 2009; White, 1997).

In general, Africa is faced with a poor health status due to a triple burden of disease arising out of a combination of poverty-related diseases, emerging chronic diseases and injuries. In the last few years, this burden of disease has been compounded by HIV/AIDS (Afrihealth, 2002; GHETS, 2005). According to the World Health Organization's Africa Regional Office (WHO-AFRO), communicable diseases remain the most important health problem in Africa, with the most common causes of death and illness in the region being acute respiratory tract infections, diarrhoeal diseases, malaria, tuberculosis, HIV/AIDS, STIs and infections preventable through vaccination (WHO-AFRO, 1999). Consequently, average life expectancies in many African countries are among the lowest in the world (GHETS, 2005).

The HIV/AIDS scourge in particular has devastated Africa and is by far the greatest challenge that Africa has been confronted with (Kaunda, 2004; UNAIDS, 2008; UNAIDS, 2009). According to United Nations AIDS Organization (UNAIDS), of the 33.4 million people worldwide who were living with HIV in 2008, 22.4 million resided in sub-Saharan Africa, thus accounting for 67 per cent of HIV infections (UNAIDS, 2009). At a global level sub-Saharan Africa is considered the epicentre of the HIV/AIDS pandemic. Southern Africa remains the most heavily affected by the epidemic, with South Africa considered as the epicentre of the pandemic in Africa (Coutinho, 2004; UNAIDS, 2008). AIDS has been reported to be the number one killer on the continent, with an estimated 1.4 million AIDS-related deaths in 2008. AIDS has killed ten times more people than war and has thus reversed

any advances made in health care, education, life expectancy, economic growth and human security (UNAIDS, 2008; UNAIDS, 2009).

According to the Global Health through Education, Training and Service (GHETS) project, women in Africa bear the brunt of the burden of ill health, supposedly due to poverty, inequality and limited decision-making power (GHETS, 2005). The HIV/AIDS epidemic is increasingly manifest in women, especially young women (Biddlecom et al, 2004). HIV/AIDS, along with STIs, has been reported to have a serious gender dimension, with women being hardest hit by the pandemic. Sixty per cent of those infected in sub-Saharan Africa in 2008 were women and girls (UNAIDS, 2009). Apart from HIV/AIDS and STIs that have been highlighted as a major gender and health problem afflicting Africa, other prevalent gender-related health problems that have been noted are maternal mortality and unsafe abortions (Khan et al, 2006; Pattinson et al, 2009; UNICEF, 2009; WHO et al, 2007), violence against women (Abrahams, 2004; Abrahams et al, 2006; WHO, 2005), female genital mutilation (Mitike & Wakgari, 2009; UNICEF, 2005; WHO, 2005; WHO et al, 2007), and the absence of men as a part of solutions to gender and health problems (ADB, 2010; Exner et al, 2009; Keeton, 2007; Nadeau & Bankole, 2004; UNICEF, 2009).

1.1.2 Personal location

The interest and motivation for carrying out this research were directed by my professional and academic circumstances. In 2002 I worked as a consultant on the Afrihealth project. (See Section 2.2.2.7a.) Through this experience, I was exposed to schools of public health and the programmes they offered. However, the data collected during this period was of a quantitative nature and neither addressed the issues nor used the methodologies proposed in this inquiry. I was formally employed by a school of public health from 2004 to 2010, where I offered lectures on gender in various modules and also coordinated the Gender, Education and Training (GET) project. (See Section 2.2.2.7b.)

Given this exposure to the public health curriculum, research and programmes on the one hand, and faced with the stark realities of pervasive gender inequalities in Africa, coupled with suggestions that the health sector had yet to adequately address gender concerns, I felt the need to explore the connections between gender and the public health curriculum.

1.2 Problem statement and research questions

Gender inequalities are still widely pervasive and deeply institutionalised, particularly in Africa, where the burden of disease is highly gendered. However, the public health response to gender as a determinant of health has been slow and inadequate. At the same time, there has been a concerted global push to incorporate gender into all programmes, policies and even curricula. But, this push is based on the assumption that there is a clear and common understanding of what gender is. Milward (2007) indicates that problems around gender terminology raise questions about whether the language of gender has itself been part of the problem in taking gender equality forward. The author points out the need for further investigation and elaboration on the influence of language and how gender concepts could be and have been communicated.

Through this inquiry I wanted to gain a deeper insight into the different ways in which gender was constructed, experienced and thus represented in the public health curriculum in sub-Saharan Africa. The aims of this study were:

- To deconstruct taken-for-granted dominant discourses on gender, leading to reflection and new knowledge; and
- To explore ways in which perceptions of gender in higher education public health programmes could be approached.

In order to achieve this, my inquiry was guided by the following questions and sub-questions:

1. How is gender represented in the public health curriculum in sub-Saharan Africa?
2. What are the emerging discourses on gender in the public health curriculum?
 - (a) How do these discourses relate to mainstream and marginalised discourses?
 - (b) How do these discourses produce and reproduce conventional constructions of gender?
3. What are the perceptions of public health academic staff with regard to gender?
 - (a) What resources have shaped these perceptions?

- (b) How are forms of subjectivity constituted and taken up within these discourses on gender?
- (c) How do academics' own perceptions and experiences construct current discourses on gender in the public health curriculum?

It was not the aim of this study to come up with a singular perspective on gender. Therefore, a discursive poststructuralist framework was chosen to allow for the exploration of multiple understandings of gender and gender subjectivities constructed through discourse. Diverse perspectives on gender were explored through a poststructuralist lens based on the assumption that meaning was created through language (discourse), context and subjectivity. A more detailed exposition of poststructuralism and discourse analysis is offered in Chapter 3.

1.3 Research design and methodology

An interpretive qualitative approach was selected for exploring the meanings that were brought to bear on the concept of gender in the public health curriculum. The research design had two legs encompassing a survey and two case studies. A survey of documents was carried out to gather information on how gender was represented in the curricula of Master of Public Health programmes of schools of public health in anglophone countries in sub-Saharan Africa. Ten schools fulfilled the inclusion criteria but one school was excluded due to its busy restructuring schedule. Two schools of public health were then purposively selected as case studies to provide a more in-depth and nuanced understanding of gender representations in the public health curriculum. The two case studies comprised in-depth interviews with seven members of academic staff in each of the institutions. The two sets of data collected were first subjected to content analysis and subsequently to discourse analysis.

1.4 Significance of the inquiry

This study is the first to reconstruct gender meanings associated with official curriculum documents and staff members' constructions of gender in public health curricula in sub-Saharan Africa by means of discourse analysis. By using a poststructuralist framework as theoretical lens this study makes a significant contribution to understanding the diverse and multiple ways in which gender is constructed in the public health curriculum, instead of

relying on a conventional singular definition of gender. This implies moving away from focusing on gender as a concept to a process of understanding gender.

This reconceptualisation of gender to include an expanded construction of gender should lead to an enhanced understanding of the teaching of gender in public health. Awareness of gender construction in public health curricula could also lead to a process of reflection by schools of public health on the way in which gender is constructed through their official curricula and through the mediation of staff members. When gender is reflected upon and is better understood, it is expected that the interpretations would be better applied to the teaching of public health and to public health practice. Curriculum changes that accommodate different understandings of gender could subsequently, through more gender-sensitive graduates, make a contribution towards efforts in understanding the reasons for the pervasive gender inequality in society and addressing the gaps in the public health response to gender concerns.

Finally, the findings from this inquiry could be useful for informing policy to address gender inequality in sub-Saharan Africa.

1.5 Organisation of the thesis

The report comprises seven chapters. The introductory chapter has given the framework in which this inquiry was carried out by setting out the background, the research questions, the research design and the significance of the study. Below follows an overview of the organisation of the rest of the thesis:

Chapter 2 comprises a literature review of gender in higher education and in the public health environment.

Chapter 3 presents the theoretical poststructuralist framework in which this study was located.

Chapter 4 contains a description of the research design and methodology, including an exposition of the trustworthiness of the findings of the study, the limitations and ethical considerations.

Chapter 5 provides key findings on gender from the analysis of the official curriculum documents.

Chapter 6 presents findings emerging from the interviews with staff in the two schools of public health selected as case studies.

Chapter 7 provides a summary of and reflects on the key findings presented in Chapters 5 and 6 from a discursive poststructuralist perspective, outlines the conclusions and suggests recommendations emanating from the findings.

1.6 Conclusion

This chapter provided a brief overview of why and how gender has appeared in the limelight over the past few decades and the importance of gender as a determinant of health status, with specific reference to Africa. The researcher also provided a synopsis of how she had come to locate herself in this inquiry. This was followed by an outline of the aims of the study, the research questions and a short discussion on the significance of the study. The chapter concluded with a lay-out of the rest of the chapters in this thesis.

The focus of Chapter 2 is the positioning of gender in the higher education landscape in general and in the public health education environment in particular.

Chapter 2

Gender in higher education and the public health education environment

Schools of public health, which are the study sites for this inquiry, operate within the broader context of the higher education environment. Since gender is the central construct for this study, it was crucial to firstly review the literature that is related to how gender is positioned within the higher education environment and what gender issues are being addressed within this system. This review was for the purpose of identifying gaps in the literature and delineating the scope of the inquiry. The theme of gender in higher education is discussed in the first part of this chapter. A global picture of gender in higher education is presented first, followed by a special focus on gender in higher education in Africa, interspersed with a few examples from other non-African countries. Since gender is being investigated within public health education, the second part of the chapter will give an exposition of the public health education environment in general and also explore how gender is located within this environment. Examples of public health education are drawn from both African and non-African countries where this information was available.

2.1 Gender on the agenda in higher education

Universities comprise one of the major sites at which scholarship in gender and its contested meanings and values take place (Pereira, 2002; Unterhalter & North, 2010). In addition, education is a vehicle for gendered discourses (Ducklin & Ozga, 2007). Available reports indicate that gender is firmly on the agenda of general and higher education (Aikman & Unterhalter, 2005; Arnot & Fennel, 2008). Aikman and Unterhalter (2005) contend that the world we live in is characterised by extensive gender inequalities in general. With specific reference to higher education, the United Nations Children's Fund (UNICEF) reports that despite the great strides that have been made to open up access to women in higher education, various socio-economic, cultural and political obstacles continue to impede the full access and effective integration of women into higher education. In terms of simple access, gender is a hindering factor for the female population of lower socio-economic status (Assié-Lumumba,

2006). In Tanzania, for example, it was found that girls with full potential of getting into undergraduate education often left school early to get married in order to comply with social norms (Rathgeber, 2003). Politically, there are fewer women in decision-making positions in higher education and women therefore have limited say in the issues that affect them (Assié-Lumumba, 2006). To this end UNICEF (2005) calls for the elimination of gender inequalities in higher education and the following in particular: gender considerations in different disciplines; the consolidation of women's participation at all levels and in all disciplines in which they are underrepresented; the enhancement of women's active involvement in decision making; and finally, the promotion of gender studies and women's studies as a field of knowledge.

In some circles there is a firm belief that education has an important role in bringing about gender equality (UNESCO, 2003; UNESCO, 2005). This belief has resulted in concerted efforts at international level to come up with targets for achieving gender equality in education (Aikman & Unterhalter, 2005; Arnot & Fennel, 2008; North, 2010). Consequently, a common gender and education agenda has been forged around the globe as countries strive to achieve these targets (Aikman & Unterhalter, 2005; Arnot & Fennel, 2008). These targets are found in several international declarations, including Education for All (EFA), the Beijing Platform for Action and the Millennium Development Goals (MDGs) (North, 2010). Each of these declarations will be discussed briefly below.

Education for All was first launched in Jomtien, Thailand, in 1990 and then reaffirmed in Dakar, Senegal in April 2000. It is an international commitment to bring the benefits of education to every citizen in every society. Goal number 5 of EFA emphasises that girls should have complete and equal access to basic education of good quality and it calls for the elimination of gender disparities in primary and secondary education by 2005, and the achievement of gender equality in education by 2015 (UNESCO, 2005; World Bank, 2009). Although the focus of EFA is on primary and secondary education, the United Nations Education and Scientific Organization (UNESCO) believes that the higher education sector should be more visible in its contribution to the achievement of the EFA targets (UNESCO, 2005). Accordingly, UNESCO (2004) brought together the higher education community in order to explore various ways in which it could contribute to the achievement of EFA. UNICEF (2005) suggests that universities could play a role in "... conceiving and implement-

ing educational projects, organising training projects for non-formal education programmes, research in educational sciences and production of pedagogical materials” (p.1).

In contrast to the EFA targets, which made no mention of gender in higher education, the *Beijing Platform for Action* (1995) was very explicit in its reference to gender and higher education. Strategic objective B.1 refers to eliminating gender disparities in access to all areas of tertiary education by ensuring equal access to career development, training, scholarships and fellowships for women. In addition, strategic objective B.4 calls for the support and development of gender studies and research at all levels of education, with particular emphasis on the postgraduate level. Further, the Beijing Platform for Action (1995) proposes that gender issues be considered in the development of curricula, textbooks and teaching aids, and in teacher training programmes. Finally, the Beijing Platform insists that the study of the human rights of women as they appear in United Nations conventions be included in the programmes of higher institutions of learning (UN, 2007).

In 1996, following the Beijing Platform for Action, UNESCO (2005) launched a special project on *Women, Higher Education and Development*, which culminated in the World Declaration on Higher Education for the Twenty-first Century. Article 4 of this declaration pertains to enhancing participation in and promoting the role of women in higher education. Several objectives were put forward to promote women in higher education, which included:

- The promotion of the rights of women as citizens to full participation in all areas of social development;
- Efforts to improve the access of women, especially those from developing countries, to higher education; and
- Measures to ensure that highly qualified women would participate fully in the decision-making processes of society (Womensciencenet, n.d., p.1).

The Millennium Development Goals were formulated to respond to the world’s development challenges. They were derived from the actions and targets in the Millennium Declaration adopted by 189 nations and signed by 147 heads of state and governments during the UN Millennium Summit of September 2000 (UN, 2002; WHO, 2003). There are eight goals to be achieved by 2015. These include reducing poverty, improving education and general health and nutrition, reducing maternal and child mortality, combating HIV/AIDS and other diseases and achieving gender equality. In the MDGs, the relevant goals for education are goal number

2, namely to achieve universal primary education and goal 3, to promote gender equality and empower women. Although the MDGs refer only to issues of universal primary education in goal 2, there is an implicit implication in goal number 3 that higher education would strive to promote gender equality and empower women as advocated by UNICEF (2005). Thus, the MDG framework has been used in a number of organisations to leverage action on gender, primarily with regard to improving girls' access to schooling and achieving gender parity – equal numbers of girls and boys in school (North, 2010).

So, with gender firmly on the agenda of higher education, what is the nature of gender issues that are being addressed in higher education in Africa? Arnot and Fennell (2008) discuss research on gender and higher education in both developed and developing countries, pointing out that many more large-scale empirical social scientific studies on gender and schooling have been carried out in Western Europe and North America than in developing countries. Morley (2006a) affirms that the dominant literature in the field of gender and higher education is from the United Kingdom (UK), the United States (US), Northern Europe, Canada, Australia and New Zealand. Wernersson and Ve (1997) report, for example, on various areas that have formed part of gender and education research in the Nordic countries such as studies on gender and ability, learning and achievement, gender aspects of classroom interaction, single-sex learning arrangements, action research and gender identity.

A search of the literature on gender and higher education in Africa revealed that a broad range of gender issues is on the agenda of higher education. These issues are explored below and include: access and participation of women in higher education; gender and institutional culture; sexual harassment and sexual violence; teaching sexualities in universities; gender, curriculum and research; gender and institutional policies; the double burden of women in academia; and masculinities.

2.1.1 Access and participation of women in higher education in Africa

Bennet (2002a) reports that initial studies on gender and education in Africa were “... wrapped into a quantitative tale of numbers, ratios, and gaps” (p.1), emphasising mainly issues of access and participation of women in higher education (Ducklin & Ozga, 2007; Morley, 2007). Some of these studies demonstrated that the higher one goes up the academic ladder, the fewer women one finds. Mama (2002), for example, describes the under-

representation of women as intellectual leaders in African universities, with women comprising fewer than six per cent of the professors, a fact confirmed by UNESCO (2002). Shackleton (2007) reports of a similar pattern for South African universities with only three of the 23 vice-chancellors in the country being women at the time of the study, and women filling fewer than 30 per cent of the senior positions (deans, executive directors and deputy vice-chancellors). According to Morley (2007), less policy emphasis has been placed on the qualitative aspects of student access or universities as employers.

With regard to public health in Africa, two studies also highlighted the unequal ratios between men and women. A study undertaken by Afrihealth in 2004 indicated that male staff comprised 63 per cent of the total number of 854 members of staff in schools of public health in Africa. In addition, the study found that 82.9 per cent of male staff had a masters or doctoral degree compared to 71.6 per cent of female staff (Jsselmuiden et al, 2007). In terms of ranks, a Gender, Education and Training (GET) study carried out in 10 schools of public health in sub-Saharan Africa in 2004 also showed that the higher one goes up the academic ladder, the fewer women one finds. The GET study revealed that women comprised 17 per cent of professors, 14 per cent of associate of professors, 36 per cent of lecturers, and 45 per cent of junior lecturers. In terms of leadership, the GET project found that very few women held leadership positions. Women comprised 23 per cent of deans, 21 per cent of academic heads of department, 29 per cent of heads of department and 20 per cent of committee chairs. As far as student enrolments were concerned, women comprised 34 per cent of the total student enrolment (Mwaka, 2007).

There have been concerns that even though access and participation issues have been raised constantly in previous research, the achievement of equal numbers of men and women getting access to and participating in education has not been accompanied by equity in outcomes such as throughputs (the same number of men and women completing their studies in the required time) (Gunawardena et al, 2006). Other concerns centre on the fact that by placing emphasis on quantitative measurements of access and participation, the ways in which institutions are gendered are obscured and the gendered experiences of men and women within national educational institutions are never taken into account (Arnot & Fennell, 2008).

There are various reasons that could explain the gender gap in higher education. Firstly, even though access to higher education institutions has been opened up considerably for female

students, the enabling environment that would harness the capacity and full potential of female students is lacking (Assié-Lumumba, 2006). Gaidzwana (2007), for example, reports of an unfriendly and hostile environment at the University of Zimbabwe that hinders female student participation. Mlama (1998) also writes about a hostile atmosphere and rampant sexual harassment at higher education institutions where male-dominated courses serve as obstacles for women students to reap the full benefits from their university education and learning experiences. There have been observed weaknesses at the policy, institutional, organisational and micro-political levels of putting into place strategies to combat gender inequality in higher education – what Assié-Lumumba (2006) refers to as “timid” policies (p.14). Finally, there are also reasons that are related to the colonial legacy of higher education in Africa, where it is argued that African universities were established to nurture African male elite and in this way located women at the margins of higher education (Assié-Lumumba, 2006).

Calls have therefore been made for the broadening of the concept of gender equity to go beyond numbers and encompass more qualitative issues and the transformation of gender relations within educational institutions as well (Aikman & Unterhalter, 2005; Arnot & Fennell, 2008; Barnes, 2007; Morley, 2006b). A further concern raised by Harrop et al (2007) is the treatment of students in higher education as a homogeneous group. These authors lament the fact that most research in higher education has been conducted with groups of students undifferentiated by gender, implying that gender differences were unimportant and or negligible. They conclude that researchers ought to be wary of conducting research into various aspects of higher education without considering potential gender differences.

Despite the fact that the studies on access and participation focused mainly on statistical data (Arnot & Fennell, 2008; Bennet, 2002a), there is a general feeling that these studies were able to provide empirical evidence that highlighted the unequal ratios of women to men in schools, in tertiary education, in different courses, in professional ranks, and in management and leadership positions within institutions of higher education in Africa (Barnes, 2007; Bennet, 2002a; Kwesiga & Ssendiwala, 2006). Furthermore, they were able to show how access to education was an important driver of women’s social and economic empowerment (Bennet, 2002a; Mama, 2002).

Notwithstanding the quantitative nature of previous research there is now an emerging and growing body of work on gender equity in education in general, and higher education in particular, in developing countries (Morley, 2006a), which is increasingly using qualitative methods, including local historical narratives, to explore issues of gender access and participation in higher education. This research is evident in high level research and publications that have emanated from studies on gender equity in higher education in low-income commonwealth countries (Kwesiga & Ssendiwala, 2006; Morley, 2006a; Morley, 2006b) and from *Feminist Africa*, a publication of the Africa Gender Institute (AGI) at the University of Cape Town, to name a few. *Feminist Africa* (2008) asserts that it is a journal that seeks to “... challenge the technocratic fragmentation resulting from donor-driven and narrowly developmentalist work on gender in Africa” (p.1).

Gunawardena et al (2006) used qualitative methods to study if increased access in terms of numbers had succeeded in empowering women in university education and found a discrepancy between numerical parity and equity in outcomes and change in the quality of education. In general their findings showed that there was negligible participation of women in teaching and learning, extra-curricular activities (including politics) and decision-making bodies. Kwesiga (2002) used quantitative data to depict the enrolment ratios of males and females in sub-Saharan African universities. However, she went further and used a ‘qualitative lens’ to unearth the underlying reasons behind the low enrolments of women in higher education and found that these were mainly related to the family, the state and the institutional culture. Morley (2006b) also reports of a study in several higher education institutions that combined a scrutiny of existing quantitative data with the collection of original qualitative data. She adds that “[q]ualitative data were sought to illuminate and provide some explanatory power for the statistics, e.g. why there are so few women students in science subjects and why there are so few senior women academics and managers in higher education” (p.539). Consequently, Bennet (2002a) emphasises that issues of gender disparities need to be linked to context-specific histories of the interplay of class, ethnicity and race, as this illuminates the gender gap. She urges researchers to illuminate specific and disaggregated cases of gender disparities, unequal power relations within different institutions and why affirmative action policies have not made any profound impact in order to offer more nuanced and deeper understandings of the gender gaps (Bennet, 2002a).

In public health, the Afrihealth project used mainly quantitative data (IJsselmuiden et al, 2007). The GET project tried to explore in more nuanced and localised ways, the gender difference in access to study finance and resources and obstacles that impeded the progress and completion of the Master of Public Health (MPH) degree (Mwaka, 2007). The study showed that, in general, women students had less access to scholarships and personal resources such as personal computers and laptops to use away from the campus, and these, together with additional household tasks made it difficult for them to complete their MPH degree within the required time and at the required standard.

As has been pointed out by several authors, quantitative measures do not lead to equality and empowerment of women. What eventually leads to equality are the processes put in place to level the playing field and create an enabling environment that harnesses the capacities of and facilitates the realisation of the full potential of female students. In this way the educational outcomes and the value attached to them could be achieved by both male and female students. Female students become truly empowered when the benefits they accrue from the academic results and social outcomes of their educational experiences lead to

... economic productivity, the exercise of social and political responsibility and the authority to demand the respect of individual and group rights ... to use the knowledge acquired to bring informed insights into social and political decision-making processes ... (Assié-Lumumba, 2006, p.14)

2.1.2 Gender and institutional culture

Other studies have focused on the gendered nature of institutions. Bennet (2002a) reports that some dynamics that involve the process of becoming gendered have received relatively little attention by gender-equity theorists. However, some later studies have explored this issue. Barnes (2007) examined the institutional and organisational structures that perpetuated and reproduced gendered inequality in African universities. Some of the main findings relate to a “chilly” (p.22) climate that isolates and marginalises women students and administrators, while privileging hegemonic masculinities as the norm. The studies referred to in the paragraph that follows are cited as examples of the above.

Mbongo et al (2007) conducted a case study inquiring into challenges of building a gender-responsive institutional culture in higher education at the University of Buea in Cameroon. These authors found a strong patriarchal gender culture, sustained through unquestioned

everyday procedures, practices and values, to be the major stumbling block. A study by Odejide et al (2006) at the University of Ibadan in Nigeria found that while gender was not explicitly on the university's agenda, university life was a highly gendered experience. Besides, for female staff, power relations symbolically constructed and regulated their experiences of work. The authors recommended the formulation, implementation and evaluation of gender-equity policies to address gendered experiences of female staff at the university. Morley (2006b) analysed women student and staff experiences of the gendered organisational culture of higher education in commonwealth countries. She found that discrimination against women took place in higher education, but occurred in subtle and complex ways, even in institutions where equity policies were in place. Shackleton's (2007) case study of an initiative to study institutional culture provided some insights into the persistence of deep-seated gendered attitudes contributing to maintaining male privilege, even in a liberal higher education environment. Morley (2010) wraps up the issue of gender and institutional culture by claiming that women experience a range of discriminatory practices and gendered processes within higher education. She concludes that the everyday experiences of women in higher education are shared in a very real way by gendered power relations. My study also explored institutional power relations prevailing in public health and training.

2.1.3 Sexual harassment and sexual violence

A gender issue that is increasingly receiving attention in higher education is sexual harassment and sexual violence and, according to Rice (1996), has become a concern of some philosophers of education. Bennet (2002b), who has been tracking work conducted on sexual harassment and sexual violence in African universities, remarks that “[i]t is rare to find a discussion of gender and higher education in Africa which does not mention sexual harassment and sexual violence as critical sources of injury to women on campus” (n.p.). She contends that over the previous 12 years, sexual harassment and sexual violence have increasingly become important areas of study within higher education. Bennet (2002b) also reports on studies that began in several Southern African universities on the nature and practice of sexual harassment and sexual violence on their campuses in the early 1990s. These studies were geared towards the development of policy on sexual harassment and sexual violence. It was found that there were many different forms of sexual abuse occurring simultaneously within higher education institutions. These studies have produced some concrete results such as the institution of new policies, educational programmes and

disciplinary procedures. Kwesiga and Ssendiwala (2006), for example, report that at Makerere University in Uganda a public outcry about sexual harassment resulted in the formulation of policies and regulations against sexual harassment. This university's sexual harassment policy is a regulatory framework through which sexual harassment against students and staff can be prevented or redressed in case it occurs. It aims at tackling acts of sexual harassment at all levels within the structures of the university. Other studies between 2005 and 2006 in several Southern African universities investigated the effectiveness of official institutional policies on sexual harassment in highly gendered and complex environments that are typical of institutions of higher learning. Bennet (2002b) maintains that the prevalence of sexual harassment in institutions of higher learning raises a pertinent question about the core business of universities, which demands further investigation.

2.1.4 Teaching sexualities in African universities

A new area of gender study that is slowly finding its way onto higher education research and scholarship agenda is sexuality. The Gender and Women Studies for the Transformation of Africa (GWS Africa) contends that although sexuality is an integral part of the experience of being human, there has been silence about its study within academia in Africa (GWS Africa, 2009). This silence is perhaps a reflection of how sexuality is perceived in Africa. Gune and Manuel (2007) claim that in most of sub-Saharan Africa the issue of sexuality has been shrouded in silence and is often regarded as a sensitive topic, if not a taboo that must not be mentioned in public. The African Population and Health Research Center (APHRC) explain that "... cultural and social barriers inhibit the discussion of sexuality within sub-Saharan Africa's academic arena" (APHRC, 2010, p.1).

With regard to homosexuality, GWS Africa (2009) states that there seems to be widespread homophobia directed at homosexual people, led by some prominent African state leaders. The Psychological Society of South Africa (PSYSSA) describes this homophobia as follows:

In much of sub-Saharan Africa, homosexuality is first of all interpreted as foreign, portrayed as un-African and a white import. In some traditional African beliefs those of a same-sex sexual orientation are considered cursed or bewitched. In primarily Christian and Muslim African countries alike, gay men and lesbian women are confronted with religious condemnation. (PSYSSA, 2010, p.3)

Accordingly, the questions raised by a focus on sexualities are often deeply controversial, and may have implications for both research and teaching in African contexts (GWS Africa,

2009). GSW Africa (2009) suggests that when teaching about sexualities, one needs to negotiate a careful path and respect the different spaces in which students may be embedded.

Apart from homophobia, another emerging issue among sexuality scholars and researchers is that of women's sexuality – it is argued that most of the writing on women's sexuality is about their experiences of pain and disempowerment (GWS Africa, 2009). GSW Africa (2009) points out that African women's sexuality is perceived as inherently pathological and is therefore often medicalised with themes such as sexual violence, female genital mutilation, reproductive health and rights, and HIV/AIDS. These themes also mirror common health problems among women reported at the end of Section 1.1.1. But, in contrast to the common pathologisation of women's bodies, there is great silence when it comes to positive discourses on women's sexuality such as eroticism and pleasure, and positive power (GWS Africa, 2009). Consequently, suggestions are emerging to promote more positive constructions of sexuality that affirm pleasure and desire (Correa 2002; Jolly, 2007; Klugman, 2000; Petchesky 2005; Tamale, 2005). (See also the latter part of Section 5.3.1.2.) GWS Africa (2009) acknowledges, however, that it is only over the last decade that increasing attention has now started to be paid to sexuality studies in the academy in Africa.

2.1.5 Gender, curriculum and research

Universities are viewed as principal sites of the production of gendered knowledge (Pereira, 2002). Accordingly, it was important to this inquiry to explore studies that explain what kind of gendered knowledge is produced in institutions of higher learning.

According to Arnot and Fennel (2008), there is a paucity of research on gender and curriculum in higher education. Bennet (2002a) also decries the almost complete absence of gender analysis as a key tool of social research in curricula and research. Arnot and Fennell (2008) point out that “[s]chool knowledge with its gendered assumptions and attributions plays a key role in the formation of gender identities, and helps sustain rather than challenge gender hierarchies and inequalities within a society” (p.519).

While there is no direct and detailed reference to gender issues that are addressed in the curriculum, most authors write about women's and or gender studies as a field of teaching and research. Mama (1996) contends that “[t]he almost worldwide emergence of women's studies

as a field of research, teaching and study is generally viewed as resulting from the impact of the international women's movement on the academic establishment” (p.1). There is no doubt that the women's studies that emerged in the 1970s and 1980s had a specific feminist purpose – liberating women and ensuring that women's lives, realities and concerns were central to the content of knowledge production (Mama, 1996; Pereira, 2002). Mama (1996) characterises this knowledge as research and teaching conducted “on women, by women, for women” (p.5). However, she laments that although a number of university courses on gender have been established over the years, many of them are faced with problems such as under-staffing, lack of resources and marginalisation. In most cases, these courses are hinged on the efforts of one individual and volunteers.

Where Mama (2002) focuses exclusively on women's studies, Pereira (2002) tries to make a clear distinction between women's studies and gender studies. She explains that although both fields have a shared concern for the status and conditions of women, gender studies specifically focus on the socially constructed differences between men and women in a given context. Consequently, gender studies involve a wider scope of work. Pereira (2002) refers to two ends of a spectrum. One end includes those studies that desire to show neutrality and inclusiveness by taking into account analyses of men's relations with women, without necessarily challenging women's domination and oppression by men. Pereira (2002) goes on to explain that the other end of the spectrum includes analyses that recognise inequalities and gendered relations of power. She concludes that studies within women's studies and gender studies that aim to subvert oppressive gender hierarchies (rather than merely describe the relevant phenomena concerning women and or gender relations) have the potential to deal with issues of change and transformation and, in the process, radically transform social knowledge, including what traditionally counts as knowledge.

Some references to gender issues addressed in curriculum and research have been made by a few authors. While examining the content of gender research and women's studies in Africa in the 1990s, Mama (1996) found that these could be loosely categorised into the following clusters:

- Women and the state: governance, politics, nationalism, liberation movements and structures for women;
- Culture: religion, sexuality, identity and life history studies; and

- Work and economy: urban and rural, formal and informal sectors, domestic labour and sex work.

Lewis (2002) reports that most taught courses on gender have been informed by feminist theories and have emanated mainly from literary and cultural studies. According to this author, the content has evolved from examining the symbols and codes that reproduce a range of social processes to popular culture (for example, in black urban popular culture) and, more recently, to readings of television texts. Pereira (2002) explains that at a workshop held in November 1996, participants reviewed the concepts ‘woman’, ‘women's struggles’, ‘gender’, ‘feminism’ and ‘feminist theory’, with the aim of developing more meaningful and effective concepts that could be grounded in local realities for women’s studies in Nigeria. The participants concluded that what was significant was the particular conceptualisations related to how this expanded or restricted the possibilities for diverse categories of women and men, given their different social contexts. The study by Odejide et al (2006) examined the agriculture curriculum at the University of Ibadan, Nigeria, and found that it lacked a gender perspective due to limited knowledge and expertise, the bureaucracy involved in curriculum change, poor pedagogy, and a prevalent negative attitude to gender.

In her analysis of women’s studies, one of Mama’s (1996) objectives was to understand how these studies successfully reflected the African feminist agenda of transforming gender relations in the direction of greater equity. Lewis (2002) states that the current field of gender studies is “... dynamic, receptive to new directions and findings, and vitally attuned to priorities for transformation and justice in Africa” (p.3). When interrogating the status of gender and women's studies in Nigeria, Pereira (2002), however, was concerned when she found that at that point gender and women's studies lacked the ability to further the strategic objectives of women for gender justice.

The aim of this study was also to explore the status of gender by interrogating the various ways in which gender was understood and represented in public health curricula in sub-Saharan Africa and which strategic interests the curricula were advancing. The status of gender in schools of public health is further discussed in Section 2.2.2.5.

2.1.6 Gender and institutional policies

Bennet (2002a) found that policies on gender equity varied from institution to institution and depended on various contextual and historical factors such as the influence of the state, institutional leadership and ideology, internal and external pressure from women's groups, and prevailing economic and political policies of the time.

According to Bennet (2002a), most African universities lack a gender-equity policy, let alone putting direct measures in place to increase female student populations. The popular and most common form of gender-equity policy is affirmative action (Bennet, 2002a; Kwesiga & Ssendiwala, 2006). Morley (2006b) comments that affirmative action is a policy priority for universities in South Africa, Tanzania and Uganda that comes in various forms and includes the following: setting quotas for women students; additional course credits for women; setting targets for appropriate numbers of female staff, especially at management level; and highlighting the variable impact of these interventions (Bennet, 2002a; Kwesiga & Ssendiwala, 2006). Bennet (2002a) explains that the call for affirmative action on the continent is a result of the recognition of the profound impact of education on the lives of women and girls. In addition, women and girls are faced with insurmountable barriers in accessing and completing their education. (See also UNESCO, 2003; UNESCO, 2005.)

Bennet (2002a) further observes that demands for gender-equity policies often compete with other discourses on historical exclusions. For example, in South Africa debates on equity and affirmative action are dominated by questions of race, where policies and processes to transform universities concentrate mainly on changing the racial profiles of students, staff, and management, particularly in previously 'white' universities (Morley, 2006b; Shackleton et al, 2006). At universities in other countries issues of poverty and the rights of marginalised populations within a country have raised vibrant equity debates (Kwesiga & Ssendiwala, 2006). Bennet (2002a) gives examples of Uganda, where the national policy on higher education stipulates that access criteria be based on the potential students' ability to finance their education and on their region of origin. The equity policies of the University of Zimbabwe are considered mature and special entry options exist to give access to war veterans (Bennet, 2002a).

In addition, affirmative action has been criticised as a blanket cover that ignores other forms of inequality by assuming that female students are a homogeneous group (Hankivsky, 2005; Kwesiga & Ssendiwala, 2006). Some of these forms of inequality relate to the rural-urban divide and the lower level of attention given to people with disabilities and students from war-torn and hard-to-reach areas (Kwesiga & Ssendiwala, 2006).

Affirmative action has been accompanied by vehement backlash, stigmatisation and name-calling of women who enter universities through affirmative action (Bennet, 2002a; Morley, 2006b). Such incidents are underpinned by a deep resentment towards women students and misplaced perceptions about the inferiority of women's brains, suggesting that women's intellectual potential should automatically be assumed to be weaker than that expected from men (Bennet, 2002a). Nonetheless, affirmative action is to be viewed as a necessary evil that facilitates access for women to higher education and that is essential if carried out from informed conviction (Bennet, 2002a; Kwesiga, 2002). Besides, affirmative action is seen as a concrete strategy for improving poor ratios of female students compared to males and has an impact on statistics describing student populations (Kwesiga, 2002).

2.1.7 The double burden of women in academia

Another gender issue that has been highlighted in higher education is the "... double burden of women, where they pursue their academic obligations, while at the same time meeting their 'traditional obligations' such as labour-intensive child-care, household management, support for the elderly, and so on" (Tamale & Oloka-Onyango, 2000, p.5). Bennet (2002a) describes how a few decades ago, women's burden became an advocacy issue on various campuses where women organised and demanded the provision of crèches and child care facilities on campus, maternity leave, and benefits that could accommodate family needs for health and housing. She asserts that this trend of activism raises new questions about the core business of universities and demands that there be institutional recognition of women's dual labour.

2.1.8 Masculinities

Huang (2008) emphasises the significance of men's studies for gender equality education and points out that men's studies could promote this and open new opportunities for practice. However, most studies on gender in higher education in sub-Saharan Africa have until

recently focused on women and femininities. By 2002, the AGI was of the view that masculinities remained a major under-researched area for African scholars (AGI, 2002). Morley (2006b) reports how a study carried out in various institutions of higher learning revealed that "... masculinities were rarely problematized" (p.541). Morley (2007) also contends that masculinities are rarely considered in relation to gender mainstreaming in higher education.

On the other hand, Macleod (2007) indicates that in recent times there has been "a burgeoning of literature on masculinity" (p.4) in Africa, both within and outside academia. Ouzgane and Morrell (2005), for example, edited a book on African masculinities in which they explore what it is for an African to be masculine and how male identity is shaped by cultural forces. Uchendu (2008) also edited an array of papers by various scholars from different disciplines with a research interest in the study of men and masculinities in Africa. These papers critically examine the varieties and consequences of Africa's masculinities and what these mean for the people of Africa and for gender relations on the continent.

In the field of education, Chagonda and Gore (2000) carried out some research on masculinities in Southern Africa that demonstrated the complexity, tension, and difficulty of becoming a man at the University of Zimbabwe. Bennet (2002b), however, reports that not much work on masculinities has been carried out in Western and Eastern Africa. According to Macleod (2007), the bulk of studies on masculinities in Africa related to the many various forms of violence such as wars, genocides, familial violence and crime are located in South Africa. Masculinity topics that have been researched in South Africa have focused on "boys, guns, sport, violence, families, kinship, performing masculinity, identity, sub-cultural practices, work, leisure, travel, sexuality, race, homosexuality and heterosexualism" (Macleod, 2007, p.5). Lewis (2002) also refers to research conducted on the crisis of masculinity in post-apartheid South Africa and adds that the subject of masculinity is increasingly becoming an important theme in research, writing and curricula in South African gender-studies programmes.

2.1.9 Approaches to gender and education

All the studies on gender and education produced by different researchers and described in the previous section could be categorised into different approaches to gender and education. For the purpose of understanding this categorisation the outline by Aikman and Unterhalter (2005) is used – the women in development approach (WID), the gender and development (GAD) approach and the poststructuralist approach. Although gender mainstreaming (GM) is mainly linked to gender and development as a strategy for achieving gender equality, it was included as the fourth approach in the analysis. A summary of the main features of these four approaches is provided in Table 2-1. (See also Section 3.2.1.1 on feminist perspectives on gender.)

2.1.9.1 Women in development approach

According to Aikman and Unterhalter (2005), the women in development (WID) framework places a strong emphasis on ensuring the access of girls and women to the school system. In this framework, education is understood as schooling, while gender is equated with women and girls viewed in terms of their biological differences (World Bank, 1994). Empirical work utilising the WID approach has been mainly quantitative and has focused on gender issues of access, retention and achievement. Other analyses have highlighted the social benefits of sending girls to school to increase income-earning potential and reduce birth rates and infant mortality, indicating that the benefits of women’s education are to be realised in the household. In this way the WID approach is integrally linked to liberal feminism discussed in Section 3.2.1.1a in the next chapter. Both the Afrihealth and GET projects, discussed in Sections 2.1.1 and 2.2.2.7b respectively, followed a development approach where the aim was to highlight the difference between men and women in public health education.

According to Aikman and Unterhalter (2005), the way in which equality is interpreted on the WID framework directs the actions of the users of the framework. These authors posit that in the WID framework “... equality is understood in terms of equal numbers of resources: for example, places in school for girls and boys, male and female teachers employed, or equal numbers of images of women and men in textbooks” (p.5).



Table 2-1: Key features of the WID, GAD, GM and poststructuralist approaches to gender equity

Approach	Women in development (WID)	Gender and development (GAD)	Gender mainstreaming (GM)	Poststructuralism
Origin	Development politics and practices 1970s	1980s	Feminist activism Mid 1990s	Academia in the North 1960s to 1980s
Key construct	EQUALITY			Recognition of difference
Focus	<ul style="list-style-type: none"> Girls and women 	<ul style="list-style-type: none"> Power, relations, social structures 	<ul style="list-style-type: none"> Transforming mindsets and actions Changing organisational culture 	<ul style="list-style-type: none"> Understanding identity
Aim	<ul style="list-style-type: none"> Equal numbers Access and resources 	<ul style="list-style-type: none"> Removal of structural barriers 	<ul style="list-style-type: none"> Gender-aware policy and practice 	<ul style="list-style-type: none"> Questioning the stability of gender definitions and knowledge production
Methods / strategies	<ul style="list-style-type: none"> Providing access and resources 	<ul style="list-style-type: none"> Gender policies Restructuring of institutions Empowerment of women Gender mainstreaming 	<ul style="list-style-type: none"> Guides and toolkits Integration Agenda setting 	<ul style="list-style-type: none"> Deconstruction
Achievements	<ul style="list-style-type: none"> Women recognised as important players in the development process 	<ul style="list-style-type: none"> Included men and women and the relations between them Recognised other markers of inequality such as age, race and class Addressed broader economic, social and political processes 	<ul style="list-style-type: none"> Created gender awareness 	<ul style="list-style-type: none"> Recognised complex social identities Affirmed subordinated identities
Shortcomings	<ul style="list-style-type: none"> Ignored social structures that produce equality Focus on public sphere and neglect of private sphere 	<ul style="list-style-type: none"> Measures intended to benefit women specifically can be lost when men are incorporated 	<ul style="list-style-type: none"> Gender treated as a unitary category Strong focus on integrationist approach – people and institutions remained unchanged 	<ul style="list-style-type: none"> Lack of recognition of agency Ignored material conditions of people

2.1.9.2 Gender and development approach

Aikman and Unterhalter (2005) trace the origin of the gender and development approach (GAD) to the late 1980s, with its main focus on the importance of gendered power structures of inequality in varying contexts and the complexities involved in the reproduction and transformation of gendered relations.

GAD's understanding of equality differs significantly from that of WID. Aikman and Unterhalter (2005) point out that the GAD framework depicts equality in terms of the elimination of the structural barriers to gender equality. Hence, research and policies based on this framework encourage strategies that address deeply entrenched and sometimes unacknowledged gender inequities at all levels of society – schools and universities, education ministries, political decision making, families, and the labour market. Gender issues arising from practice and interpreted according to this framework include: bias in the curriculum; mixed or single-sex schools; the appropriation of femininities in schools; approaches to sex education; levels of sexual harassment across the education system; and the intersections of race and gender discrimination.

GAD was adopted as an attempt to move away from a focus on gender relations and the social structures that shape women's disadvantage (Kanji, 2003). It was increasingly recognised that a specific focus on women would not help in understanding the problems faced by women. Further, women are not a homogeneous category, but are divided by class, race, ethnicity and other socially constructed identities and relationships (Cos-Montiel, 2004). In the 1980s attempts to integrate women into development did not achieve the required results, largely because of the gendered nature of institutions. This failure led to a greater emphasis on the need to restructure institutions to ensure that they reflect and represent women's interests (Cos-Montiel, 2004).

Aikman and Unterhalter (2005) highlight some of the achievements of the GAD approach in the education sector. They maintain that the GAD approach has changed some educational approaches and practices such as "teachers' understanding of work in a gendered classroom, linking of education-related demands to wider demands for empowerment, and the ways in which advocates of gender equality work in institutions" (p.17).

2.1.9.3 Gender-mainstreaming strategy

Gender mainstreaming (GM) is an international phenomenon that emerged in the 1980s and was associated with feminist activism that culminated in the United Nations (UN) Decade for Women (1976–1985) (Unterhalter & North, 2010). The main motivation behind the introduction of GM was the marginalisation of women’s needs and interests from the mainstream of development processes (Unterhalter & North, 2010). GM was then adopted as a key area of action during the Beijing Conference on Women in 1995 and since then, policies to effect GM have been adopted worldwide in over 100 countries (Morley, 2010; Unterhalter & North, 2010). Furthermore, GM has been adopted as a strategy for achieving gender equality at all levels of the education system, including higher education (Karlsson, 2010; Morley, 2010; North, 2010; Para-Mallam, 2010; Silfver, 2010; Unterhalter & North, 2010; Vaughan, 2010). The adoption of GM as a strategy for achieving gender equality by many countries and institutions worldwide means that there would be multiple interpretations and, in this regard, GM remains a contested space in terms of its conceptualisation and practice (Morley, 2010). Accordingly, a number of tensions and shortcomings have been highlighted by several gender researchers and are presented below.

Firstly, the tension is between *gender mainstreaming and feminism*. Several authors claim that although GM is a strategy that was originally informed by feminist theory, it has increasingly been neutralised, leaving it empty of the intended feminist ideals of transforming gender relations (Hartmann et al, 1996; Morley, 2010; Unterhalter & North, 2010). The second tension is that between *policy intention and practice*. Morley (2010) is frustrated with heightened policy-making activity that has not translated into any tangible material gain for women and claims that policy commitments to gender have a “... tendency to evaporate during implementation” (Morley, 2010, p.535). (See also Section 1.1. in relation to the status of gender equality on the African continent.) The third tension is that between *technical and transformative interpretations*. Gender researchers seem to be in agreement that too many guides and toolkits for GM have been developed, resulting in the perception of GM as a technical, mechanistic and inflexible operation (Morley, 2010; North, 2010; Unterhalter & North, 2010; Vaughan, 2010). The fourth tension is that between *an integrationist and agenda-setting approach*. According to Morley (2010), “[t]he integrationist approach seeks to introduce a gender perspective into existing policy while an agenda-setting approach seeks to challenge and transform policy paradigms in the process of engendering policy” (p.536). But

in practice, GM is supposedly associated more with the integrationist approach where women are “added in” to various policies and programmes (Unterhalter & North, 2010, p.390). According to Unterhalter and North (2010) and North (2010), undue focus on an integrationist approach means that more substantive understandings of gender that relate to the experiences of girls and women in and beyond school remain unproblematised and unaddressed. (See similar comments in Section 2.1.1.)

Apart from the tensions mentioned above, GM is perceived as assuming a homogeneous category of gender and by being perceived in this way, it seems to ignore the intersection of gender with other markers of inequality, such as race, ethnicity, age, socio-economic status, disability, sexual orientation and religion (Morley, 2010). GM also tends to concentrate on differences between men and women, treating each category as a unitary, one-dimensional unit of analysis. In this way, it is said to obscure the differences between women, thereby missing out on more nuanced understandings of differences among women. (See also Harrop et al, 2007.)

Some suggestions have been offered by gender researchers on how to move beyond an integrationist gender-mainstreaming approach to one that will address substantive gender equality. Firstly, Silfver (2010) highlights the need for GM to move beyond counting numbers to paying closer attention to local understandings of gender – the specific historical and political contexts in which gender-equity politics and mainstreaming policies are developed. Secondly, there is a need to move beyond quantitative measurements and move to addressing and changing deep-seated values and relationships that are held in place by patriarchal power and privilege (Morley, 2010). Thirdly, there is a need to pay close attention to the intersection between gender and other social divisions and identities (Unterhalter & North, 2010). Finally, there is a need to go beyond technical measures to engage critically with sexist interpretations of religious texts and cultural norms to transform patriarchal education systems (Para-Mallam, 2010).

2.1.9.4 A poststructuralist approach to gender and education

The last approach outlined by Aikman and Unterhalter (2005) is the poststructuralist approach, which questions stable gender definitions and promotes the interpretation of fluid processes of gendered identification and shifting forms of action. In linking education to

poststructuralism, these authors contend that education is, in a way, a process of recognising this fluidity and questioning the process of marginalisation of identities that could not conform to the norm. Hence, the objective of poststructuralism is not equality, but rather the recognition of difference. Whereas WID and GAD emerged out of development politics and practice, and GM from feminist thinking, poststructuralism emerged directly from academics located in universities in Western Europe, North America and Australia (Aikman & Unterhalter, 2005).

Poststructuralist writers on gender, education and development have been employed in higher education, with those from developing countries either working with or closely connected with their Western counterparts. Aikman and Unterhalter (2005) and Arnot and Fennell (2008) decry the scarcity of poststructuralist work in developing countries. However, Aikman and Unterhalter (2005) suggest that the complex challenges posed by the HIV/AIDS epidemic have contributed to the expansion of poststructuralist work in developing countries. This work includes topics such as the gendered and sexualised identities of learners and teachers, ways in which meanings associated with school spaces challenge concerns with gender equality, and the shifting identities of educated women in Africa and India. Finally, they credit poststructuralism for placing on the agenda the recognition of complex social identities and the affirmation of subordinated identities. In this inquiry, a poststructuralist approach was chosen to explore multiple understandings of gender and gender subjectivities that are constructed through discourse. This approach forms the theoretical underpinning of this study and is discussed in more depth in Chapter 3.

2.1.10 Conclusion

The preceding section highlighted the gender issues currently addressed in higher education and showed the gendered nature of higher education institutions. Different approaches to addressing gender in higher education were also discussed. We now turn to the public health higher education environment.

2.2 The public health environment in higher education

Since this inquiry focuses on gender in the public health curriculum, it is important to give a brief overview of the public health education environment in which the inquiry was conducted and to explore where gender fits into this environment. It is also important to point out that there is a paucity of information on public health education, and particularly on the public health curriculum in Africa. Mokwena et al (2007) observe that education efforts have been hampered by a shortage of data, and it is only recently that IJsselmuiden et al (2007) published results of a survey of public health institutions across the continent.

2.2.1 The concept of public health

Baum (2002) emphasises the importance of comprehending the various ways in which health is understood, since this would be important in appreciating the changes in thinking about health over time. The term ‘public health’ has evolved through time from a narrow definition, which limited it essentially to sanitary measures and communicability of disease (Orne et al, 2007; Pickett & Hanlon, 1990) to a much broader concept that encompasses actions taken to protect or improve the health of the public (Hamlin, 2002; Orne et al, 2007). Given the lack of information on the history of public health in Africa, a look at the UK’s history gives a precise picture of how public health evolved from sanitary measures in the nineteenth century, to community medicine in the mid-twentieth century, with a focus on managing disease at a population level (Orne et al, 2007). In the 1980s the focus shifted to an ecological perspective of health, with a focus on environmental determinants of health. At the same time there was a growing concern about the role of socio-economic factors as determinants of health status and health inequalities. Consequently, the concept of public health was broadened, with the emphasis on tackling the root causes of poor health through collaborative action on the socio-economic determinants of health (Griffiths et al, 2003; Orne et al, 2007).

There have also been efforts to clear the common misunderstanding between the concepts ‘medicine’ and ‘public health’ (World Bank, 2002). Gruskin and Tarantola (2002) explain that, on the one hand, care and consultation in medicine is primarily concerned with the physical health of individual patients – hence the emphasis on diagnosis and treatment of disease. On the other hand, public health’s main concern is with promotion and preventive

aspects of health – hence the focus on the health of populations and the behavioural, social and economic determinants of health.

Public health is currently conceptualised as an art and science that deals with disease prevention and health promotion (ASPH, 1999), prolonging life, protecting and improving health through the organised efforts of society with the universal goal being the health of the public (Hamlin, 2002; Sein & Rafei, 2002). Additionally, Griffiths et al (2003) consider a public health approach to include the following characteristics:

- Population based;
- Emphasis on collective responsibility for health, its protection and disease prevention;
- Recognition of the key role of the state, linked to a concern for the underlying socio-economic and wider determinants of health, as well as disease;
- Multidisciplinary basis, incorporating quantitative and qualitative methods; and
- Emphasis on partnerships with all the role-players who contribute to the health of the population.

Public health professionals are “... those responsible for providing leadership and expert knowledge to health systems at district, provincial, national and international levels to manage the health of the public” (Ijsselmuiden et al, 2007, p.914). These professionals work to overcome the barriers caused by differences in gender, social class, ethnicity and race that prevent available tools and interventions from being applied equally (Merson et al, 2001). This latter concept of scope of work of public health professionals at least refers to gender and it was therefore important to find out how public health professionals in this inquiry represented gender in public health curricula.

The focus of public health on the health of populations – including the behavioural, social and economic determinants – implies that it should be able to tackle the health problems highlighted for Africa, and particularly the gender and health problems, since they seem to fall within this scope. This inquiry was therefore conceptualised to explore how public health as a discipline has represented and incorporated gender in its curricula in order to respond to the health problems facing Africa.

2.2.2 Schools of public health

This section provides background information on schools of public health as the chosen sites of my study and offers some insights into the following: the history of schools of public health; the need for such schools; access to schools of public health; the qualification and curriculum offerings of these schools; challenges; and finally, some initiatives taking place in schools of public health.

2.2.2.1 Establishment of schools of public health

Fee and Liping (2007) suggest that an examination of the creation of schools of public health is useful in determining the choices and options for the future of global public health education. According to Sim et al (2007), schools of public health in the UK have existed since the late 1890s. In the US, schools of public health began to emerge in the early decades of the twentieth century, mainly with the sponsorship of the Rockefeller Foundation that recognised the need for this kind of education. The Foundation continued to contribute to the creation of public health schools around the world in the 1920s and 1930s. Since then, there has been a proliferation of schools of public health all over the world. A recent survey by the World Health Organization (WHO) revealed that there are approximately 400 schools around the world, excluding departments of community medicine or similar programmes attached to medical schools (WHO, 2006b). A distribution of the schools shows that the US has 40 accredited schools and Brazil 40. Africa has about 50 schools and South Asia is estimated to have 12 (Buss, 2007; Petrakova & Sadana, 2007).

In Africa there is lack of research that gives a historical perspective on the development of schools of public health. However, a survey by Afrihealth indicated that out of 53 countries, only 22 offered postgraduate public health programmes, with 11 countries offering only one programme and the other 11 countries more than one. In addition, the results indicated major regional differences. Anglophone sub-Saharan African and North African countries had more developed postgraduate public health training programmes than francophone and lusophone countries. The largest gaps occurred in lusophone countries (Jsselmuiden et al, 2007).

A World Health Organization Africa Regional Office (WHO-AFRO) study found that postgraduate schools of public health had different names, varying between schools or

institutes of public health hygiene, community medicine, preventive medicine, tropical medicine, hygiene and tropical medicine, laboratory of social medicine, national teaching unit and the high institute of public health. With specific reference to schools of public health, common designations included departments of public health, hygiene and social medicine, social and preventive medicine, social medicine and public health, and social and occupational health (WHO-AFRO, 1990). Afrihealth (2003a) results and also a report by Petrakova and Sadana (2007) reveal four types of institutions offering postgraduate education and training in public health. These include schools of public health, departments of community health, and institutes or faculties of public health.

2.2.2.2 The need for schools of public health

Schools of public health have been set up to offer training that emphasises the health of the population through health promotion and health prevention, mainly at postgraduate level. In 1973, the WHO (1973) described a school of public health as “... a functional entity whose main purpose is to provide general and specialist public health training for members of health and other professions who require it”, adding that “[a]mong the courses offered there should be a basic course leading to a post-graduate level qualification in public health” (p.1).

Many authors acknowledge that the establishment of schools of public health was a top priority that was necessitated by the health crisis in most low- to middle-income countries (Afrihealth, 2003a; Braine, 2007a; Heller et al, 2007; IJsselmuiden et al, 2007; Mokwena et al, 2007; Tangcharoensathien & Prakongsai, 2007). As has already been mentioned in Chapter 1, these countries are faced with health problems ranging from the spread of AIDS, tuberculosis and common infectious diseases, to the emergence of chronic disease epidemics and the deterioration of health systems. These health problems in turn have a deleterious effect on the economic development of those countries (Heller et al, 2007). It was therefore imperative to set up schools of public health that would train urgently needed qualified health personnel to address current and emerging health problems (Braine, 2007a; Mokwena et al, 2007). Braine (2007b), for example, reports that the University of Ghana School of Public Health in Accra was created to meet the urgent need for health personnel to fill posts in newly created administrative districts and municipalities. Mokwena et al (2007) emphasise that a priority in African countries is training and increasing the number of health-care personnel.

There was also the need to create public health knowledge and re-orientate the curriculum. Bloom (2007) highlights the critical role of schools of public health in the development of knowledge and information about the health of populations and countries. The focus of public health on the health of the population necessitated a paradigm shift from curative measures to disease prevention and health promotion, and this reorientation could only be met by public health training programmes (Mokwena et al, 2007). Sim et al (2007) confirm that this same paradigm shift also took place in the UK when public health was expanded to include people from professions other than physicians. These authors report on the Faculty of Public Health's development of a revised curriculum and the creation of common training requirements for all public health specialists.

2.2.2.3 Access to schools of public health

A few authors observe that access to schools of public health has been limited to the medical profession and other health workers, to the exclusion of other professions. Sim et al (2007), for example, indicate that until the 1990s, the medical profession dominated specialist practice of public health in the UK. Other authors concur and explain that in several countries many postgraduate public health programmes limit access to health workers or even to medical practitioners only (Braine, 2007a; Buss, 2007; IJsselmuiden et al; 2007). IJsselmuiden et al (2007) suggest that this could be largely due to the emergence of these schools from departments of community health or community medicine and their parentage in medical schools. Griffiths et al (2007) expound on this argument by narrating how the Faculty of Public Health in the UK was born out of the Royal Colleges of Physicians and was initially only open to members of the medical profession.

Evans and Dowling (2002) point to the need to broaden the public health workforce from its traditional medical base to include people from a wide range of professional backgrounds, due to the range of roles needed to undertake public health work such as communicable disease control and tackling inequalities and the wider determinants of health. However, Sim et al (2007) acknowledge that during the past decade access to public health practice by people from diverse disciplines has been opened up and their contributions have become recognised, respected and valued. Braine (2007b) gives examples of the University of Ghana and the Arkhangelsk International School of Public Health in Russia where many students come from diverse backgrounds and disciplines and fields other than health such as social workers,

psychologists, university teachers, health administrators, computer engineers, nurses and journalists. Griffiths et al (2003) conclude that whilst doctors have an important contribution to make in improving the public's health, so too do other skilled specialists in the professional community.

2.2.2.4 Qualifications offered by schools of public health

Available data indicates that the focal qualification offered by schools of public health is the degree of Master of Public Health (MPH) (Afrihealth, 2003b; ASPH, 1999; HRSA, 2004; Mokwena et al, 2007; WHO, 1973; WHO-AFRO, 1990). The Health Resources and Services Administration (HRSA) states that schools of public health vary greatly in a number of ways but the primary commonality among the schools is with respect to the MPH degree, which they all offer (HRSA, 2004). IJsselmuiden et al (2007) confirm that the MPH degree seems to be growing very rapidly in Africa, while Braine (2007b), in a snapshot of the world's schools of public health, states "[t]hese institutions share at least one thing in common – they all offer a masters degree in public health" (p.910). Thankappan (2007) reports that the MPH has received recognition in the job market in India and that there is increasing demand for MPH graduates of the Sree Chitra Tirunal Institute for Medical Sciences and Technology (SCTIMST) (which had the only accredited MPH programme in the country at the time of publication), as well as from other institutions within India. Other qualifications offered in schools of public health include the Diploma in Public Health (DPH), certificate courses, the Doctor of Philosophy (PhD) degree and in a few cases, the Doctor of Public Health (Dr PH) (Afrihealth, 2003b; ASPH, 1999; Braine, 2007b; IJsselmuiden et al, 2007; Mokwena et al, 2007; WHO, 1973; WHO-AFRO, 1990).

My study focused on identifying gender concerns only at the MPH level, which seems to be the most common qualification in public health postgraduate training, as discussed above. The selection of the MPH degree as the focus for this inquiry is further justified in Section 4.2.

2.2.2.5 Curriculum offerings in schools of public health

The WHO-AFRO (1990) points out that schools of public health have been acknowledged as the primary educational systems for training health personnel who are needed to operate public health, disease prevention and health promotion. It was therefore useful to explore how

the public health curriculum equipped these cadres of personnel to address gender and health concerns.

Braine (2007a) submits that there are generally five core disciplines offered in most schools of public health. These include biostatistics, epidemiology, health policy and management of health systems, health education and behavioural science, and environmental health. However, there is great variation in the courses offered (Tangcharoensathien & Prakongsai, 2007). Voyi (2007) emphasises that the focus area of study depends on the burden of disease and health of the population in each region and country. For example, the countries around the Asia Pacific region are constantly faced with threats of avian influenza and, according to Tangcharoensathien and Prakongsai (2007), scaling up surveillance of avian influenza should be a key public health competency.

Apart from the core group of courses mentioned above, various schools offer other different courses, although it is not clear from the literature whether these form part of the core or whether they are elective courses. These other additional courses cited by Braine (2007a; 2007b) are summarised in Table 2-2. Thankappan (2007) also reports that additional courses on offer at the SCTIMST in India include health economics, gender issues in health and anthropology. Since this is a study on gender, it is instructive to note that not more courses focusing on gender issues in health have been reported in Braine's review (2007; 2007b). However, IJsselmuiden et al (2007) lament that in Africa many postgraduate public health programmes remain traditional, with a narrow view of public health. One of the Afrihealth (2003a) reports also indicates that the curriculum is predominantly biomedical in nature.

One element of the curriculum that has been greatly underscored is the need for interdisciplinarity and multidisciplinary. Evans and Dowling (2002) argue that developing multidisciplinary public health training is an international as well as a national public health imperative. Voyi (2007) emphasises that in order to deliver public health services adequately, there is a need to broaden the scope of public health by incorporating other non-medical disciplines. These sentiments are echoed by various authors who go on to expound on how they have broadened their respective curricula to make them more intersectoral and multidisciplinary (Bloom, 2007; Griffiths et al, 2003; Griffiths et al, 2007; Haines & Huttly, 2007;

Table 2-2: Additional public health courses cited by Braine (2007a&b)

Name of course	Public health institution	City and/or country
<ul style="list-style-type: none"> • Communicable and non-communicable diseases 	<ul style="list-style-type: none"> • James P. Grant School of Public Health • School of Health Systems and Public Health • School of Public Health 	<ul style="list-style-type: none"> • Bangladesh • Pretoria, South Africa • Ghana
<ul style="list-style-type: none"> • Health financing 	<ul style="list-style-type: none"> • James P. Grant School of Public Health 	<ul style="list-style-type: none"> • Bangladesh
<ul style="list-style-type: none"> • Health economics • Sociology and psychology 	<ul style="list-style-type: none"> • Schools of public health 	<ul style="list-style-type: none"> • Switzerland
<ul style="list-style-type: none"> • International health • Biomedical laboratory science • Maternal and child health 	<ul style="list-style-type: none"> • Some schools of public health 	<ul style="list-style-type: none"> • United States
<ul style="list-style-type: none"> • Tropical health • Microbiology • Occupational health and hygiene • Family health 	<ul style="list-style-type: none"> • High Institute of Public Health 	<ul style="list-style-type: none"> • Alexandria, Egypt
<ul style="list-style-type: none"> • Nutrition 	<ul style="list-style-type: none"> • High Institute of Public Health • Some schools of public health 	<ul style="list-style-type: none"> • Alexandria, Egypt • United States
<ul style="list-style-type: none"> • Information and communications technology • Health communications • Research methodology in health and health surveillance 	<ul style="list-style-type: none"> • Sergio Arouca National School of Public Health 	<ul style="list-style-type: none"> • Rio de Janeiro, Brazil
<ul style="list-style-type: none"> • Health promotion • Health research ethics 	<ul style="list-style-type: none"> • School of Health Systems and Public Health 	<ul style="list-style-type: none"> • Pretoria, South Africa
<ul style="list-style-type: none"> • Population and reproductive health planning 	<ul style="list-style-type: none"> • School of Public Health 	<ul style="list-style-type: none"> • Ghana

Sim et al, 2007). For example, in the UK, the Faculty of Public Health opened up its membership to non-medically qualified graduates, developed a common curriculum for all public health specialists, and opened up most of the senior posts to both medically and non-medically qualified public health specialists (Griffiths et al, 2007; Sim et al, 2007). According to Griffiths et al (2007), this progress is translating into a public health workforce with rich and diverse skills, from a wide range of backgrounds, yet with a common core of public health sciences, theory and practice.

2.2.2.6 Challenges faced by schools of public health

Schools of public health are currently faced with many challenges. One of the major challenges is balancing both quantity and quality of their educational offerings. On the one hand there is the need to increase and scale up the output of public health professionals, while on the other hand there is the need to develop appropriate skills and competencies to improve the health of populations (Bloom, 2007; Mokwena et al, 2007; Petrakova & Sadana, 2007). Getting the balance between teaching and research and addressing the challenge of providing relevant public health education are further challenges (Petrakova & Sadana, 2007). Petrakova and Sadana (2007) lament the mismatch that exists in many countries between the skills and competencies of public health graduates and the task of addressing the population's health needs, especially with regard to health policy, health management and leadership. Mokwena et al (2007) refer to the challenge of reorienting the curriculum so that there is a significant shift and expansion of focus from curative measures to disease prevention and health promotion (Mokwena et al, 2007). Sim et al (2007) argue that this type of expansion will pose other challenges of recruiting and training the range of people needed to deliver diverse and effective intersectoral and multi-sectoral public health services. According to Petrakova and Sadana (2007), a further challenge faced by schools of public health is the ability to collaborate with policy makers, public health managers, communities, researchers, educators, public health practitioners and international partners in order to make the curriculum relevant. A final challenge is developing a curriculum that reinforces public health approaches, such as intersectoral, interdisciplinary and community-oriented approaches. It could be expected that developing a gender and health curriculum would face similar challenges and competing priorities.

2.2.2.7 Initiatives in public health education in Africa

Although there are many public health initiatives focusing directly on health promotion and prevention, only a few of them focus on public health education and training and the curriculum. Below are some initiatives that have been identified as having a focus on public health or medical education in Africa.

a) The Afrihealth project

In response to the health crisis in Africa described in Section 1.1 and in the spirit of the New Initiative for Africa's Development (NEPAD) that solutions to problems facing African countries must emanate from Africa itself, an initiative known as Afrihealth was established in 2002. The aim of Afrihealth is to increase public health education capacity in and for Africa as one of the solutions to address the health crisis in Africa. The Afrihealth secretariat is located at the School of Health Systems and Public Health, University of Pretoria, South Africa. One of its major activities was to map the capacity of schools of public health in Africa to offer public health programmes. Afrihealth survey results indicated that Africa had limited capacity to offer public health education at postgraduate level as evidenced by the few countries offering public health programmes, the few public health programmes being offered in each of these countries surveyed, and under-resourcing of schools in terms of facilities and staff (Afrihealth, 2003a).

b) The Gender Education and Training (GET) project

Out of Afrihealth's concern about gender issues in postgraduate education and training in public health, the GET project was established as a sub-project of Afrihealth. The aim of this project was two-fold. The first aim was to map the gender landscape in postgraduate education and training in public health in Africa with regard to staff and students. This was mainly through quantitative survey methods. Secondly, the aim was to assess postgraduate public health curricula from a gender perspective. In this regard, when asked which gender courses they offered, the ten respondents who were institutional managers or their representatives responded in various ways. Two of these schools did not respond and instead referred the researcher to their Internet websites. Two schools represented gender in a more direct way with explicit gender representations by means of phrases such as "gender issues" and "gender and health". Three schools cast gender indirectly or implicitly by using sexual, reproductive and family health themes as proxies for gender. Two other schools again represented gender implicitly by submersion under broader themes such as "social dimensions of health" and "behaviour change" (Mwaka, 2006). In one school gender as representation was absent. These different representations are summarised in Table 2-3.

Table 2-3: Representation of gender at public health school level in sub-Saharan Africa
(unpublished data)

School code	Reported gender courses	Representation
1500	Gender issues in health	Explicit representations
2500	Gender and health	
1700	Reproductive health Adolescent health Family health	Implicit representations – proxy
1800	Reproductive and family health	
2100	Sexual and reproductive health	
1200	Social dimensions of health Population, health and development	Implicit representations – submerged
1500	Theories of behaviour change	
1800	School health education	
1600	No gender course	Absent representation (non-represented)
2200	No response – referred to Internet	-
2400	No response – referred to Internet	-

My inquiry for a PhD project focused on understanding these representations in greater detail and mainly used qualitative methods of data collection and analysis. (See Chapter 4 and Figure 7-1.)

c) The Global Health through Education, Training and Service (GHETS) project

GHETS is a US-based, non-governmental, non-profit organisation committed “to improving health in developing countries through innovations in education and service” (GHETS, 2005, n.p.). Among its many projects is one that focuses on women’s health, also in recognition of the many links between social and economic inequalities and women’s health challenges. (See Section 1.1.1.) GHETS has elected to work with an international network of universities, policy makers and community leaders in developing countries to improve the health of women and their families. Together with these partners, they strive to “... improve women’s health by reducing barriers to healthcare for women in underserved communities and equipping healthcare providers with the knowledge and skills to respond to the needs of women in their communities” (GHETS, 2005, p.1). This network also believes that “[w]ell

trained and supported doctors, nurses and allied health workers are key to sustainable change” (GHETS, 2005, p.1). The GHETS project focuses on medical and nursing education, as opposed to the Afrihealth and GET projects whose focus is public health.

d) The Network: Towards Unity for Health (TUFH)

The TUFH Network is a global association of institutions for education of health professionals with its secretariat currently in Belgium. It is committed to contribute to the improvement and sustainable development of health in the communities in which these networks serve through education, research and service (TUFH, n.d.). One of TUFH’s objectives of interest to this inquiry is to promote the creation of curricula for the education of health personnel in relation to the priority health needs of the community. With funding from GHETS, TUFH has, together with some of its collaborating partners, developed educational materials for use in medical and nursing schools on various gender and health topics (GHETS, 2005). Again, the TUFH project deals with medical education and curricula (TUFH, n.d.).

2.3 Conclusion

This chapter has highlighted the higher education and public health environment in which this study was located. In the higher education environment, it was emphasised how at a global level, gender has been firmly placed on the agenda of higher education. An overview of the gender issues addressed in higher education was then laid out, followed by approaches used for the teaching of gender. The reasons for the prevailing gender gap in higher education were identified as: the absence of an enabling environment for female students to thrive and benefit from higher education; weak institutional policies for gender equality; lack of progress towards higher education due to low socio-economic status, especially of female students; cultural values like early marriage; and the historical colonial legacy that privileges the male over the female in higher education. With regard to the public health environment, a description of the concept of public health was given, followed by a historical account of the evolution of public health. The curricula of schools of public health and the challenges faced by these schools were examined. The chapter ended with a presentation of public health initiatives related to gender. The next chapter provides the conceptual framework that guided the study.

Chapter 3

Towards a poststructuralist framework of inquiry

This inquiry was carried out according to a poststructuralist framework. A framework is particularly useful for highlighting the different categories of elements and factors to be included in any analysis and the key issues to be explored (Shields & Tajalli, 2006). This chapter provides a conceptual understanding of the term ‘poststructuralism’, along with its key elements and features. Additionally, my inquiry was conceptualised around other key constructs like ‘discourse’, ‘gender’ and ‘curriculum’ that had to be positioned within a poststructuralist framework. A detailed conceptual and theoretical exposition of these key constructs and their link to poststructuralism follows the exposé on poststructuralism.

3.1 Poststructuralism

This section starts with a historical perspective of poststructuralism, followed by a look at poststructuralism as a paradigm. Secondly, the key features (parts) of poststructuralism and their inter-relationships and relationships to the ‘world’ are discussed. This is followed by an analysis of the benefits and uses of poststructuralism. Finally, a justification of why poststructuralism was selected as the main paradigm for this inquiry is put forward, including reasons why it was not meshed with postmodernism.

3.1.1 Origins of poststructuralism

Although the three terms ‘poststructuralism’, ‘postmodernism’ and ‘deconstruction’ have been employed interchangeably, ‘poststructuralism’ initially referred to those theoretical movements emerging in France in the mid to late 1960s that had grown out of and opposed structuralism and humanism that had earlier been challenged by structuralism (McLaughlin, 2003; Peters, 1999; Pinar et al, 1995; Weedon, 1997; Wood & Kroger, 2000). Poststructuralism therefore comes after, and is a reaction to structuralism. The most prominent post-structuralists have been identified as Michel Foucault, Roland Barthes, Jacques Derrida, Jacques Lacan, Gilles Deleuze and Julia Kristeva (Gavey, 1998; Weedon, 1997; Wood &

Kroger, 2000). In order to understand why these poststructuralists rejected structuralism, it is necessary to get some insight into what the latter entails.

Structuralism, described as an intellectual movement, is mostly associated with the linguist Ferdinand de Saussure who emphasised that meaning was to be found within the structure of a whole language. In general, structuralism emphasises the examination of cultural phenomena according to the underlying formal systems in which these phenomena are currently to be found. Structuralists advance the view that the individual is shaped by definite sociological, psychological and linguistic structures over which he or she has no control, and that these could be uncovered by using objective methods of investigation (Bush, 1995; Lye, 1997). A wide range of theoretical stances are included in the structuralist paradigm, including Marxism and psychoanalysis. Marxists believe that truth of human existence could be understood by an analysis of economic structures (Weedon, 1997), whereas psychoanalysts describe the structure of the psyche in terms of an unconscious (Alsop et al, 2002). Thus, poststructuralists reacted against the analytical processes of structuralism, which claimed that meaning could be derived from a text or work of art by treating it independently of its cultural context. Secondly, they accused structuralism of being ahistorical, implying that life and thought were static; they did not change. Thirdly, they dismissed the structuralist assumption that there was an already existing reality, just waiting to be discovered through scientific methods (Lye, 1997; McLaughlin, 2003).

Several authors have tried to answer the question on what exactly poststructuralism is by demonstrating the futility and difficulty of trying to define poststructuralism (Foucault, 1984; Gavey 1998; Peters, 1999). Gavey (1998) posits that a definition is not possible, since a definitive attempt would go against the very grain of the nature of poststructuralism, which is inherently against a unifying and singular conceptualisation of any concept. Foucault (1984) states that “[t]he premise of poststructuralism disallows any denominative, unified, or proper definition of itself” (p.108). He adds that in broad terms, poststructuralism “... involves a critique of metaphysics: of the concepts of causality, of identity, of the subject, of power, knowledge and of truth” (p.108). In addition, the futility of defining poststructuralism also lies in the fact that it comprises of a variety of perspectives and therefore the term should not be used to convey a sense of homogeneity, singularity and unity (Peters, 1999; Weedon, 1997).

However, in general, poststructuralism can be summarised as an array of approaches (Burman & Parker, 1993) applied to a range of theoretical positions (Weedon, 1997) that are based on certain assumptions (Lye, 1997). Poststructuralists are united in their concern of going beyond the structure of language to consider a wide variety of features of language use and the ways in which discourses construct objects and subjects. They also pay special attention to various sorts of oppositions and ways to deconstruct them (Wood & Kroger, 2000). McLaughlin (2003) adds that poststructuralists are concerned with finding modes of thought and action able to "... open up structuralist ideas to difference and subjectivity" (p.93), and thus turn to the search for discursive truth, whether in the world itself or in the protocols of science. Peters (1999) views poststructuralism as "... a contemporary philosophical movement that offers a range of theories (of the text), critique (of institutions), new concepts, and forms of analysis (of power)" (p.1). For the Africa Gender Institute (AGI) poststructuralism offers new possibilities of thinking about subjectivity, power and discourse (AGI, 2002).

3.1.2 Poststructuralism in relation to postmodernism and social constructionism

Several authors have pointed out that poststructuralist theories are often termed 'postmodern', leading to the two terms either being used interchangeably, or conflated as one. In some cases, poststructuralism is subsumed under postmodernism and is in this case viewed as a sub-theory of postmodernism (McLaughlin, 2003; Peters, 1999; Weedon, 1997). On the other hand, Zeeman et al (2002) claim that social constructionism and poststructuralism are two distinct theories that developed along the postmodern line of thought that rejects universal theories or "grand narratives" (p.97). In their contribution to this topic, Hodgson and Standish (2009) add that postmodernism and poststructuralism are "... shaped by the rejection both of modernist grand narratives and of the belief in the possibility of universal truths" (p.310). It is therefore important to comment on the convergence and divergence of other theories in relation to poststructuralism in order to position the theoretical framework for this inquiry.

3.1.2.1 Postmodernism

Postmodernism emerged as an area of academic study only in the mid 1980s. The literature indicates that it is also a complex, contested and ambiguous term and, as such, defies definition (Klages, 2003; McLaughlin, 2003; Weedon, 1997). An attempt at defining postmodernism is also futile because postmodernism spreads across a wide range of disciplines or

fields of study such as art, architecture, literature, film, music, communications, sociology, fashion and technology (Klages, 2003; Weedon, 1997). It has therefore been described in various ways by people working from different perspectives (McLaughlin, 2003). Klages (2003) finds it reasonable to regard postmodernism as a term used to describe a variety of trends and ideas. Some of these trends and ideas will be summarised below.

Lyotard (1984) and Rorty (1989) are considered as two of the most significant theorists of postmodern thought (McLaughlin, 2003; Weedon, 1997). In general terms, postmodernism rejects modernity, a period of the Enlightenment that attempted to describe the world in rational, empirical and objective terms and assumed that there was a universal truth to be uncovered, a way of obtaining answers to the questions posed by the human condition (Klages, 2003; McLaughlin, 2003). According to McLaughlin (2003), postmodernism critiques the status of general universalising theories, the “meta narratives” or “grand narratives” (p.91). Klages (2003) adds that “[i]n rejecting ‘grand narratives’, postmodernism favours ‘mini-narratives’, stories that explain small practices, local events, rather than large-scale universal or global concepts. Further, postmodern ‘mini-narratives’ are always situational, provisional, contingent, and temporary, making no claim to universality, truth, reason, or stability” (p.1).

Bush (1995) refers to poststructuralism as a “second cousin” (p.1) to postmodernism, while Peters (1999) refers to the two terms as having a “kinship” relationship (p.1). Peters (1999) contends that the two terms can be distinguished by recognising the difference between their theoretical objects of study. While postmodernism rejects the major beliefs of modernity, poststructuralism, on the other hand, rejects those of structuralism. Klages (2003) sees the major difference between postmodernism and poststructuralism as the fact that postmodernism is closely associated with an era – a period in history after the modern age – the “post-modern” (p.1). On the other hand, Klages (2003) views poststructuralism as a position in philosophy within the postmodern era, “... which represents views on human beings, language, society, and many other issues, and not just names of an era” (p.1). Peters (1999) states that poststructuralism can be characterised as a “mode of thinking, a style of philosophizing” (p.1).

3.1.2.2 *Social constructionism*

As already mentioned, Zeeman et al (2002) distinguish between social constructionism and poststructuralism as two theoretical formulations that reject universal theories or grand narratives along the lines of postmodern thought. Poststructuralism, social constructionism and postmodernism all share the same ontological beliefs, specifically that reality is socially constructed and multiple (Michael, 1999). They also share a common epistemological view of knowledge as contextual and historical, and a concern with language and construction of meaning, rather than with measurement and prediction of behaviour (Michael, 1999). (See also Sections 3.1.3.1 and 3.1.3.2.) Furthermore, they reject an essentialist approach that assumes that there is a core and essence of humanity that makes people what they are and that this essence could be studied and discovered (Burr, 1995; Gavey, 1997). According to them, voices that differ from the norm are silenced and suppressed by these assumptions of universal, all encompassing principles (Butler, 1990).

Van Wagenen Wrin (2004) points out that poststructuralist theorising incorporates some constructionist foundations and builds new directions. She identifies the divergence between social constructionists and poststructuralists as follows: for social constructionists, reality arises from interaction; for poststructuralists, reality arises from discourse. (See Section 3.1.3.3.) She also considers poststructuralists' focus on the deconstruction of text as a radical break from social constructionism.

3.1.3 Poststructuralism: key features and assumptions

My inquiry followed a poststructuralist philosophical position (within the postmodern era) that was based on social constructionist assumptions (Klages, 2003; Peters, 1999). I was attracted to poststructuralism because of its strong philosophical position, as well as its well-articulated and convincing assumptions about the nature of reality. In education, poststructuralism questions the very nature, construction and effect of forms of knowledge (Hodgson & Standish, 2009). In this inquiry, I set out to interrogate how knowledge of gender was constructed and the discursive effects of these constructions in the public health curriculum. I was thus guided by a poststructuralist set of beliefs, which will be discussed below.

3.1.3.1 A poststructuralist view of reality (ontological assumptions)

From the works of Blake (1997), Groden and Kreiswirth (1997), Weedon (1997), Gavey (1997), Peters (1999) and Hodgson and Standish (2009) the ontological position of poststructuralism about the nature of reality can be summarised as follows. Poststructuralists believe:

- There is no one single, universal reality. Grand narratives or universal explanations of reality are critiqued and rejected.
- Reality is socially constructed through language, implying the existence of more than one reality. Hence there is an emphasis on plurality and tolerance to difference.
- Language constructs subjectivity and therefore the existence of a natural subject with a core and essence is rejected.
- The construction of reality depends on contextual factors such as culture and history.

Burman and Parker (1993) therefore suggest that any appeals to human nature must be rejected in favour of a research orientation based on the socially constructed nature of reality.

3.1.3.2 Reality is constituted through language

For poststructuralists, language is key, since all knowledge is conveyed through language and, consequently, language should be the object of study (Gergen, 1994). Weedon (1997) expounds further on the role of language within poststructuralist theory. Firstly, she advances the view that language is the common factor in the analysis of social organisation, social meanings, power and individual consciousness. Secondly, Weedon (1997) emphasises that language is also the place where actual and possible forms of social organisation and their likely social and political consequences are defined and contested. Language is viewed in terms of competing discourses – that is, competing ways of giving meaning to the world, a site of struggle. She concludes that this struggle implies differences in the organisation of social power. In this case, Weedon seems to have made for us the links between the poststructuralist paradigm and the primary constructs (gender and curriculum) – how gender has been given meaning in the curriculum as text (through discourse, language, subjectivity and power) and its implication for social organisation (public health education). Thirdly, Weedon (1997) acknowledges that language is also the place where “... our sense of ourselves, our subjectivity is *constructed*” (p.21) (emphasis added). Thus, the link between

poststructuralism, language and subjectivity is the belief that language constructs our subjectivity as well. Fourthly, in line with the poststructuralist emphasis on context, Weedon (1997) insists that language needs to be viewed as a system always existing in historically specific discourses. Following this thread of argument, Burman and Parker (1993) assert that language, organised into discourses, has an immense power in shaping the way people experience and behave in the world.

Hodgson and Standish (2009) claim that in recent decades qualitative researchers have come to recognise the poststructuralist assumption about the role of language in the construction of knowledge. In line with this claim, my study was based on the assumption that language is central in the construction and representation of gender in the public health curriculum.

3.1.3.3 Discourse and poststructuralism

Both Cheek (2000) and Weedon (1997) view discourse as a key feature within poststructuralist thought. Since discourse is a central construct that forms part of the title for this inquiry, it is important to explore its meaning, key features, assumptions and its analytic power and to clarify its implications for this inquiry.

a) Discourse as a construct

In very simple terms, Wetherell (2004) refers to discourse as "... all forms of talk and writing – all forms of spoken interaction, formal and informal, and written texts of all kinds" (p.2). However, there seems to be a very strong link between language, one of the key features of poststructuralism discussed in the preceding section, and discourse. Gergen (1997) explains that discourses grow from the language used within a culture and, therefore, to participate in the use of language is to participate in a way of life or tradition, while adhering to certain discourses. Finally, Freedman and Combs (1996) describe a discourse as a system of statements, practices and institutional structures that share common values.

Apart from language, another strong link has been demonstrated between discourse, knowledge and power. Nightingale and Cromby (1999) add that discourse reflects prevailing structures of social and power relationships and that these relationships exist within the context of culture (Nightingale & Cromby, 1999). Many other authors have explored the

concepts of knowledge and power by drawing on Foucault's work (1974; 1982; 1984) (Cheek, 2000; Hodgson & Standish, 2009; McLaughlin, 2003; Van Dijk, 2004; Weedon, 1997). Foucault challenges notions that knowledge is objective and value free, inevitably progressive and universal. Instead, he explores the knowledge-power link through the concept of discourse by arguing that knowledge is inextricably linked to power (Cheek, 2000). Foucault's work on the link between knowledge and power has been expounded on in various ways to demonstrate and emphasise this link. Weedon (1997) explains that discourses create discursive frameworks that order reality in a certain way. However, these discursive frameworks both enable and constrain the production of knowledge in that they allow for certain ways of thinking about reality, while excluding others (Cheek, 2000). Further, at any one point in time, people are confronted with a number of possible discursive frames for thinking, writing and speaking about aspects of reality. However, not all discourses carry equal weight or authority. The discursive frame that will end up carrying more weight is a consequence of the effects of power relations (Cheek, 2000; McLaughlin, 2003; Weedon, 1997). Gavey (1989) refers to these as dominant discourses and elaborates that dominant discourses are those sets of statements by which everyone measures their lives within a given society and that define people's identities and realities. According to Hodgson and Standish (2009), dominant knowledge is a reality that is transmitted through ideology and becomes rooted in institutions and ways of speaking, writing and representing.

The dominant discourses legitimate existing power relations and tend to constitute the subjectivity of most people most of the time (Gavey, 1998). Van Dijk (2004) advances the view that a powerful group may limit the freedom of actions of others but also influences their minds through either recourse to force or through other means such as persuasion or manipulation. He demonstrates the crucial link between knowledge and power by stating that "[m]anaging the minds of others is essentially a function of text and talk" (p.302), that is, discourse. However, Nightingale and Cromby (1999) argue that on the surface it is not easy to recognise these regimes of truth since they seem to be held in place by conditions that lie deeper than what is evident on the surface – the power and materiality of a culture. Van Dijk (2004) supports this line of argument: "Dominance might be enacted and reproduced by subtle, routine, everyday forms of text and talk that appear natural and quite acceptable" (p.302). Thus, discourses possess the power to reproduce and transform institutional structures and power plays an influential role in the social making of meaning (Potter, 1996b). In conclusion, discourse analysis then enables us to search for underlying mechanisms

maintaining power relations and provides an opportunity to explore the discourses that perpetuate, or otherwise naturalise the social order, and especially relations of inequality (Fairclough, 1989; Nightingale and Cromby, 1999).

Hodgson and Standish (2009) caution against the misuse of the Foucauldian conception of power in educational research. They complain that power is interpreted as an entity in line with Marxist thinking that views power in dual terms of oppressor and oppressed. These authors contend:

The assumption is that if neither oppressor nor oppressed has power, we must all be inert, unable to act. It appears to be informed by Marxist or neo-Marxist understanding of power, which presupposes a dual power relation of oppressor and oppressed. In educational research concerned with social justice the group or individual is seen as without power and the research process is concerned with empowerment – the giving or getting of power – it is perhaps this kind of power that characterizes much of the desire to work for social justice in education research. (p.315)

They explain that in Foucauldian terms power becomes apparent when a person becomes conscious of and acts according to norms that produce the effects of power. In this sense power is not an entity but a process that involves power relations (Peters, 2004).

Several discourse researchers also view discourse as social practice (Antaki et al, 2008; Potter, 1996b; Shaw & Bailey, 2009; Van Dijk, 2001). Language is not neutral, but rather, is used “to do something” (Potter, 1996b, p.3). According to Potter (1996b), “[d]iscourse is the way people construct their world in their talk and texts and what is done with those constructions and the way descriptions are made factual and what those descriptions are used to do” (p.3). This assertion is reinforced by Antaki et al’s (2008) statement that one of language’s functions is to do things at the societal level. This thread of thought is also found in Van Dijk’s (2001) emphasis that the words we use to describe things bring with them a very heavy set of implications that go a long way beyond the dictionary. Consequently, discursive research goes beyond the literal meanings of language by examining the social functions of talk (Shaw & Bailey, 2009).

b) The construction of discourse in this inquiry

In this inquiry, a poststructuralist focus on text as discourse was emphasised by primarily viewing discourse as both spoken and written text (Wetherell, 2004). In this choice, I was

guided by the assumption that texts represent a certain reality, which may appear quite natural and taken for granted but that, on the contrary, when scrutinised analytically as discourse, may reveal certain underlying assumptions about the discourse. However, this inquiry was not only interested in the way a text represented an aspect of reality; rather, it aimed to go further and unearth some of the ‘legitimised’ practices and assumptions that underpinned the shaping of the text or discourse in question.

However, to focus only on discourse as both spoken and written text would be narrow minded and naïve. The concept of discourse was expanded to incorporate other useful components such as language use and meaning making in these texts. Additionally, discourse was also viewed as social practice, located within specific institutions, which in turn are culturally and historically situated (Potter, 1996a).

This inquiry viewed both gender and curriculum as specific discourses that had been constructed through language and were represented as text. The reality of how gender was represented within the public health curriculum therefore lay in these texts, as mediated through language. However, this inquiry was not only interested in how gender was represented in the public health curriculum but, more importantly, in how it came to be represented the way it was. In order to explore the way gender was represented, the inquiry critically analysed both spoken text (interviews with academic staff) and written text (public health curriculum documents), with an emphasis on language use, meaning making, and how these affected social practice; that is, the representation or non-representation of gender within the curriculum, and how this had come to be legitimised.

Secondly, the inquiry viewed these discourses of curriculum and gender as social practices existing in specific schools of public health in sub-Saharan Africa, which were based on their specific cultural and historical contexts. Their discourses would more or less reflect how the wider society constructed gender as issues included or not included in the development of curriculum, research, programmes, policies and interventions. However, I also viewed curriculum and the construction of gender as a process, as sites of struggle where their constructions were not permanent but fluid and constantly changing. Furthermore, although some conclusions were reached about the constructions of gender in the public health curriculum in this inquiry, it was with the understanding that they were temporary and subject to change, depending on context, specific historical moments and people’s subjectivities.

Thirdly, with regard to the issue of discourse, knowledge and power, one of the assumptions of this inquiry was that knowledge reproduced power. It was assumed that public health had specific domains that it used as a framework to organise the public health curriculum – its reality – through text and language use. A history of public health indicates that with time it has grown from its narrow conceptions of public health focusing on curative aspects of disease to more preventive aspects of health such as environmental health (Section 2.2.1.) It was further assumed that any additions to the conception of public health, and thus additional domains to its curriculum, depended on the power relations in an institution and the cultural and historical contexts of the institution and the country. Although the issue of gender has now been laid squarely on the table of public health, negative cultural gender norms and values still persist in Africa (Doyal, 2004a; Doyal 2005; Health Canada, 2000; WHO, 2006b; Wong, 2003).

c) Discourse as analytical tool

Discourse analytic approaches have been influenced by a variety of disciplines such as anthropology, linguistics, cultural studies, gender studies, social psychology and philosophy (Potter, 1996a; Potter, 1996b; Potter & Wetherell, 1987). Burman and Parker (1993) acknowledge that there are multiple varieties of discourse analytical tools and, as such, one cannot talk of discourse analysis as a single unitary entity. Shaw and Bailey (2009) outline three different approaches to discourse analysis:

- *Micro-level studies* (e.g. sociolinguistic discourse analysis) involve the detailed study of language in use (Shaw & Bailey, 2009). These studies emerge from conversation analysis that provides a conceptual framework for systematically analysing face-to-face talk (Silverman, 2000). Micro-level studies focus on the participants' perspective, and in doing so bring to the fore the cultural and communicative patterns that inform their behaviour and perceptions (Roberts et al, 2000). Analysis, therefore, focuses on how interactions are organised moment by moment through subtle processes that appear normal and are taken for granted (Shaw & Bailey, 2009).
- *Meso-level studies* (e.g. discursive psychology) focus more on the links between discourses and broader social and cultural contexts (Shaw & Bailey, 2009). In these studies discourse informs specific ways of talking about reality and defines acceptable ways of talking, writing or conducting. Accordingly, discourse is seen as serving a range of social functions (Potter, 1996b).

- *Macro-level studies* (e.g. Foucauldian approaches) normally focus on the study of language and ideology in society (Traynor, 2006). They examine the role of power and knowledge in society and illustrate how language constitutes aspects of society. These studies are also concerned with how and why language constrains what we are able to think, say and do (Fairclough, 2001). Macro-level approaches are able to unearth taken-for-granted assumptions and the meanings individuals and wider society attach to these. They also explore possible alternatives to accepted ways of doing things (Armstrong, 2002).

My study was guided by a similar distinction between three levels developed by Morley (2007): macro (national and international policy); meso (organisational); and micro (individual experiences, interpersonal and social relations).

Shaw and Bailey (2009) maintain that some discourse studies tend to draw on more than one approach and that despite the variety of origin and definition, discursive approaches share several assumptions and conceptions about social life. The first shared conception is that language and interaction are best understood in context and, hence, interpretation of data involves understanding contexts such as local circumstances. The second shared conception is that reality is socially constructed; hence social worlds are subjectively understood and experienced. The third shared conception is that discourse analysis goes beyond the literal meanings of language and instead examines the social functions of talk.

In general, therefore, discourse analysis has an analytic commitment to studying discourse as texts and talk in social practices (Wood & Kroger, 2000). Potter and Wetherell (1987) highlight some of the major assumptions of discourse as an analytic tool. Firstly, in carrying out discourse analysis, there is a focus on language as action. The focus needs to shift away from the interest in the phenomenon to which the discourse refers to a focus on the discourse itself, since it is the discourse that is constitutive of the phenomenon. For example, in my inquiry, I was not interested in gender as a phenomenon, but in how gender was constructed and represented. Therefore, talk was the event of interest.

Talk constructs different versions of the world and is oriented to different functions (Shaw & Bailey, 2009). Variability between persons and within persons is therefore another feature of discourse (Potter & Wetherell, 1987). Wood and Kroger (2000) also report that their research participants used variability to construct their talk for different purposes, for different

audiences, and for different occasions (see also the section on subjectivity below). This recognition of variability produces multiple realities. Where standard social science approaches search for general laws and consistency, discourse thrives on variability. In this inquiry, it was assumed that the academic members of staff were different people, whose perceptions of gender had been shaped by different social and historical contexts. It was therefore my expectation that there would be different understandings of gender and the way gender was represented within the public health curriculum.

d) Discourse as analytical tool in health

Nearly two decades ago Lupton (1992) lamented the neglect of the use of discourse as analytic tool by public health practitioners, a tool with the potential to unravel the ideological dimension of phenomena such as lay health beliefs, the doctor-patient relationship, and the dissemination of health information. In recent years discourse analysis has been highlighted and used in the field of health care more often, particularly in family practice and nursing. Taken-for-granted and hidden aspects of meaning, delivery and practice of health care in different contexts have been revealed through the analysis of how common words and terms had been used to invoke social practices, knowledge and power (Crowe, 2005; O'Connor & Payne, 2006; Shaw & Bailey, 2009). Shaw and Greenhalgh (2008), on the other hand, used Foucauldian discourse analysis to study the historical, social and ideological origins of policy texts and the role of power and knowledge in policy development. They show how certain discourses shape, enable and constrain health policy and conclude that their insights in this type of research were useful in challenging apolitical accounts of health research and revealing how health research serves particular interests. My study is a further contribution to the growing field of findings in public health, challenging the official accounts of gender in the public health curriculum.

3.1.3.4 Subjectivity

The terms 'subject' and 'subjectivity' are central to poststructuralist theory and seem to be in direct contrast to humanist conceptions of people as objects and to an emphasis on objective ways of perceiving reality. Weedon (1997) describes subjectivity as "... the conscious and unconscious thoughts and emotions of the individual, their sense of self and ways of understanding their relation to the world" (p.32). In a further analysis of subjectivity, Weedon

(1997) also emphasises the importance of context: our subjectivity is the product of the society, culture and historical contexts in which we live.

The second point Weedon (1997) tries to illustrate is that poststructuralism is regarded as a paradigm for transformation and change. She explains that when confronted with new social, cultural and historical situations, our subjectivity may enable us to construct our reality or meaning in two ways. Firstly, there is the possibility of resisting alternative ways of knowing, having grown up within a particular system of meanings and values. Secondly, there is the possibility of embracing new alternatives, as we move out of familiar circles, through exposure to social processes such as education or politics. The transformative notion of poststructuralism lies in its belief of "... decentering the subject and abandoning the belief in essential subjectivity" (p.32), thus exposing and opening up subjectivity to change. Lastly, Weedon states that "[p]oststructuralism theorizes subjectivity as a site of disunity and conflict, central to the processes of political change and to preserving the status quo" (p.21).

As already discussed, our subjectivity enables us to construct meaning. Burman and Parker (1993) maintain that when we talk about any phenomenon, we draw on shared patterns of meaning and contrasting ways of speaking. This manner of speaking also implies that meanings are multiple and shifting rather than unitary and fixed. However, available discourses shape the meanings we give to our daily lives and structure our social realities, which depend on the power and political strength that these discourses present (Weedon, 1997). Weedon (1997) furthermore explains that when one is confronted with constructed reality, "... the individual becomes its bearer by taking up the forms of subjectivity and the meanings and values which it proposes and acts upon them" (p.34). In this regard, language is considered to both produce and constrain meaning (Burman & Parker, 1993).

My inquiry was based on the poststructuralist assumption that subjectivity is necessary for the creation of meaning. In line with Hodgson and Standish's (2009) position that claims to knowledge are held to be subjective, one of my points of departure was, therefore, that different meanings of gender were created subjectively in the course of public health curriculum development.

So far some of the key concepts of poststructuralist thought have been explored: language, subjectivity, discourse and power and how they are key in the construction of meaning. The relationship between these key constructs is illustrated in Figure 3-1.

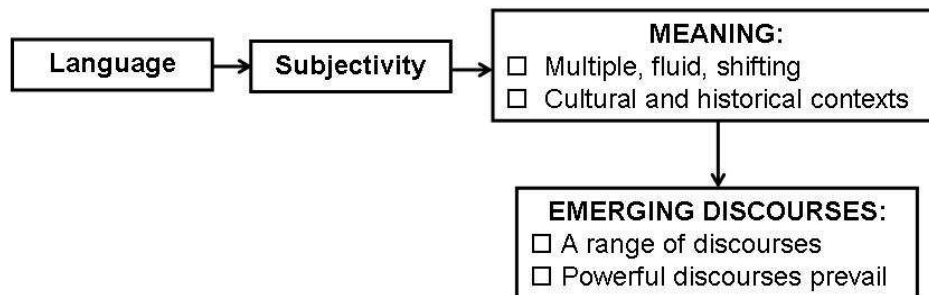


Figure 3-1: The relationship between language, subjectivity, meaning and discourse

3.1.3.5 Poststructuralist focus on text

Cheek (2000) and Lye (1997) view the main distinction between postmodernism and post-structuralism to be the poststructuralist focus on text, both literary and cultural texts. Cheek (2000) elaborates that “[t]exts can be pictures, poems, procedures, conversations, case notes, artwork or articles” (p.40). This view is also supported by Burman and Parker (1993), who refer to text as both spoken (conversations, debates and discussion) and written texts. Parker and the Bolton Discourse Network (1999) describe a text as “... any tissue of meaning which is symbolically significant for a reader” (p.4). Derrida (1998) once remarked that “[n]othing is ever outside a text since nothing is ever outside language, and hence incapable of being represented as text” (p.35). Burman and Parker (1993) write that reality, behaviour and subjectivity (our sense of self) is always in a text. In other words, texts represent reality or conventionalised practices (Fairclough, 1992), which Van Dijk (2004) refers to as everyday forms of talk and text that appear quite natural and acceptable. Cheek (2000) points out that in discourse analysis, we should not only be interested in the way a text represents an aspect of reality – the conventionalised practices and assumptions that underpin the shaping of the text itself – but what the text actually describes. Lye (1997) contends that by reading a text in a reflective and self-conscious way, poststructuralists may find unconscious and unintended meanings, which may be directly contrary to the surface meaning.

3.1.3.6 *Poststructuralism and deconstruction*

The term ‘deconstruction’ is closely associated with poststructuralist texts, which were discussed in the previous section. Cheek (2000) and Weedon (1997) consider deconstruction as another approach that is associated with the exploration and interrogation of texts using poststructuralist perspectives. Lye (1997) views deconstruction as an offshoot of post-structuralist theory.

a) Deconstruction as a construct

Deconstruction is popularly associated with Jacques Derrida, who developed it as a technique for uncovering the multiple interpretations of texts (Bush, 1995; Cheek, 2000; Lye, 1997; Weedon, 1997). This term, similar to ‘poststructuralism’, is highly resistant to formal definition. Weedon (1997) believes that Derrida was careful not to classify his work as belonging to any particular theoretical orientation. According to Lye (1997), Derrida never offered a straightforward definition of the term (Lye, 1997). Moreover, deconstruction does not represent a unitary concept, but rather represents a range of approaches, each with its own emphasis (Bush, 1995; Lye, 1997).

Derrida’s focus (1998) was on language systems, but with a focus on deconstructing them. Through deconstruction he aimed to highlight the role of binary oppositions in constructing meaning in language. He argues that systems of meaning are built from opposition, one of the most important being the ‘self’ and ‘other’. He explains that in each pair, one term (for example, ‘white’) is valued over the other (‘black’). By indicating the relationship between the two terms, the terms no longer appear in opposition; instead, they depend on each other to have any kind of meaning.

According to Cheek (2000), all deconstructive approaches focus on text as their core unit for analysis. They seek to find the meaning within or of any text, thus challenging the very meanings as assumptions on which those meanings are founded. A basic assumption of deconstruction is that a text cannot convey a unitary, stable, just, or even coherent message to all readers or audiences (Gergen, 1994). Upon investigation a text can be shown to contain contradictory meanings that deconstruct whatever meaning it can be said to contain, leading to multiple interpretations (Bush, 1995). That is why poststructuralists call for a

deconstruction of truths we take as for granted (Burman & Parker, 1993); for example, ‘truths’ in the public health curriculum. Lovlie (1992), on the other hand, defines deconstruction as being a hybrid between “destruction” and “construction” (p.123), conveying the idea that old and obsolete concepts have to be demolished for new ones to be erected. From Gergen’s (1994) point of view, deconstruction means disentangling established ideas, whereas Arnot and Fennell (2008) refer to the overturning of metanarratives and the disordering of hegemonic knowledge construction.

Gergen (1994) highlights two criticisms levelled against deconstructive readings. Firstly, they have been accused of being nihilistic, parasitic, and often useless. Secondly, they seem to be out of touch with reality. However, he concludes that despite these criticisms, deconstruction is still a major force in contemporary philosophy and literary criticism and theory.

b) Application of deconstruction theory to the inquiry

I view my inquiry as a deconstruction of the public health curriculum text in anglophone sub-Saharan Africa. It aims to examine and highlight commonly held assumptions about public health curricula and the representation of gender within these curricula. I was guided by the assumption that the public health curriculum as text did not contain a single, unitary truth about public health or about gender. There was more than met the eye. A deeper look underneath the surface had the potential to reveal more layers of ‘truths’ – the assumptions underlying the construction of a curriculum and that held the text into place as the legitimate public health curriculum that should or should not represent gender within it. In this way, legitimised ways of viewing the public health curriculum and how gender should be represented in that curriculum could be deconstructed and challenged.

Secondly, uncovering other layers of meaning could lead to newer or alternative ways of viewing the public health curriculum and the representation of gender in it, thus leading to the ‘deconstruction’ of old ways of viewing the curriculum in relation to gender and replacing them with a multiplicity of perspectives. It was envisaged that this could lead to new ways of understanding the public health curriculum in relation to gender, enabling not only the transformation of the curriculum but also broader changes in society, in how gender could be viewed and represented in programmes, policies and interventions.

3.1.4 Political uses and benefits of poststructuralism

Poststructuralism has been termed as a fruitful (Hodgson & Standish, 2009) and productive theory that has the potential to bring about change and transformation by unearthing existing power relations in various social processes and institutions. Our subjectivity, which serves as site of struggle, thus has the potential of bringing about change through resistance and through embracing new realities (Weedon, 1997). Poststructuralism has an emancipatory and empowering potential – it has the potential to open up different and new ways of thinking about research and social practices (Hodgson & Standish, 2009; Youdell, 2006). It was expected that a poststructuralist perspective in this inquiry would have the political edge of unearthing power relations in the construction of gender and how these constructions become legitimised in the public health curriculum (Usher & Edwards, 1994). (See also Section 3.3.4.4.)

3.1.5 Limitations of poststructuralism

One of the major accusations against poststructuralism is that it is abstract and not specific (Arnot & Fennell, 2008). It has been accused of being in denial about the physical existence of the human subject (lack of embodiment). It is argued that the poststructuralist view of decentering the subject weakens the power of agency in changing people's circumstances. The second attack levelled against poststructuralism is that it seems to be in denial about the physical nature of the world we live in, thus failing to acknowledge people's stark material and physical realities and suffering (McLaughlin, 2003; Nightingale & Cromby 1999; Youdell, 2006). Hodgson and Standish (2009) also highlight the limitations of poststructuralism in educational research:

The use of poststructuralism in educational research is constrained by the tension between, on the one hand, what is considered to be its emancipatory and empowering potential and on the other, a reluctance to be distracted from practical concerns and hence, a fear of alienating the practitioner by speaking in the theoretical or (worse) philosophical terms. (p.309)

Poststructuralists have responded to these criticisms by adopting a much more respectful stance that acknowledges 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. Further, existing structural understandings of the world are limited and, consequently, poststructuralism offers alternative ways of understanding the world (Youdell,

2006). According to Youdell (2006), poststructuralism provides “... an additional set of conceptual, analytical and political tools that might be taken up in order to generate particular types of understanding and pursue particular avenues for change” (p.41).

3.2 Gender as a construct in this inquiry and its relationship to poststructuralism

‘Gender’ was indicated as the primary construct for this inquiry. Aikin and Unterhalter (2005) confirm that different meanings and understandings have been ascribed to the concept of gender, resulting in different interpretations and actions related to gender work. This section attempts to give an exposition of the different ways in which gender is theorised and conceptualised and some of the debates surrounding the concept of gender. It then ends with a description of the link between gender and poststructuralism and with how gender was constructed in this study.

3.2.1 Feminism(s)

Gender theory is deeply rooted in feminism (Weedon, 1997; Wyckoff-Wheeler, 2002), as feminist theory has played a significant role in shaping the concepts of gender as they are understood today (Lorber, 1997; McLaughlin, 2003). Therefore, one cannot talk about gender without recognising the contribution of feminism to gender discourse. However, there is no single coherent feminist framework. On the contrary, feminism is a complex concept, with many and diverse perspectives (Lorber, 1997; McNeany, 2004). Because of these many strands, Saulnier (1996) and Lorber (1997) prefer to talk of “feminisms”. However, each perspective has made important contributions to improving women's status, but each also has its own limitations. Because some of these perspectives are important to this inquiry, the main issues and debates they raise about gender will be highlighted briefly in one of the subsections.

According to McNeany (2004), feminism is a theory that men and women should be equal politically, emotionally and socially, and those who believe in this theory are called “feminists” (p.1). Thus, the focus of feminism is on equality between men and women in all spheres of life, and this emphasis is referred to as “core feminism” or core “feminist theory” (p.1). However, this core focus of feminism is directed at women, highlighting their great

disadvantage in society, and furthers women's causes (Lorber, 1997). For many decades, feminist work has focused its time, energy and resources on the 'woman' question – that is, an analysis of who 'woman' was, and the implications of being a woman (Jackson & Scott, 2002; McLaughlin, 2003; Weedon, 1997). Viewed as a whole, feminism could be described as a theory, a movement (McNeany, 2004) and a politics directed at changing existing power relations between women and men in society (Weedon, 1997).

Historically, feminism is sometimes divided into three phases. The *first wave feminism* of the eighteenth and nineteenth centuries focused on enlarging basic legal and property rights and on women gaining access to education and economic independence and acquiring rights to vote (McLaughlin, 2003; Wyckoff-Wheeler, 2002). The first wave was thus a political movement aimed at challenging the lack of rights for women in the public sphere (McLaughlin, 2003).

The *second wave feminism* in the late 1960s and early 1970s dealt with the liberation of women from gender-imposed roles and expectations, by advocating that they be free to seek personal fulfilment in all social spheres (Jackson & Scott, 2002; McLaughlin, 2003; Wyckoff-Wheeler, 2002). Second wave feminism, in different ways, provided a link between the continued gaps in the rights and opportunities women experienced in the public arena and the roles they played in the private sphere (McLaughlin, 2003). The focus on the private sphere brought a new range of issues into activism and the development of feminist ideas. The new areas included sexuality, reproduction, domestic labour and domestic violence. Second wave feminism went on to challenge the masculine values embedded in how social and political thought approached many issues (Jackson & Scott, 2002; McLaughlin, 2003). These feminists fundamentally challenged theory's lack of interest in the private sphere. According to McLaughlin (2003), "[o]nce the private came under investigation, feminists were able to identify patterns of power, harm and abuse women suffered in this sphere and push for legislation to challenge this abuse" (p.2), and accordingly, "the personal became political" (Weiler, 2008, p.1; see also David & Clegg, 2008). Weiler (2008) adds that during this period there was a call to explore how wider social structures such as law, politics, religion, family and the economy affected both men and women, since they were shaped by these broader forces in society.

Postmodern feminism could possibly be considered as *the third wave feminism*. The key concerns of postmodern feminists are the binary divide of gender, an essentialist approach to gender and the view of women as a unitary coherent entity, devoid of multiplicity and cultural, social and political positions (ADB, 2010; Arnot & Fennell, 2008; Butler, 1990; Cornwall, 2007; Elmhirst & Resurreccion, 2008; Gavey, 1997; Jackson, 1993; Wyckoff-Wheeler, 2002). The binary categories of male and female have been viewed as one of the most natural, common-place categories of identity, so they are rarely questioned (Gavey, 1997; Keating, 2002; Pauw, 2009; Shaw & Bailey, 2009). It has been argued that when constructed as binary categories of male and female, these categories appear as stable categories of identity, that exclude other forms of identity such as intersex and transgender people (Butler, 1990; GWS Africa, 2009). Further, these binary categories assume heterosexual relationships, in this way isolating other sexual orientations such as gay men and lesbian women (Butler, 1990). (See also Sections 2.1.4 and 3.2.1.1b.)

Owing to the inherent problems associated with the theory of the binary gender divide some feminist theorists have begun to question this theory of biological determinism and, instead, have called for a distinction to be made between sex and gender (Oakley, 1972; Rubin, 1975) – a theory that has come to be known as the “sex-gender system” (Keating, 2002, p.2). According to this system, a distinction is made between sex, which refers to the biological differences between males and females, and gender, which refers to the social meanings that cultures assign to these biological differences (Oakley, 1972; Rubin, 1975). The Gender and Women’s Studies for Africa’s Transformation (GWS Africa) reports that the idea of separating ‘sex’ from ‘gender’ was proposed as a way of examining societies through a focus on the social construction of gender (GWS Africa, 2009).

But several postmodern gender theorists find the sex-gender system to be problematic (Butler, 1993; Emslie et al, 1999; GWS Africa, 2009; Kriegler, 2003). These authors argue that the distinction between sex and gender has become blurred in its usage as research and scholars use gender differences and sex differences interchangeably or conflate the two terms. Butler (1993) is of the view that, while a distinction should be made between sex and gender, the two could still be studied in conjunction. In the health sector, similar concerns about the conflation of sex and gender have also been raised, leading to calls for gender to be separated from sex so that both are addressed adequately in health (Doyal, 2001; EngenderHealth, 2000; WHO, 1998). (See also Section 1.1.1.)

Some of the gender aspects specifically contributed to in this period came from social constructionism and were built on during the postmodern era. Social constructionism and postmodern feminisms are discussed in Section 3.2.1.1c.

Each of these different waves of feminism has produced important approaches to understanding the processes and structures that lie behind the oppression of women and the role of gender in shaping society in different areas of the globe and in different periods. However, feminism is much more complex than described above, for it is not a single unified movement or theory – the issues and debates it raises cannot just be lumped into historical periods (Alsop et al, 2002; Lorber, 1997; McLaughlin, 2003). Instead, these authors suggest a theoretical perspective on gender that captures the main arguments, debates and issues raised among the different feminisms, the contexts in which these have been raised, as well as continuity and convergences over time.

3.2.1.1 Feminist perspectives on gender

A useful way of looking at feminist theories or perspectives on gender is through a framework that groups the different feminist perspectives into three broad categories: “gender-reform feminisms, gender-resistant feminisms, and gender-revolution feminisms” (Lorber, 1997, p.8). The different strands of feminism within these three perspectives are summarised in Table 3-1. (See also Section 2.1.9 on approaches to gender and education.)

Table 3-1: Feminist perspectives on gender

Gender-reform feminisms (1960s and 1970s)	Gender-resistant feminisms (1970s)	Gender-revolution feminisms (1980s and 1990s)
<ul style="list-style-type: none"> • Liberal feminism • Socialist feminism • Development feminism 	<ul style="list-style-type: none"> • Radical feminism • Lesbian feminism • Psychoanalytical feminism • Standpoint feminism 	<ul style="list-style-type: none"> • Multi-ethnic feminism • Men’s feminism • Postmodern feminism • Social construction feminism • Queer studies

a) Gender-reform feminisms

Lorber (1997) identifies three perspectives that fall under this category, namely liberal feminism, Marxist and socialist feminisms, and development feminism. She locates them

within the beginning of the second wave feminism of the 1960s and 1970s and adds that their ideas were rooted in the eighteenth and nineteenth century liberal political philosophy.

Liberal feminism aims to achieve full equal opportunities in all spheres of life without radically transforming the present social and political system. The realisation of its aims means the transformation of the sexual division of labour, of social services and of contemporary forms of femininity and masculinity (Weedon, 1997) to ensure equality between men and women (Saulnier 1996; Trigiani, 1999). Drawing out the main gender argument of this perspective, Lorber (1997) posits that theoretically liberal feminism holds the view that gender differences are not based in biology and that, therefore, no basic difference exists between women and men, implying that they should then not be treated differently under the law. It would also require provision for domestic labour and childcare outside of the nuclear family (Weedon, 1997). The main contribution of liberal feminism to the feminist movement was to show how much modern society discriminated against women. It has been credited with breaking down many barriers to women's entry into formerly male-dominated jobs and professions, helping to equalise wage scales, and getting abortion and other reproductive rights legalised (Lorber, 1997).

Liberal feminism has, however, been criticised for its exclusive focus on equal treatment *outside* rather than within the family, thus accepting and endorsing the division between public and private life and implying that freedom of opportunity rests in the public sphere (Saulnier 1996). Liberal feminism has also been accused of ignoring the problems faced by poor white women and women of colour and addressing only the needs of a rather select group – white, middle class women of Western industrialised countries (McLaughlin, 2003; Saulnier 1996). McLaughlin (2003) argues that “[i]n identifying the oppression women faced, their values and the difference they could make to a better society, feminism presumed an identity and perspective shared by all women, and in this way the category hiding a variety of important areas of both identity and division” (p.8; see also Weiler, 2008.)

Socialist feminism is used as an umbrella term for socialist, materialist and Marxist feminisms (Jackson & Scott, 2002; Lorber, 1997; Saulnier, 1996). For socialist feminists, patriarchy is an integral component of class and race oppressions and can only be eliminated by fully transforming the social system (Jackson & Scott, 2002; Weedon 1997). Socialist feminism does not view gender as an essential entity, but as socially produced and historically changing.

Further, socialist feminists stress the need to take account of biology, but also to see its meaning as historical and social (Weedon, 1997). According to Saulnier (1996), these feminists have been credited with highlighting the need for attention to political-economic systems and in calling for coalitions among economically oppressed groups. At the same time, they have been criticised for characterising men's work as production and women's as reproduction, thus giving a false suggestion that men create society and women maintain it.

Development feminism addresses the economic exploitation of women and makes an important theoretical contribution to feminism by equating women's status with control of economic resources (Lorber, 1997). Lorber (1997) highlights the gendered division of labour, particularly in developing countries where female workers are paid less than male workers at all levels of the economy. This issue of high levels of female poverty leading to unequal access to and control over resources in Africa has already been highlighted in Chapter 1. Secondly, it was also pointed out that in the area of health, gender inequalities may greatly hamper the access to and control over resources and services that promote and protect health. (See Section 1.1.1.) The women in development (WID), gender and development approaches (GAD) and gender-mainstreaming (GM) approaches were discussed in Section 2.1.9.

b) Gender-resistant feminisms

Lorber (1997) considers resistant feminisms as a continuity of gender-reform feminism. She argues that as gender-reform feminisms penetrated the public spheres in the 1970s and as women entered formerly exclusive male workplaces and schools, they were confronted with the stark reality of a male-dominated society that continued to dominate them. She adds that it is out of this awareness that the gender-resistant feminisms of the 1970s were born. Lorber (1997) characterises resistant feminisms as radical, lesbian, psychoanalytical and standpoint feminism.

“Radical feminism's theoretical watchword is ‘patriarchy’, or men's pervasive oppression and exploitation of women, which can be found wherever women and men are in contact with each other, in private as well as in public (Lorber, 1997, p.16; emphasis added). Thus, the only way in which women can assert their autonomy from men and recover their true and natural femininity is in separation from men and from the patriarchal structures of society (Weedon, 1997), by forming “... non hierarchical, supportive, woman-only spaces where

women can think and act and create free of constant sexist put-downs, sexual harassment, and the threat of rape and violence” (Lorber, 1997, p.17). It seems as if the fight against patriarchy still has a long way to go. Connell (2005) asserts that at a global level, the attainment of gender equality would be a great loss to men because they “... collectively continue to receive a patriarchal dividend” (p.1808). Arnot and Fennell (2008) add that current measures of gender equality tend to conceal the historical, economic, social and cultural sub-structures of gender and in doing so, continue to perpetuate male power and privilege. From an educational perspective, the authors call for more nuanced analyses of patriarchal relations, which would address the impact of historical, social and cultural processes on the construction of gender in educational institutions.

In general, radical feminists have been credited for exposing the ideology underlying pornography, sexual harassment, rape, woman battering and prostitution. They have also been instrumental in developing services that centre on women’s needs (Saulnier, 1996). A major criticism against radical feminism is its generalisation of women’s oppression and its failure to recognise additional oppressions among women such as lesbians, women of colour, women with disabilities, or impoverished women, thereby ignoring issues of race, class, ethnicity, religion, disability and sexual orientation (Lorber, 1997; McLaughlin, 2003; Saulnier, 1996; Zein-Elabdin, 1996).

Lesbian feminism emerged in the late sixties mainly in the United States (US), Canada and the United Kingdom (UK), representing one of many social groups seeking liberation from oppression. Their main fight was with patriarchy and the institutionalisation of heterosexuality – the “... disciplinary production of gender effects a false stabilization of gender in the interests of the heterosexual construction and regulation of sexuality within the reproductive domain” (Butler, 1990, p.135). This enforced organisation of sexuality essentially marginalised “othered” sexualities (p.135) that did not conform to the heterosexual matrix and (hetero)normalised constructions of sexuality. According to Ferfolja (2007), “[l]esbian sexualities are publicly forced into the private sphere, and are simultaneously publicly scrutinized, regulated and derided”. Despite feeling frustrated and marginalised, lesbian feminists have been credited for bringing private matters such as domestic labour, child care, and birth control to the fore in line with the wider feminist movement's objectives. Lesbian feminists were also able to offer a positive re-analysis of female homosexuality as well as provide a critique of heterosexuality (Chenier, 2004). The lesbian feminist movement

has been credited for mobilising a network of social and political support that assisted lesbians to cope with the isolation, stigma and legal problems that many homosexuals struggled with (Lorber, 1997). According to Chenier (2004), lesbian feminists have, however, been criticised for ignoring and failing to understand the complexities of intersecting and multiple oppressions.

Psychoanalytical feminism has its roots in Freudian psychoanalytic theories (Alsop et al, 2002). It maintains that gender is not biologically based, but is related to the psycho-sexual development of the individual (Brennan, 1999). Psychoanalytical feminists believe that gender inequality originates in early childhood experiences, leading men to believe themselves to be masculine and women to believe themselves feminine (Alsop et al, 2002). Chodorow (1991) further explains that the unconscious awareness of self and gender that we develop from early infancy continues to shape both our experiences as men and women and the patterns of inequality and differences that exist throughout our society and culture. Abel (1990) credits psychoanalytical feminism with improving our understanding of sexual difference, but also reports on severe criticism for doing little to change the concrete social conditions of sex relations and for being indifferent to racial, class, and cultural differences. Psychoanalytical feminism is further criticised for ignoring the material conditions of people that are grounded in their everyday social practices and interactions (Abel, 1990).

Standpoint feminism focuses on confrontation with the dominant sources of knowledge and values. This is an important perspective for my inquiry because it is a critique of the absence and marginalisation of women from knowledge making and research. Standpoint feminism emphasises and foregrounds women's own knowledge as emerging from their situated experiences (Harding, 1997). This 'situatedness' is located within a woman's specific experiences and knowledge in her material world (Olesen, 2000). These feminists argue that "[w]hoever sets the agendas for scientific research, whoever shapes the content of education, whoever chooses the symbols that permeate cultural productions has *hegemonic power*" (Lorber, 1997, p.21; emphasis added). They insist that women's "voices" are different from men's, and they must be heard if women are to challenge hegemonic values (Lorber, 1997, p.21).

c) Gender-revolution feminisms

According to Lorber (1997), revolution feminists “... deconstruct the interlocking structures of power and privilege that make one group of men dominant, and thus have the revolutionary potential of destabilizing the structure and values of the dominant social order” (p.25). She locates the emergence of revolution feminists in the eighties and nineties and lists them as multi-ethnic feminism, men’s feminism, social construction feminism, postmodern feminism and queer theory.

Multi-ethnic feminism seems to be a response to the critique against Marxism for homogenising women and their experiences (Lorber, 1997). It recognises that, apart from gender, there are other inequalities that exist alongside it, such as race, ethnicity, religion and social class. There are thus multiple strands of oppression and exploitation that are intertwined in structural relationships. It is argued that these multiple inequalities, including gender, comprise a “... complex hierarchical stratification system in which upper-class, heterosexual, white men *and* women oppress lower-class women *and* men of disadvantaged ethnicities and religions” (Lorber, 1997, p.25). Lorber further points out that according to this perspective, any analysis must also include the viewpoints and experiences of women and men of different races, ethnicity, religion and socio-economic class.

The ‘legitimacy’ of *men’s feminism* is widely contested. Lingard and Douglas (1999) posit that the relationship between men and feminism has been complex. Although many men have engaged with feminism and supported the feminist cause, there is a lot of controversy and semantics surrounding the term ‘men’s feminism’ and there is still a raging debate over whether or not men can be feminists (Brod, 1993; Lingard & Douglas, 1999). There are those who emphasise intrinsic differences between the sexes and maintain that men cannot be feminists simply because they are not women. These protagonists claim that due to inherent privileges that are granted to men, they cannot identify with feminist struggles and with feminism (Funk, 2004). Another school of thought takes the position that the strongest stand men can take in the struggle against sexism is to be identified as a feminist. This school recommends that men should be allowed, or even be encouraged, to participate in the feminist movement (bell hooks fan, 2004; Brod, 1993). In order to get some middle ground, Brod (1993) adopted the term “profeminist” (p.197) because of its seeming neutrality – it offers a degree of closeness to feminism without co-opting the term. This neutrality has allowed a

number of men to continue to engage with feminism by lobbying and campaigning for equal rights for women (Flood, 2004; Messner, 2002).

For *postmodern feminism* the question of how women are produced as a category is central (Jackson & Scott, 2002). The emphasis shifted from culture and linguistic structures to a mere fluid notion of how gender is constituted through discourse – in the words of Barrett (1992), a “shift from ‘things’ to ‘words’” (p.102). According to Alsop et al (2002), this shift was necessitated by feminists who became wary of undue attention to patriarchal structures, “things” (in the earlier liberal, socialist and materialist feminisms), and who thus saw the need to shift to “words” (p.21). Barret (1992) clarifies that “things” refer to women’s position in the labour market and in the household, women’s education, male control of sexuality and the pervasiveness of rape, while “words” refers to the turn to ideology or “discursive constructions” (p.201). According to Alsop et al (2002), the ‘discursive turn’ was a time when particularly Marxist and socialist feminists began to examine the role of ideology in defining the processes of the social construction of gender and when attention also began to shift to an evaluation of the meaning of gender for individuals. Finally, another reason for this “shift” is that the materialist accounts of gender construction had failed to accommodate gender as an aspect of subjectivity (Alsop et al, 2002). Lorber (1997) seems to share the views of others that poststructuralism is subsumed under postmodernism. (See Section 3.1.2). The relationship between poststructuralism and gender/feminism will therefore be further explored in Section 3.2.2 below.

Social constructionism, as with poststructuralism, is viewed by some authors as part of postmodernism and has been credited for the sex-gender system theory. (See Sections 3.1.2.2 and 3.2.1.) Social construction feminism views society and all its structures as gendered. This implies that as a social institution, gender determines the distribution of power, privilege and economic resources (Lorber, 1997). Thus, the study of the social construction of gender helps us to understand how gender is shaped and given meaning by the social structures of a society (Alsop et al, 2002). Secondly, social construction feminism focuses on the processes that create gender differences and also make the construction of gender invisible, such as the gendered division of labour in the home, gender segregation and gender typing of occupations, and selective comparisons that ignore similarities (Lorber, 1997). Thirdly, social construction feminism argues that the essentialist binary of male and female biology and physiology are produced and reproduced by social processes. The taken-for-granted

expressions of gender as based in natural or biological difference are therefore questioned (Van Wagenen Wrin, 2004). Finally, social construction feminists believe that the processes of gender differentiation are all manifestations of power and social control, where maleness is constructed as strong and powerful and femaleness as weak and submissive (Webb & Macdonald, 2007). In their view, long-term change of this deeply gendered social reality would have to mean a conscious reorganisation of the gendered division of labour in the family and at the workplace. This would also entail undermining the normalised beliefs about the capabilities of women and men that justify the status quo (Lorber, 1997). In health, for example, there is a concern that if the status quo of the social construction of femininities and masculinities that prescribe the behaviour of men and women in society is maintained, it could potentially affect their health, especially in this era of HIV and AIDS (Courtenay, 1998; Courtenay, 2000; Sabo, 1999). Therefore any change in this deeply gendered order is unlikely to occur unless the pervasiveness of the social institution of gender and its social construction are openly contested (Lorber, 1997).

Social constructionist feminists have been credited with “denaturalising” gender and demonstrated that masculinity and femininity are unstable categories that vary across cultural and historical periods (Keating, 2002, p.3). Grodan (2008) also credits social constructionist feminists with being instrumental in shaping research around the concepts of ‘gender’, ‘sex’, ‘sexuality’, ‘masculinity’ and ‘femininity’ and how these terms have been socially constructed.

Queer studies gained recognition in the nineties with proponents such as Eve Kosofsky Sedgwick, Judith Butler, Adrienne Rich and Diana Fuss. As they were all largely following the work of Michel Foucault (Barry, 2002), queer theory is derived to a large extent from poststructuralist theory and deconstruction (Edwards, 1998). ‘Queer’ as used within queer theory is less an identity than an embodied critique of identity. Major aspects of this critique include: the role of performance in creating and maintaining identity (Green, 2010). “The basis of sexuality and gender, either as natural, essential, or socially constructed; discussion of the way that these identities change or resist change; and of their power relations vis-a-vis heteronormativity” (MedLibrary.org, n.d., n.p.). Critics of queer theory maintain that it completely neglects the material conditions that underpin discourse – that it is nearly impossible to speak of a lesbian or gay subject, since all social categories are produced

through discourse. By ignoring these material conditions, queer theory ignores the social and institutional conditions within which lesbians and gays live (Gamson, 2000).

3.2.2 The relationship of gender and feminism with poststructuralism

This section takes a closer look at gender and how it fits in within the overarching framework for this inquiry: a poststructuralist perspective. In the first instance, poststructuralist feminists argue that gender differences dwell in language. Gender is socially constructed through language and there is therefore nothing “natural” about gender itself (Alsop et al, 2002, p.23). They argue that language contains the most basic categories that we use to understand ourselves. Further, poststructuralist feminism challenges gender categories as dual, oppositional and fixed, arguing instead that gender comprises shifting, fluid, multiple categories (Cheek, 2000; Cornwall, 2007). (See also Section 3.1.3.6a.) Accordingly, poststructuralism challenges stable definitions of gender, while emphasising fluid processes of gendered identification and shifting forms of action (Aikman & Unterhalter, 2005; Rathgeber, 1990). This is one of the reasons why gender researchers tend to reject the singular use of the words ‘femininity’ and ‘masculinity’, since they seem to portray static and essentialist gender categories. Instead they support plural forms of ‘femininities’ and ‘masculinities’ to depict shifting and multiple ways of being (Cheng, 1999; Craig, 1993; Donovan, 2006; Munro & Stychin, 2007; Person, 2006; Skelton & Francis, 2006).

Secondly, poststructuralist feminism recognises subjectivity in the constitution of gender – this subjective constitution varies greatly in different social locations. Such a perspective requires that gendering should be seen as a process rather than as a ‘role’. In this process, the roles of culture and language are key. The emphasis on process implies that gender is a concept that is constantly being reproduced, contested and negotiated and that might yield quite unexpected and contradictory effects (Alsop et al, 2002) such as resistance, indifference or acceptance (Kabeer, 1994).

Weedon (1997) enumerates various uses and benefits of poststructuralist feminism. Firstly, she explains that poststructuralism can aid in the understanding of those social and cultural practices that constitute, reproduce and contest gender power relations. Secondly, poststructuralism enables us to grasp the range of possible normal subject positions open to women, and the power and powerlessness invested in these positions. Finally, poststructuralist

feminism pays special attention to historical contexts that produce women's subjective positions, modes of femininity and women's place in the overall network of social power relations. In this way, we are able to gain "... insights into small gendered acts of citizenship, religious identities, and feminist modes of organization for gender change, the limitations of poverty reduction strategies and public/private partnerships that ignore gender" (Arnot & Fennell, 2008, p.516).

3.2.3 The construction of gender in this inquiry

My inquiry was interested in investigating how gender was represented within the public health curriculum. The foregoing analysis indicates that gender is understood differently in different historical and social contexts. In certain cases there are overlaps and continuities, leading to different responses, in order to arrive at the core project of feminism – gender equality. Often, some of these gender theories oppose or critique each other and this has been highlighted by discussing some of the weaknesses of the various theories as pointed out by the opposing theories. For example, the feminist focus on women has been criticised by gender and development theorists who feel that men should also be included in the gender agenda (ADB, 2010). Another example is a poststructuralist opposition to theories that view gender as having a fixed core essence as opposed to unstable fluid notions of gender. (See Section 3.1.3.1.) The analysis in Section 3.2.3 informed my inquiry in its effort to understand the different ways in which gender was understood by academic staff, and how these understandings then produced different responses to how gender was represented in the curriculum.

It was not the intention of my study to develop or impose a unitary definition of 'gender' but rather to explore and gain further insight into the multiple ways of using and understanding gender within the public health curriculum. Thus, my position on gender was loosely viewed as the way in which we make sense of being male and female. Gender was therefore not viewed as a fixed, stable concept. Rather, my inquiry was guided by the assumption that gender was socially constructed through language, thus yielding multiple and fluid meanings in the different cultural and historical contexts of the different schools of public health under study. Consequently, a range of discourses on gender would emerge, with the most dominant being a reflection of prevailing gender discourses in society. This view of gender is depicted in Figure 3-2.

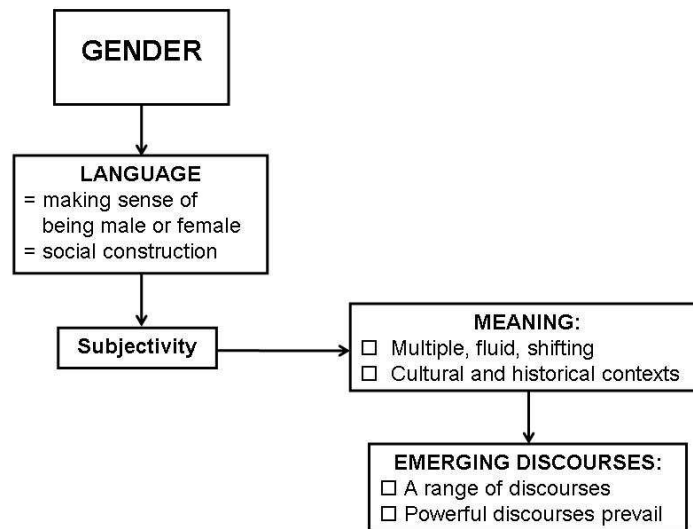


Figure 3-2: The researcher’s construction of gender in the inquiry

3.3 Curriculum as a construct in this inquiry and its relationship to poststructuralism

Another key construct for this inquiry was ‘curriculum’. In this section, the different ways in which curriculum is understood are reviewed, followed by a demonstration of the link between curriculum and poststructuralism and, finally, a description of how curriculum was constructed in this study.

Arnot and Fennell (2008) state that investigation of the curriculum with regard to gender has not been given its due importance in research, particularly in developing countries. Yet, according to Hatchell (2006), “[s]chools represent a central arena where learning takes place. It is also one of the places where race/ethnicity and gender are constructed” (p.7). In addition, Marshall and Arnot (2007) argue that school knowledge with its gendered assumptions and attributions plays a key role in the formation of gender identities and, more often than not, helps sustain rather than challenge gender hierarchies and inequalities within a society. In this study, curriculum was chosen as one of the ‘sites’ for the construction of gender and it was expected that an understanding of curriculum as text would give us more insight into the relationship between curriculum and the construction of gender in the higher education landscape. Higher education institutions serve as an extension of school education, with similar issues and scenarios in terms of gender constructions going on underneath the surface.

3.3.1 Defining curriculum

Many authors have expressed the difficulty of defining the term ‘curriculum’, since its very definition is based on one’s philosophical beliefs, which result in numerous definitions (Hoadley & Jansen, 2002; Kelly, 1989; Oliva, 1988; Ornstein & Hunkins, 1998; Pinar et al, 1995). However, Ornstein and Hunkins (1998) contend that having a plethora of definitions should not be viewed in a negative light, as it is a reflection of the dynamism of varied voices in the field. These authors add: “These voices introduce diverse interpretations by drawing on specific modes of thought, particular ideologies, diverse pedagogies, unique political experiences and various cultural experiences” (p.111).

Available definitions of ‘curriculum’ tend to range from specific, prescriptive and rather narrow interpretations to broad, all encompassing interpretations (Hoadley & Jansen, 2002; Ornstein & Hunkins, 1998; Pinar et al, 1995). These perspectives are discussed below.

3.3.1.1 *The narrow, specific and prescriptive perspective*

From the narrow perspective, ‘curriculum’ is defined as a plan or prescription for action, or a written document that includes strategies for achieving desired goals or ends, for example, a syllabus and policy statement (Hoadley & Jansen, 2002; Ornstein & Hunkins, 1998; Pinar et al, 1995; Posner, 1995). In some cases, curriculum is described as the content of a particular subject or area of study. Expounding further on this narrow perspective, Oliva (1988) observes that curriculum could be viewed as “... a discipline, a subject of study, or a systematic group of courses or sequences of subjects required for graduation or certification in a major field of study” (p.6).

In their critique of this perspective, Hoadley and Jansen (2002) point out some disadvantages of this narrow understanding of curriculum as official documents only, as it

- Implies that whatever is not planned must fall outside the concept of curriculum, thus limiting planning to a consideration of the content or the body of knowledge that should be transmitted;
- Rests on the assumption that the teacher’s role is that of transmitting knowledge rather than developing curriculum; and

- Assumes that knowledge is fixed and should not be changed in classroom practice, which would limit any curriculum analysis.

Adding to the disadvantages of a prescriptive approach, Ornstein and Hunkins (1998) warn that a prescriptive approach has the potential of ignoring the power of both the hidden and null curriculum discussed in Section 3.3.2 below, as students often construct more powerful learning from the hidden and null curricula. Further, these authors argue that the omission of both the null and the hidden curriculum may lead students to conclude that what is left out is not considered of value and is thus not important within the purpose of schooling.

3.3.1.2 The broad, all encompassing perspective

The broad, all encompassing view describes ‘curriculum’ as dealing with the experiences of the learner (Ornstein & Hunkins, 1998; Pinar et al, 1995). This view considers almost anything in school – even outside of school – as part of the curriculum, whether academic, athletic, emotional or social, as long as it is planned (Hoadley & Jansen, 2002; Ornstein & Hunkins, 1998; Pinar et al, 1995; Posner, 1995; SAQA, 2000). Educators who hold this perspective argue that curriculum is more than a set of documents (Ornstein & Hunkins, 1998; SAQA, 2000), and some even reject the distinction between curricular and extra-curricular activities (Posner, 1995). Pinar et al (1995) suggest that this broad definition introduces a distinction between “directed” and “undirected” experience, with the latter referring to “out-of-school” experience (p.27). The out-of-school curriculum is influenced by various institutions, ranging from the church and temple to the media and business, from day-care centres to the family. Based on the notion of “out-of-school experience”, later definitions expanded further to include the unexpected or “unwanted outcomes of schooling”, such as the hidden curriculum, the unstudied curriculum and the unwritten curriculum. Additionally, there have been definitions of the curriculum that emphasise what is not offered, the so-called “null” curriculum (Pinar et al, 1995, p.27). Hoadley and Jansen (2002) summarise this broad all encompassing perspective on curriculum as “the total programme of an educational institution” (p.5) and refer to this broad experience as “curriculum in practice” (p.4).

Ornstein and Hunkins (1998) caution that a broad umbrella perspective of curriculum as school experiences could send out the wrong message that almost everything that goes on in school could be classified or discussed in terms of curriculum, while also implying that

curriculum is synonymous with education. This in effect makes it difficult to delineate the curriculum field and separate it from other fields.

3.3.2 Types of curriculum

Even though most curriculum literature focuses on the school curriculum, the principles and issues they raise are also applicable and give some insight into the higher education curricula. Several curriculum models have been hypothesised as existing simultaneously in schools. Different authors classify them differently, although in some cases there are overlaps. The following list summarises these models:

- The *ideal curriculum* refers to the curriculum that has been recommended as what is ‘best’ for teaching about a subject. According to Sepinwall (1999), the ideal curriculum must contain a rationale, including goals and objectives, for the programme of study.
- Sepinwall (1999) refers to the *formal curriculum* as the *written curriculum*, while Posner (1995) and Hoadley and Jansen (2002) refer to the formal curriculum as the *official* or *prescribed curriculum*. The formal, official, prescribed or written curriculum is the one that has been approved and adopted for use in schools, and is set out in official documents, what Hoadley and Jansen (2002) refer to as the “blue print” (p.2). Its scope includes sequence charts, syllabi, prospectuses, curriculum guides, course outlines, lists of objectives and policy statements (Hoadley & Jansen, 2002; Kelly, 1989; Ornstein & Hunkins, 1998; Posner, 1995).
- The *null curriculum* refers to “... those subject matters and/or experiences that are not taught or learnt, but which students know, at least in a general way, exist” (Ornstein & Hunkins, 1998, p.12). Any analysis of the curriculum must therefore consider why these matters are ignored by curriculum planners and teachers (Posner, 1995).
- Sepinwall (1999) explains that the *perceived curriculum* relates to what administrators, parents and others report about what the curriculum is accomplishing, and that anecdotal reports from any or these stakeholders form the basis of the definition of the perceived curriculum.

- The *hidden curriculum* refers to those unintended but quite real outcomes and features of the schooling process (Pinar et al, 1995), which are not in themselves overtly included in the planning or even in the consciousness of those responsible for school management and curriculum planning (Cornbleth, 1990; Hoadley & Jansen, 2002; Kelly, 1989). According to Tekian (2009), these unintended outcomes stem from “... influences that function at the level of organisational structure and culture” (p.822). Examples include social roles, sex roles, appropriate behaviour, decision making, religious beliefs, rituals, norms and value systems (Hafferty, 1998; Kelly, 1989; Posner, 1995; Tekian, 2009). According to Posner (1995), the hidden curriculum is not generally acknowledged by school officials, but seems to have a deeper and more durable impact on students. He adds that the message of the hidden curriculum addresses issues such as gender, class, race, authority and also deals with the tacit ways in which knowledge and behaviour are produced outside the normal course materials and formally scheduled lessons (Pinar et al, 1995). Thus, according to Hafferty (1998), the hidden curriculum pays special attention to the importance and impact of structural factors on the learning process. However, Aultman (2005) is of the view that the formal curriculum has the hidden curriculum within it – this author states that “... the carefully scripted, formal curriculum carries with it a hidden or unintended outcome” (p.263). Increasingly, the hidden curriculum is perceived by curriculum researchers as a vital part of more general curriculum transformation (Hafferty, 1998; Morley, 2007). In line with this perception, Aultman (2005) urges educators to look beyond the formal curriculum and consider students’ learning and social environments.

Hoadley and Jansen (2002) use a different classification. They classify curriculum as *implicit* or *informal* curriculum and further split this into *covert* and *hidden* curriculum. They explain that the *covert* curriculum consists of learning that is not recorded in official curriculum documents, but which is never the less made explicit by teachers. Marsh (1992) summarises the *hidden* curriculum as involving the learning of attitudes, norms, beliefs, values and assumptions often expressed as rules, rituals and regulations, which are rarely challenged and are often taken for granted by curriculum designers and other stakeholders.

- The *extra curriculum* refers to all those experiences outside of the school subjects that are planned by schools and other educational institutions. Posner (1995) reiterates that

this type of curriculum differs significantly from the official curriculum in two ways: firstly, because of its voluntary nature and, secondly, because of its responsiveness to student interests. Further, the extra curriculum is not hidden, but is openly acknowledged as an important aspect of the school experience. Kelly (1989) adds that this extra curriculum could take place at lunchtime, after school hours, weekends, or during school holidays, and includes activities such as sports, clubs, societies and school journeys.

- The *operational curriculum* refers to what observers actually see being taught, or what is actually taking place in the classroom. Sepinwall (1999) adds that the operational curriculum can be defined and assessed by lesson plans, observational reports, and videotapes of instructional situations. Posner (1995) identifies two components of the operational curriculum – namely the content and the learning outcomes. He explains that “[t]he content refers to what is actually taught by the teachers (the taught curriculum), while learning outcomes refer to the evaluation of what the students have been taught (the tested curriculum)” (p.11).

- The *experiential curriculum* refers to what students believe they are learning and what students actually learn from the operational curriculum they are experiencing. Sepinwall (1999) elaborates by stating that the experiential curriculum can be made manifest through student questionnaires, interviews, examinations, and inferences derived from observation. Kelly (1989) refers to this curriculum as the *actual* or *received curriculum*. She emphasises that what is actually received by learners is as important as the planned curriculum.

In conclusion, Kelly (1989) reiterates that whatever definition of the term ‘curriculum’ is adopted, it must embrace at least four dimensions of education planning and practice “... the intentions of the planners, the procedures adopted for the implementation of those intentions, the actual experiences of the pupils resulting from the teachers’ direct attempts to carry out the planners’ intentions and the hidden learning that occurs as a by product of the organization of the curriculum and, indeed, of the school” (p.14).

3.3.3 Philosophical approaches to the curriculum

Anyone's philosophy is based on their own personal systems of perceptions, beliefs and values (Ornstein & Hunkins, 1998; Posner, 1995). Philosophy is of great significance to curriculum, since it is said to influence the goals and content as well as the organisation of the curriculum (Oliva, 1988; Ornstein & Hunkins, 1998). However, Ornstein and Hunkins (1998) state that often schools hold more than one philosophy, which adds to the dynamics of the curriculum within the school. Two major philosophical approaches to the curriculum have been identified as the traditional (or conservative approach) and the contemporary (or liberal approach) (Oliva, 1988; Ornstein & Hunkins, 1998). This study is interested in one of the contemporary approaches, *reconceptualism*, which has a much more direct application to the way in which the public health curriculum has been constructed in this inquiry. This philosophy is explored below.

3.3.3.1 Reconceptualists

Ornstein and Hunkins (1998) describe reconceptualists as the most vocal group within the curricular arena. Reconceptualists view curriculum with much broader lenses to include an “intuitive, personal, mystical, linguistic, political, social and spiritual” (p.52) perspective and an aesthetic perspective (Slattery, 2003). Reconceptualists believe that this broader perspective is comprehensive enough to tackle society's complex and varied problems (Ornstein & Hunkins, 1998) and to accommodate all groups of people, while, at the same time, address their human needs (Marsh, 1992). These broader lenses have expanded the curriculum to incorporate “... language and communication skills, personal biographies, art, poetry, dance, drama, literature, psychology, ethics, religion, and other aesthetic, humanistic and spiritual subject matter” (Ornstein & Hunkins, 1998, p.53). Reconceptualists shy away from the hard sciences and focus on the development of both cognitive and intellectual aspects of the person. They see the individual as the chief agent in the construction of knowledge – as a culture creator, as well as culture bearer (Marsh, 1992). Their key slogan is liberation, as they aim to liberate people from the restrictions, limitations and control of society, by moving from knowledge to activity, from reflection to action (Marsh, 1992; Ornstein & Hunkins, 1998). Reconceptualists emphasise the necessity of reconstructing and reorganising experiences by individuals and groups.

There is, therefore, a big move away from a preoccupation with curriculum *per se* to an emphasis on the social and political realms within which persons will experience specific curricula (Ornstein & Hunkins, 1998). Reconceptualisation has consequently been popularly and proudly referred to as an orientation that has brought about a shift from curriculum development to understanding curriculum (Ornstein & Hunkins, 1998; Pinar et al, 1995). Marsh (1992) expounds on the notion of reconceptualisation by explaining that it includes “... the process of reflecting on curriculum matters and seeking meaning and direction to curriculum experiences. The emphasis is more upon reflection and processes of thinking than the production of documents, curriculum plans or theories” (p.202). Thus, according to Marsh (1992), reconceptualists use different values and methods to portray curriculum and are committed to transforming or reconceptualising an existing curriculum.

Marsh (1992) has credited reconceptualists with raising serious challenges about traditional approaches to curriculum, for generating new concepts and a new language to theorise about curriculum, and with assisting in the demotion of quantitative methods of evaluating education practices from their position of pre-eminence. The author adds that reconceptualists have highlighted the qualitative aspects of educational experiences and broadened the interpretation of evaluation processes and evaluation judgements.

Ornstein and Hunkins (1998) mention that reconceptualism represents diverse voices that promote themes such as social inequality, the marginalisation of groups, and the suffering of the oppressed. In addition, there is a focus on specific issues, including race, class and gender (Ornstein & Hunkins, 1998; Pinar et al, 1995) and, more recently, on feminist, poststructuralist and postmodern discourses (Pinar et al, 1995). Since the focus of this inquiry is on gender in the public health curriculum through a poststructuralist lens, more attention was paid to gender and poststructuralist perspectives on curriculum, which could be considered to fall within the ambit of the reconceptualists.

3.3.3.2 *A feminist/gender perspective on curriculum*

A feminist perspective focuses on emancipation from a society, its schools and curriculum, which are considered to be oppressive. Thus, according to Ornstein and Hunkins (1998), a feminist perspective on curriculum raises pertinent questions such as: Who is controlling the

content of the curriculum and for what purpose? How are women depicted in the curriculum? Who has access to the privileged subjects of the curriculum?

A broad overview of *liberal feminism* was given in Section 3.2.1.1a and its application to curriculum is now discussed in this section. In education settings liberal feminists sought to uncover sexism and to examine patterns of gender discrimination in public school administration (Weiler, 2008). They focused on the theme of equity in schools by raising questions related to gender stereotyping, sexual stratification along subject lines and unequal distribution of resources, including power in schools. Liberal feminists have, however, been criticised for failing to institute reforms that would challenge and bring about changes in the structures of power, forms of knowledge and ways of knowing (Pinar et al, 1995). Weedon (1997), for example, asserts that gender relations have structured women's absence from the active production of most theory within a whole range of discourses over the past 300 years.

In Section 3.2.1.1b we looked at the key features, benefits and criticisms directed at *radical feminists*. In educational circles these feminists focused on the production and reproduction of gender in the education system, thereby exposing and challenging the unequal gendered nature of the structures of educational institutions, including the structures of knowledge themselves. They examine the ways in which gender differences are produced and maintained in society and in schools, including their implications for education, curriculum and educational research (Pinar et al, 1995; Weedon, 1997).

According to Pinar et al (1995), the liberal feminist and radical feminist analyses and critiques have had a long-lasting impact on both education and contemporary curriculum discourses, while Ornstein and Hunkins (1998) are of the view that feminist theories have succeeded in creating theories that are useful in addressing perceived inequities.

Pinar et al (1995) make a distinction between a *feminist perspective* that focuses on issues dealing specifically with women and a *gender perspective* that encompasses a feminist perspective but is much wider. A gender perspective on curriculum focuses on gender analysis, which includes meanings we give to femininity and masculinity (being male or female and its implications) and to sexual differences. It also focuses on other aspects such as radical homosexual or gay analysis. Curriculum as gender text focuses on examining the biased ways in which people are categorised due to their gender and sexuality, and the ways

we construct and are constituted by the prevailing system of gender, and the way gender permeates our concepts of knowledge and our ways of knowing. Pinar et al (1995) report that this expansion in interpretation has led to the analysis of concepts such as ‘masculinity’, ‘male sex roles’, and ‘homophobia’ within the curriculum, and the emergence of queer studies. They conclude with a remark that “[w]ith time, the movement, which had originally focused on women’s oppression, came to include a radical analysis of and attack on the entire gender system” (p.125). (See also Section 3.2.1.1c.)

3.3.4 The relationship between curriculum and poststructuralism

Hodgson and Standish (2009) caution against using poststructuralist and Foucauldian thought as a template, theory or model by fitting it into the dominant educational research framework. (See also Section 3.1.3 and subsections.) According to them, current educational research is only “... concerned with reaching a conclusion, an outcome that can be translated into policy outcome” (p.309) and in this way “... fixes the account and the subject within it” (p.309), thereby constraining and limiting change and action. This “fixing” of the research process is in direct conflict with poststructuralist thought, which views research as a process and a site of struggle leading to various forms of subjectivities and resistance – thus opening up alternative and new ways of thinking about educational practice, leading to change. In this way, educational policies and practices can be changed. Nudzor (2009) further explains that the persistent paradox between educational policy and practice is because policy is often seen as a fixed entity rather than as arising out of discourse. When the policy and practice arena is viewed as a site of struggle it gives way to various forms of subjectivities, leading to resistance and thus change.

As curriculum is one of the key constructs of this inquiry, it is necessary to explore its relationship within the overarching poststructuralist paradigm. Ornstein and Hunkins (1998) maintain that a poststructuralist view of the curriculum, which is embedded within a reconceptualist philosophy, is also concerned with wider social issues rather than with the technical issues of curriculum. These wider issues include cultural, historical, political, ecological, aesthetic, theological and autobiographical discourses. A further concern is to examine how these discourses interact with and impact on human conditions, social structures and the ecosphere. Pinar et al (1995) again emphasise that poststructuralists have brought about a paradigm shift and refocused the field from developing curriculum as a bureaucratic

function, to understanding curriculum as an intellectual, academic, as well as practical and political project.

Key features of a poststructuralist perspective on curriculum are discussed in the subsections that follow. They focus on: reality and curriculum; language and curriculum; curriculum and deconstruction; curriculum as political text; and discourse and curriculum change.

3.3.4.1 Reality and curriculum

As seen in Section 3.1.3.1, a poststructuralist perspective does not subscribe to foundational, universal truths or metanarratives (Pinar et al, 1995; Ornstein & Hunkins, 1998; Usher & Edwards, 1994). Accordingly, poststructuralists are highly sceptical of any appeal to unities, totalities, origins and first principles and view them as discursive strategies used to entrench and legitimise dominant and taken-for-granted paradigms in education that also disguise the exercise of power (Pinar et al, 1995; Usher & Edwards, 1994).

Arnot and Fennell (2008) lament that most national education policies still regard education as part of "... a single, uniform package to be offered to all its citizens" (p.517). Instead, they suggest that other broader social issues such as discrimination and exclusion should be incorporated in official education documents, since their exclusion often interferes with the educational experiences of disadvantaged men or women. Aikman and Unterhalter (2005) also cite the current international agenda of Education for All (EFA) with its focus on educational access as a strategy for ensuring that education reaches all girls and boys. These authors argue that this in essence is a homogeneous educational policy that does not take into account, for example, the religious and ethnic differences of the children involved. Arnot and Fennell (2008) also propose that the reduction of EFA goals to a mere statistical category does not allow for deeper analyses of gender power relations.

Poststructuralists reject structured, hierarchical curriculum content with the aim of teaching one single truth and turn out well-educated citizens (Usher & Edwards, 1994). They advance the view that curricular foundations are not static, have no centre and grounding, and are constantly changing (Ornstein & Hunkins, 1998; Pinar et al, 1995). Curriculum is considered a controversial field, which is continuously under debate, review and re-construction, and cannot be said to be a fixed, grounded discipline (Pinar et al, 1995). Instead, poststructuralists

advance the view of "... dispersion and multiplicity to replace unity and totality" (Usher and Edwards, 1994, p.24), *inter alia* by proposing a type of curriculum that allows for multiplicity of meanings and in which students are guided to construct their own reality. My study is a 'snapshot' on gender issues in the public health curriculum in sub-Saharan Africa at a particular point in time in a constantly changing education system that allows for the construction of multiple realities and meanings.

3.3.4.2 Language and curriculum

Poststructuralism focuses on language and how we come to create and understand it. Curriculum is written and presented in language form. There is, therefore, a need to take language seriously (Ornstein & Hunkins, 1998). Knowledge does not represent reality, but rather, discourse constructs reality (Pinar et al, 1995); discourse constructs curriculum, implying that there is no single unitary curriculum (Ornstein & Hunkins, 1998). Durrani (2008), for example, views curriculum as "... a set of discursive practices which position girls and boys unequally and differently constitute them as gendered and nationalised/ist subjects" (p.1). After studying curriculum texts from Pakistan, she concluded that in its current form, education was a means of maintaining, reproducing and reinforcing the gender hierarchies that characterised Pakistani society. Pinar et al (1995) and Ornstein and Hunkins (1998) posit that poststructuralists believe that new meanings are constantly being shaped and reshaped through language, and therefore, no true meaning of curriculum is fixed. Thus, readers deconstruct text in order to reconstruct their personal meaning of text.

3.3.4.3 Curriculum and deconstruction

For poststructuralists curriculum is a type of text and pedagogy a type of language (Ornstein & Hunkins, 1998). Therefore, curriculum as deconstructed text disrupts taken-for-granted notions of knowledge and the ways we conceive of curriculum, as Pinar et al (1995) aptly put it: "The assumed truth of constructions is deconstructed" (p.29). These authors add that by disturbing the usual rational way of thinking about curriculum, deconstructionists seek to "... dissolve, explode, and deconstruct the taken-for-granted and reified forms of curriculum that are frequently mistaken for the reality of educational experience they pretend to map" (p.29). Ornstein and Hunkins (1998) encourage the continual deconstruction of the world in general and the curriculum in particular, maintaining that this is a useful rather than

destructive practice that can lead to reflection on and the creation of new text and, thus, new knowledge. (See also Section 3.1.3.6 and subsections.)

3.3.4.4 Curriculum as political text

Poststructuralists view curriculum as political text shaped by language and power relations (Pinar et al, 1995). They focus on how power relations shape knowledge production and legitimise this knowledge (Usher & Edwards, 1994). For poststructuralists then, knowledge is power. Consequently, they ask four important questions related to knowledge and power:

- Who has knowledge/power?
- How and under what conditions do particular discourses come to shape reality?
- What counts as knowledge?
- How are those discourses selected, organised, inscribed and legitimised in a particular society? (Pinar et al, 1995)

Pinar et al (1995) also suggest that by asking these questions, poststructuralists aim at transforming the social relations of knowledge production, the type of knowledge produced, and the structures that determine how knowledge is disseminated.

Curriculum is therefore viewed as a site of contestation and conflict. It is argued 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 (Pinar et al, 1995). Ornstein and Hunkins (1998) support this view by declaring that politics as varied texts compete for our attention, while Pinar et al (1995) conclude that issues of curricular inclusion or exclusion are largely political issues, and that curriculum is constituted through discourse.

3.3.4.5 Discourse and curriculum change

Finally, Pinar et al (1995) emphasise that a poststructuralist perspective of curriculum, which tolerates plurality and difference, brings with it the promise of increased freedom, more power and change. Usher and Edwards (1994) add that a tolerance for plurality and difference provides alternative discourses, which can be appropriated for a critical examination of the theory and practice of education. They suggest that rather than hold a single, universal and invariant mode of rationality, there is a need to see rationality as having many forms,

validated in many different human practices. However, it is possible to acknowledge many and different points of view whilst denying them equal value. Pinar et al (1995) also suggest that exposing students to alternative discourses enables them to confront controversial ideas and teaches them to navigate through more than one discourse. This empowers them to communicate and make their own decisions and also gives them the ability to alter their conceptions of their self and their surroundings. In conclusion, poststructuralism offers us understandings of curriculum and teaching that open up multiple meanings and allows us to break out of frozen ways of thinking in order to think through and between dualisms and to move through to the other side of prejudices and clichés of education (Pinar et al, 1995).

3.3.5 The researcher's construction of curriculum

Based on the above exposition of curriculum, I constructed the following views of the curriculum for adoption in my inquiry:

3.3.5.1 Curriculum as text and discourse

This inquiry viewed curriculum as text and discourse that needed to be deconstructed in order to uncover the discourses on gender in the public health curriculum as they might still be entrenched in some dominant grand narratives. Using a poststructuralist lens with a focus on representation in texts, I believed that an analysis of discourses that were present could reveal much about the way in which our present understandings of gender and health have come to be as they are. Curriculum was also analysed as political text, by exploring dominant and marginalised discourses and how decisions were made with regard to the curriculum.

The curriculum text was also explored as gender text by adopting Pinar et al's (1995) wider approach to gender issues in the curriculum. It was explored from the perspective of both men and women and the meanings they gave to femininity and masculinity (being female or male), and how these in turn influenced the way in which gender was represented within the public health curriculum. It was assumed that this approach would open up multiple realities about the representation of gender in the curriculum.

Finally, the public health curriculum was deconstructed in order to come up with a reconceptualised curriculum. The aim was to reflect on and seek meaning on the way gender

was represented in order to gain insight into an understanding of this phenomenon. In this regard, there was a deliberate move away from the technical issues of curriculum design and development, to ‘understanding’ – which I viewed as a process and not a product.

3.3.5.2 *Types of curriculum*

In line with a poststructuralist paradigm, this inquiry did not rely on a definitive view of the curriculum, but instead viewed the public health curriculum in multiple ways as outlined in Section 3.1.3.1. However, because of the need to delimit the scope of the study, interpretations of only certain types of curriculum (Section 4.2.3.1) were used to answer the research questions. Firstly, data was collected from the *formal, official* curriculum documents. Secondly, the concept of a *null* curriculum was used to explore the representations of gender that were not included in the official curriculum, but which shaped the research participants’ understandings and construction of gender. The *hidden* curriculum was important in shaping the formal curriculum in subtle ways and in this case other forces that shaped gender (for example, cultural, social and historical forces) were explored. In the course of the study aspects related to the *perceived* and the *operational curriculum* also came to the fore.

The focus on the above types of curriculum does not mean that other types of curriculum were not important. For example, the *experiential* curriculum is a very important aspect, as it deals with students’ experience and constructions of gender, based on their lecturers’ constructions. However, for logistical and financial reasons, including the need for delimiting the scope of this inquiry, the exploration of a broader scope of curriculum was not feasible.

3.4 Conclusion: a conceptual framework for this inquiry

Following an exposition of the poststructuralist paradigm and the key constructs of ‘discourse’, ‘gender’ and ‘curriculum’, a summary of the way in which this inquiry was conceptualised and put together is given below. As illustrated in Figure 3-3, poststructuralism is the overarching paradigm. Guba and Lincoln (1994) define a paradigm as “... a set of basic beliefs that deals with ultimates or first principles, which represent a worldview that defines for its holder, the nature of the ‘world,’ the individual places in it, and the range of possible relationships to that world and its parts” (p.107). They add that a paradigm addresses three important questions: an ontological, an epistemological and a methodological question.

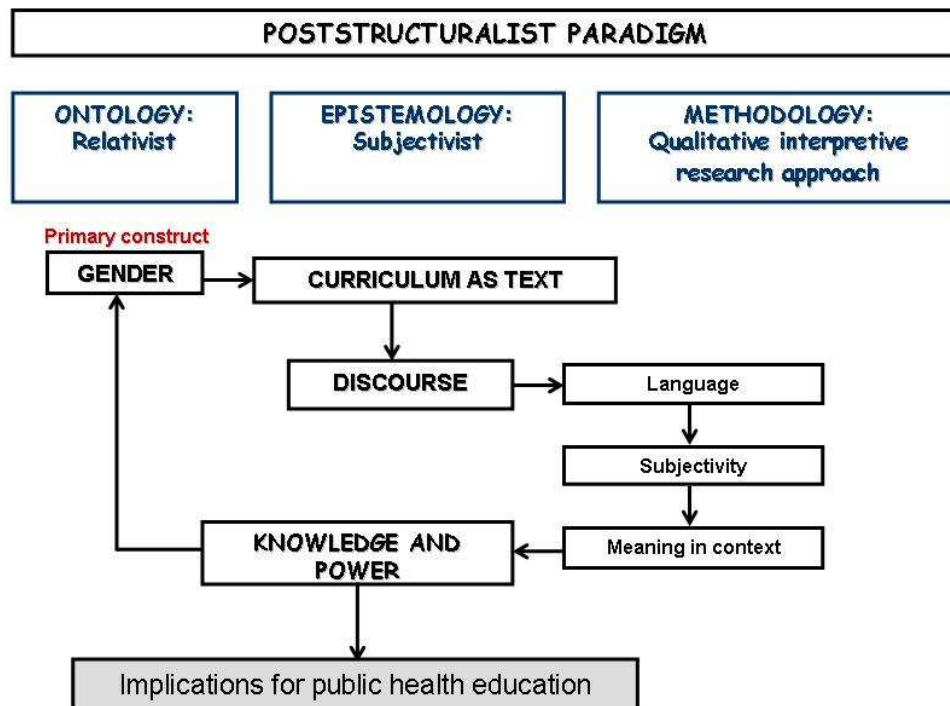


Figure 3-3: A conceptual framework for the inquiry

Firstly, the *ontological* question addresses the issue of the nature of reality and, therefore, what is there that can be known about it. In this inquiry the ontological question focused on the nature of reality regarding gender, by focusing on the questions: how is gender represented in the public health curriculum, and what are the perceptions of academic staff about gender? This is why gender was labelled as the primary construct of the inquiry. A poststructuralist ontology is *relativist* and promotes the view that reality is multiple and socially constructed (Lincoln & Guba, 2000; Lye, 1997; Neuman, 1997). For this inquiry, the aim was to investigate and highlight multiple, alternative and marginalised ways in which gender was understood and represented, rather than to try to reduce these meanings to one singular meaning. (See also Section 3.2.3 and Figure 3-2 on the construction of gender for this inquiry).

Secondly, the *epistemological* question addresses the nature of the relationship between the knower or would-be-knower and what can be known. This relationship is depicted as a process, illustrating how the researcher came to know about how gender was constructed and represented in the public health curriculum. This epistemological process was achieved by

employing the key elements of a poststructuralist paradigm: text (the official public health curriculum documents and transcribed interviews), discourse, language, subjectivity, the creation of meaning in context, and knowledge and power (Lye, 1997; Weedon, 1987). (See also Section 3.1.3.4. and Figure 3-1 on how these elements were linked and how they were employed in this inquiry.) These elements assisted me to explore the discourses on gender in the public health curriculum, including the subjective positions of academic staff and how these enabled them to give meaning to and construct their own reality of gender. This exploration was done in a transactional way, while at the same time creating meaning from this interactive process. This is known as a *subjectivist* epistemology (Lincoln & Guba, 2000).

Thirdly, the *methodological* question addresses the concern of how the inquirer can go about finding out whatever he or she believes can be known (Lincoln & Guba, 2000). Finally, from a methodological point of view, in finding out how the reality regarding gender was constructed, a qualitative, *interpretive* research approach was used, since the aim was to interpret the public health curriculum text and to unravel how gender was represented in it.

Although it was a difficult task, the pieces of the framework emerged from the title of the study, which included constructs such as discourse analysis, gender, public health and curriculum. In addition, the choice of a poststructural framework that was lodged within a qualitative method of inquiry added to the pieces of the framework. A thorough literature review of each of the constructs and their interrelationships was then carried out and this helped in establishing the linkages between the different constructs. A more practical way in which these pieces of the framework were put together is described in the *bricolage* in Section 7.6 of Chapter 7.

The implications of the ontological and epistemological assumptions of a poststructuralist conceptual framework for the research design and process are further unpacked in Chapter 4.

Chapter 4

Research design and methodology

As indicated in the previous chapter, my inquiry is located within an interpretive, qualitative research paradigm. Qualitative research is neither a method nor a single approach to research. Instead, it is a cover term for a collection of methodologies devoted to accounting for social events and experiences, using various ways of description and interpretation (Denzin & Lincoln, 2000). However, for definitional purposes, Denzin and Lincoln (2000) describe qualitative research as a research paradigm that "... involves an interpretive, naturalistic approach to the world, meaning that qualitative researchers study things in their natural settings, attempting to make sense of, or to interpret phenomena in terms of the meanings people bring to them" (p.3). Creswell (2003) contends that a qualitative inquiry employs different knowledge claims, strategies of inquiry and methods of data collection and analysis from those used in a quantitative investigation.

The conceptual framework set out in Chapter 3 provides an overview of poststructuralist assumptions, captured and categorised as ontological, epistemological and methodological assumptions as they relate to the focus of this study – namely gender in the public health curriculum in higher education. A further exposition of the implications of these assumptions for the conduct of my inquiry is provided below.

Denzin and Lincoln (2000) emphasise that qualitative researchers approach their research from a certain view of reality. According to this view, reality is socially constructed and there are multiple versions of reality (Denzin & Lincoln, 2000; Wood & Kroger, 2000). This *relativist* stance (Neuman, 1997) positions the researcher as having her own view on reality and aiming to understand multiple realities rather than one single truth (Lincoln & Guba, 1985). This, in turn, leads to a *subjectivist* stance (Denzin and Lincoln, 2000; Neuman, 1997). For this inquiry, an interpretive qualitative approach fits with a poststructuralist theoretical framework, where the social construction of the public health curriculum and the representation of gender was one of the points of departure.

From an epistemological viewpoint knowledge is created when the researcher and researched undertake the inquiry. A qualitative enquiry permits the researcher to enter the meaning worlds of the participants, subjects, objects or phenomena under study and to participate actively in the creation of meaning (Parker, 1992). Consequently, findings are said to be the creation of the process of interaction between the researcher and the participants. In this sense, qualitative research emphasises process rather than product (Parker, 1992).

Interpretive researchers study meaningful social action in natural settings (Neuman, 1997) – that is, in the localised context of the participants, where human experience, behaviour and events occur (Creswell, 2003; Denzin & Lincoln, 2000). Denzin and Lincoln (2000) further emphasise that human behaviour and responses can be better understood when the framework or the perspective within which the respondents interpret their thoughts, feelings, meanings and actions is known. Therefore, the goal of qualitative inquiry is to understand the meaning of a phenomenon for persons who experience it. Parker (1992) comments that a focus on meaning making in context is in direct opposition to many quantitative methods, which tend to decontextualise data. According to Neuman (1997), the methodology followed in such a process is referred to as an *interpretive* methodology, using research methods such as participant observation, field research and text analysis.

4.1 Research design

Denzin and Lincoln (2000) define a research design as “... a flexible set of guidelines that connect theoretical paradigms first to strategies of inquiry and second to methods of collecting empirical material” (p.22). Figure 4-1 depicts the linkages between the theoretical perspective (poststructuralism) and interpretive qualitative strategies and methods that will be discussed in the subsequent sections. Apart from different knowledge claims employed in a qualitative inquiry, Creswell (2003) also refers to strategies of inquiry and methods of data collection and analysis as important aspects of the research design.

4.1.1 Research strategies

In order to answer the research questions, this inquiry followed a two-pronged research design, a survey design and a case study design. This type of design has also been used elsewhere. Wagner (2003), for example, made use of this type of survey to gather information

on the content of undergraduate research methodology courses at South African universities, and then at the second level, explored the beliefs held by some academics that informed the way in which these courses had been constructed.

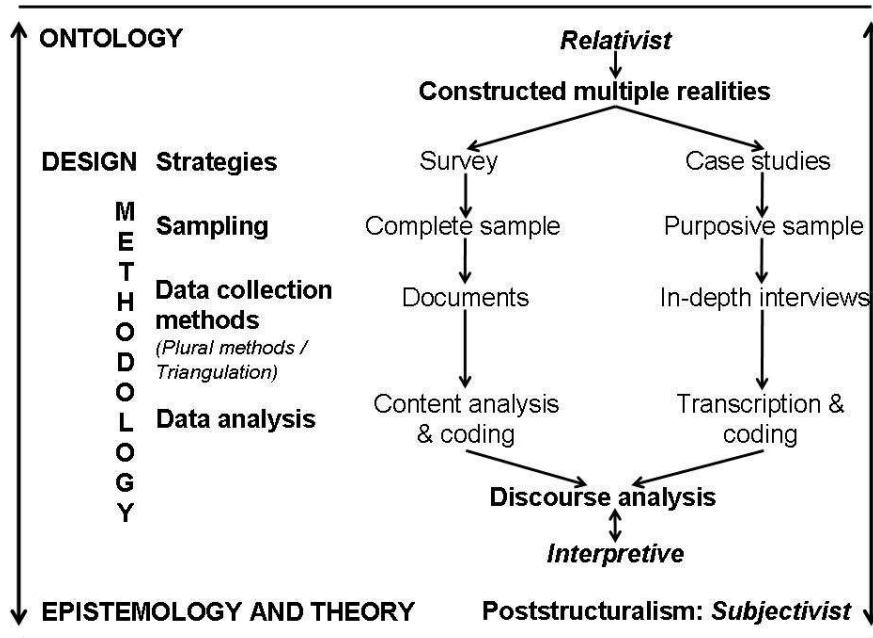


Figure 4-1: Levels of the research process

4.1.1.1 Survey design

Survey research is a popular social science research method. In this study a survey of documents was carried out to answer the question on how gender was represented within the official public health curriculum. Gathering information from documents by means of a survey is an acceptable practice. Cheek (2000), for example, describes how she surveyed and located articles appearing in Australian print media related to Toxic Shock Syndrome.

A typical survey research design involves questionnaire construction, sample selection and data collection through either interviewing or self-administered questionnaires (Babbie & Mouton, 2001). However, I did not follow this typical notion of the survey but was, instead, guided by the definition offered by the Indiana University Audit Department (1995), which seemed to resonate better with the objective of this inquiry. This department describes a

survey as a process for gathering information without detailed verification on the activity being examined, with the aim of:

- Understanding the activity under review;
- Identifying significant areas warranting special emphasis; and
- Obtaining information for use in performing the audit.

If rephrased for this inquiry, the survey was a process that was used to gather information on official public health curriculum documents, which was then used for performing further analysis on the phenomenon under study.

4.1.1.2 Case study design

Secondly, a case study of two schools of public health was employed to provide a more in-depth and nuanced understanding of how gender was represented within the public health curriculum. Stake (2000) offers some insights on case study designs. He emphasises that a case study is not a methodological choice, but a choice of what is to be studied. Therefore, the focus should be on the individual cases and what could be learnt from the single case. Stake (2000) further identifies three types of case studies:

- *Intrinsic case study*. This is employed when the researcher seeks a better understanding of a particular case – “in all its particularity and ordinariness” (p.437). In other words, the case itself is of interest and the study is undertaken primarily because of an intrinsic interest, not for theory building.
- *Instrumental case study*. This is employed when
 - ... a particular case is examined mainly to provide insight into an issue or to redraw a generalization. The case is of secondary interest; it plays a supportive role and it facilitates our understanding of something else. The case is still looked at in depth, its contexts scrutinized, its ordinary activities detailed, but all because this helps the researcher to pursue the external interest. The choice of case is made to advance understanding of that other interest. (p. 437)
- *Collective case study*. This is employed when a researcher collectively studies a number of cases in order to investigate a phenomenon, population, or general condition. It is an instrumental study extended to several cases.

In line with Stake’s categorisation, our inquiry was an *instrumental case study*. Two cases were selected for further in-depth understanding of the phenomena under study, but also to

triangulate other sources of data collection used in the inquiry. In using a case study for this inquiry, my aim was to get a deeper and more nuanced understanding of how gender was constructed and represented in the public health curriculum by the participants within their different contexts (see Denzin and Lincoln, 2000). The case studies in this inquiry, conducted by means of in-depth interviews, enabled the inquiry to answer questions on the perceptions of public health academic staff in sub-Saharan Africa with regard to gender, the resources that had shaped these perceptions, the way in which forms of subjectivity were constituted and taken up within these discourses, and how academics' own perceptions and experiences contributed to the construction of current discourses on gender in the public health curriculum.

4.1.2 The researcher's role

In qualitative research, the researcher is the primary instrument for data collection (Creswell, 2003) and also a co-creator of knowledge (Babbie & Mouton, 2001; Parker, 1992). The orientation of the researcher towards knowledge creation is termed as an outsider (etic) or insider (emic) perspective (Patton, 2002). Young (2005) defines emic as having “personal experience of a culture/society,” while etic is described as “the perspective of a person who has not had a personal or 'lived' experience of a particular culture/society” (p.152). To illustrate the concept of insider/outsider perspective, Byrne (2001) explains that “[i]f an ethnographer studied the culture of perioperative nurses and had no perioperative nursing experience, that researcher's interpretations would be from an etic perspective. If a perioperative nurse studied the culture of the OR [Operative Registered Nurses – NMAM] or the organization of AORN [Association of periOperative Registered Nurses – NMAM] those interpretations would be from an insider's, or emic, perspective” (p.83).

Eppley (2006) argues that researchers who have an insider or emic perspective share very specific and important subject positions or experiences with their participants and come close to being an insider. However, they could never reach complete insider status, but the shared subject positions and experiences at least preclude them from being an absolute outsider. Eppley (2006) further contends that insider/outsider positions are socially constructed and entail a high level of fluidity that further impacts on a research situation. This author also comments that a researcher, by nature, has to have some level of outsider perspective in order to conduct research. Although this does not necessarily mean that the insider perspective

should be surrendered, he believes that both perspectives could exist simultaneously and that it is necessary to step back or distance oneself in varying degrees. He concludes that “[t]here can be no interpreting without some degree of othering. Researchers, then, can be neither insider nor outsider; they are instead temporarily and precariously positioned within a continuum” (p.3).

With this concern in mind, Creswell calls on qualitative researchers to systematically reflect on their biographies, their biases, values and interests, and to highlight how these could shape the study, an action known as *reflexivity* (Creswell, 2003). In Section 4.3.5, I give a reflection on my subjectivity, on how my biography, experiences and interests may have shaped this inquiry and the measures I took to minimise personal bias.

4.2 Research methodology

A research methodology pinpoints the research process and the kind of tools and procedures to be used. According to Denzin and Lincoln (2000), it follows on the research design phase and entails the methods of collecting and analysing empirical material.

4.2.1 Site selection

The sites of the inquiry were schools of public health in sub-Saharan Africa offering postgraduate training. One of the reasons for this choice was the fact that I worked in a school of public health and was at that stage already working on a gender project in this region. (See Sections 1.2 and 2.2.2.7b.) I was, however, interested in exploring the phenomenon of gender in public health curricula in greater detail, using a qualitative instead of a quantitative lens.

The study was interested in those sites (schools, institutes or faculties of public health) that were autonomous (i.e. not integrally linked to schools or faculties of medicine as departments). This also implies autonomy in terms of financial, administration and programme offering. In addition, they were to be multidisciplinary (i.e. admitting students from different disciplines) and were to be offering preventive and promotional aspects of public health in their curriculum at postgraduate level. The scope was further delineated to only include the Master of Public Health (MPH) degree. Further, due to language limitations, francophone and lusophone schools and institutes of public health that met these criteria were excluded. These

criteria were used in order to delineate a uniform sampling frame and to align to the notion of public health. (See Section 2.2.1.) According to available Afrihealth (2003a) data, there were 10 such institutions in sub-Saharan Africa. Half of these were based in South Africa. There was also evidence of work on gender in the medical curriculum specifically being carried out in medical schools (Garcia-Moreno, 2005; Mwansa-Nkowane, 2005), but little or no work at all in the autonomous schools of public health.

4.2.2 Sampling

Sampling was linked to the two-pronged research design described in Section 4.1.1 and was thus carried out at two levels. Figure 4-2 gives an overview of the sampling procedures.

4.2.2.1 Sampling procedures for institutions to be included in the survey

At the first level, a complete sample of all the institutions described above was included for this analysis, except one school, which was at the time of data collection going through a huge restructuring process. There was a need to be sensitive to this and avoid adding undue pressure to the system. This brought the total number of institutions whose documents were surveyed to nine. By including all these institutions, the researcher aimed to ensure that as much diversity as possible was represented in the vast region of sub-Saharan Africa. It was important to get a broad and comprehensive view that would ensure maximisation on the range of information that could be collected and the provision of a potentially rich supply of data (Cheek, 2000) to be relevant for understanding the representation of gender in the public health curriculum. This part of the procedure is depicted in Figure 4-2.

4.2.2.2 Sampling procedures for the cases and the members of academic staff

At the next level, sampling was carried out in two phases. Firstly, the two cases were purposively selected, and thereafter the academic staff members in each of the two schools.

Institutions offering postgraduate training in public health in sub-Saharan Africa

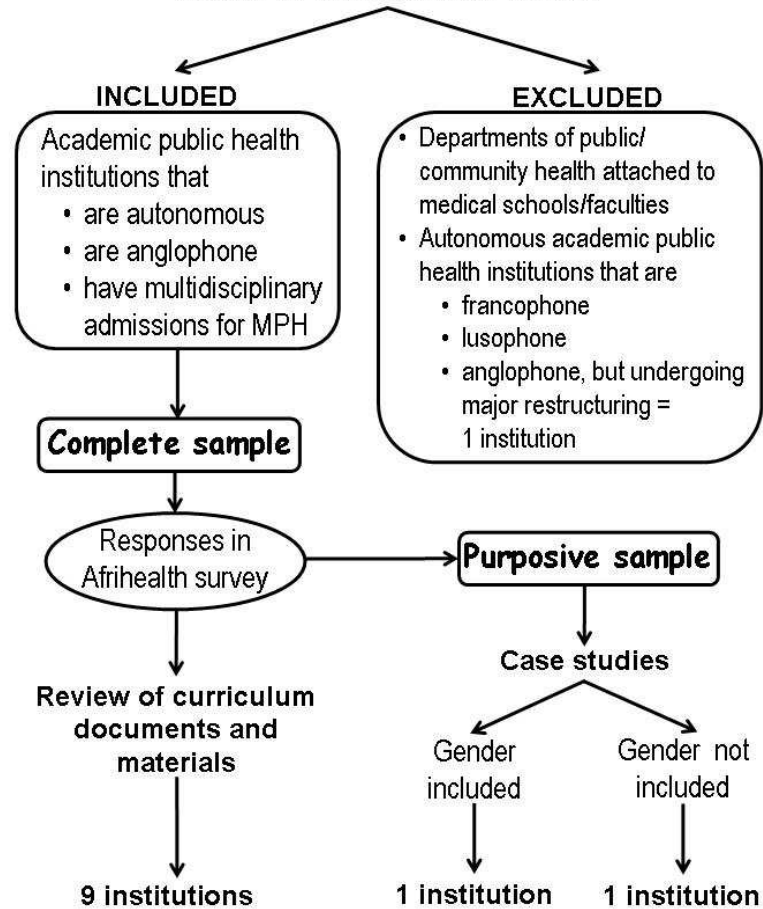


Figure 4-2: A depiction of the sampling procedures

a) Purposive sampling of the cases

From the findings of the Gender, Education and Training (GET) project (Section 2.2.2.7b) two schools of public health were selected for further in-depth analysis. The following criterion was used: one school where it was apparent that there was a dedicated course on gender, complete with staff and resources allocated to it; and one school where the reverse was true. This enabled the researcher to gain insight into how gender was understood, experienced and incorporated in the two schools. This part of the sampling is also depicted in Figure 4-2.

The sampling procedures of the two cases described above were in line with Silverman's (2000) suggestions that, firstly, purposive sampling should allow us to choose a case because it illustrates some feature or process in which we are interested (the representation of gender in the public health curriculum) and secondly, it enables us to limit the number of cases to the resources (which was also true in the case of this inquiry). Stake (2000) also proposes that we should select cases that are likely to offer us an opportunity to learn rather than focusing on the issue of representativeness. In this case the two cases were selected on the basis of what we could learn from them (absence or presence of gender and why) rather than on the basis of whether they were representative of all the units under investigation. A more detailed description of each of the schools selected as cases is given in Appendix 1.

b) Purposive sampling of the academic staff members

Stake (2000) refers to the way in which academic staff members were sampled as sampling of "cases within the case" (p.440). He explains that after sampling of the main case, there are still subsequent choices to make about persons, places and events to observe. He adds that specified criteria need to be used, and is emphatic that these criteria should be based on the opportunity to learn rather than on representativeness.

In this instance, in-depth interviews were conducted with academic members of staff from the two cases mentioned in Section a) above. Certain criteria were therefore considered in the selection of the academic members of staff and the number to be interviewed. In this case, seven academic members of staff were interviewed from each institution, bringing the total number to 14. Data had reached saturation by the time this number of members of staff from each school had been interviewed and there was therefore no need for additional interviews. Data saturation implies that no more new categories emerge from the data: "When data are saturated, events do not remain as a single instance, they have been replicated at least in several cases, and with that replication lies verification" (Morse & Richards, 2002, p.174). This number (14) was purposively decided upon in order to ensure not only data saturation, but also an adequate mixture of academic staff to be interviewed, based on the following criteria: age, sex (where possible), rank, experience, qualifications, and different domains of public health such as epidemiology and biostatistics, occupational and environmental health, health promotion, health policy and management, disease prevention and control, and family and population health.

4.2.3 Data collection procedures

This section provides an explanation of the process of data collection that included the collection of curriculum documents and in-depth interviews. These activities took place during the period August 2007 and February 2008.

4.2.3.1 Collection of documents

The researcher requested curriculum documents from the nine selected schools of public health and ensured their collection either through e-mail, post (registered or priority mail) or personal collection. It is important to point out here that all curriculum documents describing all courses were collected and not just those with gender content. The documents that were collected included:

- Course descriptions representing different domains of the public health curriculum; and
- Any course descriptions of the public health curriculum available on the Internet.

4.2.3.2 In-depth interviews

In-depth interviews were held with selected members of academic staff in the two institutions identified to serve as case studies. Each participant signed a consent form to indicate voluntary participation (Appendix 2). An interview guide was used for ensuring that all the topics of interest were covered comprehensively with the respondent (Appendix 3). Each interview lasted between 30 and 45 minutes. The researcher ensured that the interviews were conversational and interactive by encouraging the participants to talk freely, while guiding the conversation towards new topics from time to time. The emphasis was on eliciting as much narrative as possible, in order to get the participants' own perspectives and experiences – a rich description of their contexts and situations (Campbell, 1999). The main value of in-depth interviews is their ability to provide insights and understanding of the context in which behaviour occurs and the broader structural determinants of behaviour. The main disadvantage of in-depth interviews is the generation of huge amounts of data, and thus methods of collecting and analysis become very time consuming. Accordingly, smaller manageable sample sizes are encouraged (Campbell, 1999). In this case, a sample size of seven from each school was considered to be manageable.

All the interviews were audio-taped, except in one case where the researcher forgot to switch on the record button of the tape recorder. When this was discovered at the end of the day, I reconstructed this interview from the notes I had taken. This reconstruction was treated as field notes and not as an interview transcript. I aimed to conduct all the interviews in a pre-arranged room that would ensure good acoustics and privacy. However, this aspect was out of my control when the participants insisted on being interviewed in their offices, some of which were quite noisy. This made the transcription difficult and time consuming, as the recordings had to be replayed several times more than anticipated to ensure the accuracy of the transcriptions. The audio-taping was supplemented by note taking during the interview. Notes were expanded on at the end of each interview session, and again after all the interviews of the day. The advantage of audio-taping is that no information is lost and the researcher can listen to the flow of the discussion and the exact words that were used. The disadvantage of audio-taping is its intrusive characteristic, especially for sensitive topics (Campbell, 1999; Creswell, 2003). In addition, an efficient filing system was developed, which was kept under lock and key (with duplicate copies kept separately) to ensure the maintenance of a reliable audit trail (Creswell, 2003).

4.2.4 Data analysis

The data underwent three processes of data analysis, as listed and discussed below. The organisation of the data for analysis was followed firstly, by content analysis, and secondly, by discourse analysis.

4.2.4.1 Organising the data for analysis

Unique identifying codes were given to each school. The codes, which were derived from the GET project described in Section 2.2.2.7b were maintained for the schools that were included in this inquiry. The nine schools included in this study were assigned the following codes: 1200; 1500; 1600; 1700; 1800; 2100; 2200; 2400; and 2500. The gaps in the numbering represent schools in the GET project that did not fit the inclusion criteria for this study. The two schools that served as case studies maintained their school codes 1600 and 2500 respectively.

Curriculum documents were given unique identifying numbers that corresponded to the school from which they were collected. They were then available as text for content analysis and subsequent discourse analysis.

In-depth interviews with academic staff were transcribed with the help of an expert. The transcripts produced became the text that was subjected to analysis. The transcription of the material emphasised readability and did not feature detailed intonations or pause lengths. Such a detailed level of transcription was not necessary given that the analytic focus was directed at the content of the discursive practices drawn from the respondents. Where the tape recording could not be heard clearly, this was shown in the transcript as “[inaud]” (Burman & Parker, 1993). The participants selected from the two schools for in-depth interviews were given unique identifying codes reflecting their school codes, the sequence in which they were interviewed and their sex. For example, a participant from School 1200 who was the first participant to be interviewed and was female was assigned the code “1600:1F”. A participant from School 2500, who was the sixth participant to be interviewed and was male, was assigned the code: “2500:6M”. (See Table 6-1 for the rest of the participant codes).

In the rest of this thesis, the above two data sets or sources will sometimes be referred to as ‘text’ in the singular. Each of these two ‘texts’ actually comprise of a collection of texts in the traditional sense of the word. This is in line with a poststructuralist focus on text as the object for analysis as already described in Section 3.1.3.5.

4.2.4.2 Content analysis

Content analysis usually refers to analysing text (interviews, transcripts, diaries or documents). In qualitative research it is used for data reduction, helping to make meaning out of the large volume of data and other material in an effort to identify core consistencies and meanings, patterns and themes (Patton, 2002). All the above sources of data, now in the form of text, were subjected to a content analysis, but this was done separately for each data source.

In carrying out the content analysis of all the data sources, I was guided by the following steps, synthesised from several authors on qualitative research (Campbell, 1999; Creswell, 2003; Hsieh & Shannon, 2005; Marrying, 2000):

1. The data was organised and prepared for analysis as already mentioned.
2. I got ‘immersed’ in the data by reading and re-reading the curriculum documents and transcripts, to familiarise myself with the data, as well as to identify important themes, categories, dimensions and interrelationships. This action resulted in the emergence of new insights and gaining of a deeper and richer understanding of the phenomenon under study. In this way I allowed the categories and names for categories to flow from the data rather than to impose my own categories.
3. Data was then coded according to themes. Coding involved taking text data sentences or paragraphs into categories, and then labelling those categories with a term, and often terms based in the actual language of the participant (Creswell, 2003). Both manifest (obvious) and latent (underlying) content were themed.
4. A thematic analysis was then carried out to identify broad themes that emerged from the text.

While mainly considered as a quantitative technique, some qualitative researchers are sceptical of using content analysis for qualitative analysis. Stemler (2001), for example, points out that, “[t]he most common notion in qualitative research is that a content analysis simply means doing a word-frequency count” (p.1). Those qualitative researchers opposed to the use of content analysis for qualitative data include Parker (1992) and Wood and Kroger (2000). Parker and the Bolton Discourse Network (1999) reject content analysis on the grounds that it fails to capture the context in which the inquiry is carried out. He argues:

When we try to grasp patterns in a text, we always have to carry out that exercise against a cultural backdrop, which is made up of many different social worlds (such as classrooms, families, clubs), subcultures (including bands, classes and regions), and in most societies, language and dialects. These provide shared systems of meanings that we selectively draw upon to communicate to each other.” (p.2)

Wood and Kroger (2000) also reject the classification of content analysis as a qualitative approach, and instead, view it as quantitative. They argue:

Conventional content analysis involves the coding of a text into mutually exclusive categories, the counting of category occurrences and their statistical analysis. The content that is coded is limited to the representational, referential or propositional meaning of the unit. Depending on the categories that are used, the coding may involve varying degrees of interpretation, but both the categories and the way the text is to be interpreted and coded are predetermined, that is, they are not guided by the discourse. Further, there is usually a check on the reliability of the coding via some sort of quantitative assessment of the degree of agreement among coders. (p.32)

Indeed, the arguments of both Parker (1992) and Wood and Kroger (2000) are valid for any researcher interested in carrying out a discourse analysis, and this is why this inquiry went beyond content analysis.

4.2.4.3 From the descriptive to the discursive

Poststructuralist approaches lend themselves to a distinct research focus. Cheek (2000) has some useful observations about moving from the descriptive to the “discursive”. She asserts that data as text becomes the focus of analysis, emphasising that “[d]iscursive analyses of texts are thus not simply descriptions or analyses of content, rather, they are critical and reflexive, moving beyond the level of commonsense” (p.42). Texts are embedded within discursive frameworks, and therefore in discourse analysis; text is an example of the data itself. Meanings as they occur in texts are the product of dominant discourses that permeate those texts. Therefore, texts are interrogated to uncover the unspoken and unstated assumptions within them. In such analysis our concern is not so much whether these are a poor or good record of the events, but rather what the nature of the reality produced by these texts entails. Such a focus moves the research beyond the descriptive and locates it within the realm of the discursive. The focus is not so much on what is recorded, but on why it is recorded, and conversely, why other things are not recorded. Cheek (2000) encourages one then to ask incisive questions that would bring out these underlying assumptions and dominant discourses that then become taken for granted as knowledge.

In this study the descriptive findings from the content analysis were used for the further development of a discourse analysis of the representation of gender in the public health curriculum. The discursive practices in the emerging themes and patterns were explored in terms of the original research questions regarding the discourses emerging from the public health curriculum documents and the perceptions of public health academic staff in sub-Saharan Africa with regard to gender.

The emerging discursive practices were then triangulated among the two data sets to identify common and contrasting practices within the data sets.

4.2.5 Reporting the findings

Since this was a naturalistic inquiry, the findings are presented in narrative form, and in some cases interspersed with quotations and diagrammatical depictions of relationships between themes and patterns where necessary, in order to provide ‘thick descriptions’ of how gender was represented in the public health curriculum (Creswell, 2003).

4.3 Validity and reliability, trustworthiness and credibility

This section describes how issues of validity and reliability were addressed in this inquiry by embracing current constructs of quality assurance from a qualitative paradigm that include ‘credibility’, ‘transferability’, ‘dependability’ and ‘confirmability’.

Lincoln and Guba (1985; 2000) outlined some useful insights in addressing issues of validity and reliability in qualitative research. They also came up with constructs that are equivalent to those in the quantitative research paradigm and state that in qualitative research:

- Credibility is equated with internal validity;
- Transferability is equated with external validity;
- Dependability is equated with reliability; and
- Confirmability is equated with objectivity.

Based on Lincoln and Guba’s (2000) categorisation, I aimed to maintain the quality of the inquiry described in the sections that follow.

4.3.1 Credibility of this inquiry (internal validity)

Credibility refers to establishing that the results of qualitative research are credible or believable. Credibility in this inquiry was established through rigour of techniques and methods and the credibility of the researcher.

Rigour of techniques and methods. To ensure rigour of techniques and methods, a full description of the research design, methods, and the fieldwork procedures and processes has been given in this chapter.

Credibility of the researcher. The researcher gives a full report of her biography, experience, knowledge, values and biases that she brings to this inquiry. (See Section 4.3.5.) This self-reflection creates an open and honest narrative that will hopefully resonate well with readers (Creswell, 2003).

4.3.2 Transferability (external validity)

Transferability answers the question of how research findings can be applied to other contexts or to other respondents. However, the intent of qualitative research is not necessarily to generalise to a population, since the inquiry is context based (Marshall & Rossman, 1993) and uses purposive sampling. Lincoln and Guba (2002) suggest that transferability can be achieved by providing ‘thick descriptions’, by collecting sufficiently detailed descriptions of data in context, and by reporting the data with sufficient detail and precision (see also Creswell, 2003). Thick descriptions may transport readers to the setting and give the discussion an element of shared experiences. By using purposive sampling the range of information that can be collected about that context is maximised (Lincoln & Guba, 2000). In my study, sufficient data was collected from two different sources already referred to in Section 4.2.3 and subsections. In-depth interviews were conducted until the data reached saturation. The recordings were then transcribed and analysed to give thick descriptions of the participants’ narratives (Morse & Richards, 2002). Care was also taken to report on the findings in as great a level of detail as possible, and with as much accuracy as possible in order to ensure transferability (Creswell, 2003).

4.3.3 Dependability (reliability)

According to Merriam (1995), reliability revolves around repeated measures of the same phenomenon and the more times findings of a study can be replicated, the more stable or reliable the phenomenon is thought to be. However, she contends that in the social sciences the notion of reliability is problematic because human behaviour is not static:

Qualitative researchers seek to understand the world from the perspective of those in it. Since there are many perspectives and many possible interpretations – it is not possible to take repeated measures since a replication of qualitative research will not yield the same results. (p.56)

Accordingly, Lincoln and Guba (2000) address this ‘dilemma’ of reliability by suggesting the use of the term ‘dependability’ to check whether the results of a study are consistent with the

data collected. The strategies they suggest for ensuring consistency were applied in this study as follows:

Triangulation refers to the use of multiple methods in data collection. Triangulation was carried out using two different sets of data requiring different methods of data collection. One data set was collected by means of a survey of the official curriculum documents. The other set was collected by means of in-depth interviews with staff working at two diverse public health school settings. (See Figure 4-2 and Section 4.2.3 and subsections.)

Peer examination refers to the checking of the consistency of the emerging findings with the methods of data collection. Apart from providing sufficient details of the whole research process in this chapter, several presentations were given at academic meetings in the School of Health Systems and Public Health, University of Pretoria, South Africa where the findings were discussed in relation to the methodology followed. A critical reader was used not only to check the coherence of the whole thesis but also to check if there was consistency between the findings and the methods of data collection.

An audit trail describes in detail how data was collected, how categories were derived and how decisions were made throughout the inquiry (Wideen et al, 1998). The researcher kept and maintained an audit trail by developing and maintaining an efficient filing system of all the raw data, analysis printouts, curriculum documents and any other materials used for this study so that, should the need arise, these could be availed for peer examination to verify if the findings were consistent with the methods of data collection. (See also Sections 4.2.3.2 and 4.2.4.1.)

4.3.4 Confirmability (objectivity)

‘Confirmability’ refers to the degree to which the findings are the product of the focus of the inquiry and not of the biases of the researcher. Lincoln and Guba (2000) suggest that confirmability can be best achieved if the researcher leaves an adequate audit trail to make it possible for the auditor to ascertain that the conclusions, interpretations and recommendations can be traced to their sources and that they are supported by the inquiry. The audit trail should include: raw data; data reduction and analysis products; data synthesis and reconstruction products; process notes; materials related to intentions and dispositions; and instrument

development information. The way in which I kept and maintained an audit trail has already been discussed in Section 4.3.3 above.

4.3.5 Researcher's statement of subjectivity

In order for the reader to make a judgment on the credibility of the study, my personal experiences and subjectivities also need to be revealed. In both the private and public spheres of my life, I live in a world that is highly structured along gender lines, which has led me to construct gender in a special way – I therefore hold a certain view on gender. In this section I ponder reflexively on the relationship between myself, the participants and the research process in order to account for any potential bias this may have had on the findings.

I entered the field with multiple axes of difference. These included considerable academic knowledge and personal experience of gender, sex and gender differences between the researcher and the participants and differences in professional ranks and geographical space. One of the strongest points of affinity and commonality was that the researcher and the participants were all from schools of public health in sub-Saharan Africa.

As an academic from a school of public health, I felt great affinity with the other schools in which I carried out my research, which located me with my research participants. In this regard I was positioned as an 'insider' and was able to put my questions with ease and confidence. However, being an academic and coming from an academic institution made some of the participants also offer academic answers to my research questions, and in this case I had to creatively steer the questions to more nuanced and personal understandings of gender. Whilst going through the curriculum documents in search for constructions of gender, I had to consciously and constantly set aside my own prior constructions of gender in order to open up my understandings of what others were saying about gender.

Sex and gender differences also came into play during the research process. As a woman, and based on my own personal struggles of sex and gender issues, I often found that I became too deeply engrossed in and empathetic to the narratives of women participants, especially when they talked about similar struggles. I had to be consciously aware of such feelings and work through them during the research process. Most of the women were open, friendly, and gave more detailed answers, and I felt that this was due to our shared sex and gender. In general

most of the male participants were quite respectful and friendly, whereas a few were defensive and gave guarded answers. In one instance I encountered a male participant who exhibited a lot of scepticism towards the topic of gender and was somewhat difficult to interview. I had to politely engage and listen to his answers, while at the same time steer them back to my research questions. However, I felt that the responses emanating from the male participants were not necessarily due to my sex; I picked up that in one school men were generally uncomfortable talking about gender. This may have been as a result of their historical and cultural contexts in which gender issues were not openly discussed. In the other school the men were quite uninhibited talking about gender and it was apparent that their historical and cultural contexts were very different from those of participants from the first school.

Another marker of difference between the researcher and the participants was professional rank. At the time of the research I was a senior lecturer. I held interviews with a broad spectrum of academic staff, including directors of schools, heads of departments, professors and senior and junior lecturers. In order to minimise hierarchical power relations during the research process, I personally communicated with each participant, letting each one know about the research and its objective, and negotiating the day and time of the interview with them. With each communication where appropriate, I addressed them as 'Dear Colleague', a term I knew would not indicate any hierarchy and position of power. However, I still had to acknowledge and be sensitive to each position, for example by addressing professors as such, since I knew that this was very important in such contexts. I noticed that the junior lecturers were a bit too shy and too respectful and regarded me as 'other', an expert outsider who had come to ask them questions and they immediately assumed a subservient position. I worked through this by asking them a few more questions about their lives (for example, where they studied and the kind of work they were doing) until I was able to enlist their trust to continue with my main research questions.

The final difference I encountered during the research process was one of differences in geographical space. One of the case study institutions was located in a country and region of Africa that differed significantly from the country and region in which I resided. In this school, even though I felt the affinity earlier referred to, the fact that I had come from far made me feel like an 'outsider'. This community treats visitors from 'far' with a lot of respect, which actually sets you apart from the rest, further amplifying the fact that you are an

‘outsider’. This made me even more conscious of my feeling as an ‘outsider’ and made it a bit more difficult for me to negotiate and occupy my space as a researcher and not a visitor. In this respect, reverse power relations came into play and I was led and did not have much choice on where to hold the interviews. I had earlier in my communication requested a neutral venue to hold the interviews, but the participants were much more comfortable holding the interviews in their offices. I had no control over disturbances, noise and setting up my recorder. In this context, I had to work extra hard to create rapport and put the participants at ease to make them realise that I was just one of them, a colleague from a similar institution who had come to carry out research amongst them. The second school that served as a case study was in the same country as the one I resided in and I felt I was treated as a colleague and not a visitor since I had not come from ‘far’ and this helped me blend and settle in with ease.

In conclusion, I would say that the way in which I consciously negotiated and worked through my biography with its potential biases, values and interests served to enrich, rather than have a negative effect on the inquiry.

4.4 Ethical considerations

The research proposal was submitted to the Research Ethics Committee of the Faculty of Health Sciences for approval (Appendix 4). The principle of informed consent was applied. In order to collect data from the official curriculum documents, a letter was written to all the selected schools of public health, clearly setting out the aims and objectives of the study and eliciting their consent and that of the staff to participate in the study (Appendix 5). In this regard, two schools chose not to offer their official curriculum documents but instead referred me to their curriculum content on the school’s websites. No school was coerced into participating in the study.

For the in-depth interviews, the research participants were fully informed of the following in the participant information leaflet (Appendix 2):

- Aims, methods, anticipated benefits and potential hazards of the research;
- Their right to abstain from participation in the research and to terminate the interview at any time during the interview; and
- The confidential nature of their communications.

In order to protect the identity of the research participants, confidentiality and anonymity was assured, whereby identifying information would not be made available to anyone who was not directly involved in the study, and by using pseudonyms for participants and institutions. In any report emanating from this study, the schools and individual participants would therefore not be identified.

4.5 Limitations of the study

In the delineation of the scope of the study, several decisions had to be made on the areas of and perspectives on public health curricula in sub-Saharan Africa to include and exclude in the study. With regard to the theoretical conceptualisation of the study, a choice was made in favour of poststructuralism (Chapter 3) and no comparisons with findings derived from other perspectives were therefore made. Although various types of curricula were highlighted in the literature review (Section 3.3.2), this inquiry did not consider the full spectrum of types of curriculum, but only limited itself to two types of curricula: the official curriculum (public health curriculum documents) and the hidden curriculum (as reported by academic staff members).

An investigation including other types of curriculum as point of departure could have enriched the findings. This pertains especially to the exclusion of the views of student experiences of a gendered curriculum (the experiential curriculum). Inclusion of students' voices would have enriched the study by interrogating their constructions of gender and by showing to what extent students demanded tuition on gender issues and whether they felt they were getting sufficient teaching on gender. The operational curriculum was also excluded from the study. Observing exactly what the lecturers were teaching on gender, how they presented their constructions of gender and which methodologies, examples and case studies they used would have enhanced the depth of this study. However, these decisions were trade-offs that had to be made in order to navigate an already complex conceptual framework. These exclusions did not in any way compromise the rigour with which the study reported in this thesis was conducted and the quality of the data obtained. With adequate resources and time, the mentioned gaps could still be investigated and the findings compared with findings from this study.

A second limitation of the study is that descriptions of courses in official curriculum documents were not detailed enough to give a thorough version of the courses. Some schools also gave greater details than others. Accordingly, the findings from the official curriculum documents are only a reflection of what the researcher could ‘scrape’ from the available documents. To try and address this limitation, two schools were used as case studies to try and elicit a more elaborate picture of the public health curriculum through in-depth interviews. (See Sections 4.1.1.2 and 4.2.2.2.) However, again the findings from these two cases cannot be generalised to make conclusions about the other schools that were not studied in depth, as each has different contexts and histories that are different from the selected case studies. In addition, the curriculum documents were collected in 2006 and the reader who may be reading this thesis today should note that a lot of curriculum changes have since taken place in various schools. Another limitation is that the content described on paper was not necessarily what was actually taught. Changes in classroom content are not always accompanied by change in the official curriculum document. This limitation would have been overcome by an investigation into the operational curriculum through direct observation and recording of what was actually taught in the classroom.

A third limitation of the study is that only anglophone countries in sub-Saharan Africa were included due to the difficulty of translations and interpretations. (See Figure 4-2.) The findings of this study are therefore only limited to anglophone schools of public health in sub-Saharan Africa, although the other schools could still learn useful lessons from the findings. With availability of resources, this study could be replicated in francophone and lusophone countries in sub-Saharan Africa. Due to their different historical contexts, different or additional findings on the construction of gender could have enhanced the perspectives developed from the study for this thesis.

4.6 Conclusion

In this chapter an exposition of the research methodology used in the study was given, indicating the main research method, design and strategies that were used to guide the study. The criteria used for selecting the study sites and participants were elucidated, after which the way in which the data was collected and analysed was explained in detail. I also gave an account of my ‘reflexivity’ during the research process in order to account for any bias that may have affected the findings and I also addressed credibility, dependability, transferability

and confirmability concerns of my research. Finally, the limitations of the study and ethical considerations were highlighted.

The findings from the analysis of the official curriculum documents are presented in Chapter 5. Chapter 6 covers the findings from the in-depth interviews with staff members from the two selected schools. Chapter 7 is devoted to the reconceptualisation of gender in public health curricula according to the poststructuralist framework presented in Chapter 3.

Chapter 5

Institutional representations of gender

As indicated in previous chapters, the curriculum under investigation was that of the Master of Public Health (MPH) programmes because of the primacy and centrality of the MPH degree in schools of public health. This chapter presents the findings of the analysis of official public health curriculum documents of the nine schools included in this study.

In order to be able to locate gender in the public health curriculum it was necessary to first get an overview of the MPH curriculum structures and content. This chapter begins with a short analysis of the public health curricula with a view to positioning gender within the broader curriculum. This analysis is followed by discussions of the representation of gender in the structures of the public health curriculum, of gender discourses emerging from the public health curriculum, and of dominant, marginalised and silent discourses on gender.

5.1 Structure and content of the MPH curriculum

Some of the schools laid the ground for the MPH curricula by clarifying the concept of public health. Most of their definitions were in agreement with the current and much broader concept of public health as encompassing actions taken to protect or improve the health of the public (Hamlin, 2002; Orne et al, 2007). (See also Section 2.2.1.) Key concepts in public health that were highlighted are “*the protection, preservation and promotion of the health of communities and populations*” (School 1200), underpinned by pillars of “*equity, efficiency and effectiveness in the provision of health care services*” (School 2200).

These discourses circulate widely in current public health literature and practice (ASPH, 1999; Griffiths et al, 2003; Hamlin, 2002; Sein & Rafei, 2002) and demonstrate the intention of the schools to make a paradigm shift and re-orient the curriculum from curative measures only to the inclusion of disease prevention (Bloom, 2007; Gruskin & Tarantola, 2002; Mokwena et al, 2007; Sim et al, 2007; World Bank, 2002). Although it was beyond the scope of this inquiry to evaluate the public health curriculum *per se*, IJsselmuiden et al (2007) raise the issue that the public health curriculum in Africa is still largely biomedical in content, a

paradigm that leans more towards the curative than the preventive side. The question therefore remains whether schools of public health in actual fact ‘practice what they preach’ in their MPH programmes or whether the official representation of the curriculum is more rhetoric and less reality.

5.1.1 Purpose of the MPH programme

The schools articulated in their curriculum documents that the main purpose of the MPH programme was to prepare graduates to be able to address and respond to health problems at all levels of society, including national, district and community level. School 1700 referred to the effective performance “*at District, Regional and National levels within governmental, quasi-governmental, non-governmental and private organizations*”. School 2200 again described that “[g]raduates could be employed in any of the social sectors with health functions, viz. state health services, the private sector, and academic, labour, community based and non-governmental organizations.”

Integral to the aim of enabling MPH candidates to address and respond to health problems in all sectors of society is the inclusion of training geared towards leadership and management roles (Schools 2100 and 2400). School 1500 referred specifically to training towards becoming a district public health manager, whereas School 1600’s curriculum documents contained the following description: “*The current programme transforms MPH graduates into managers equipped with basic public health analytical and research skills, enabling them to take on senior management responsibilities in the health sector.*”

In order to perform these leadership and management roles in a public health career, the curriculum documents prescribed a broad range of competencies and generic skills for the MPH graduate, including:

- Policy and strategy development;
- Planning, implementation, management and monitoring and evaluation of services, interventions and public health programmes;
- Design of information systems;
- Design and performance of research; and
- Education and training.

Four schools (2100, 2200, 2400 and 2500) also acknowledged that not all graduates would have identical skills, as various career paths were available in public health. All of the above also have implications for how gender is accommodated within a curriculum.

5.1.2 A multidisciplinary and interdisciplinary public health curriculum

Public health has been described as “... a broad, multidisciplinary field, incorporating clinical, social, political, educational, and economic disciplines, and a range of analytic methods such as biostatistics, epidemiology, and demography, among others” (HRSA, 2004, p.17). In the studied curriculum documents I found that schools also placed special emphasis on the multidisciplinary nature of the MPH degree “[t]hrough acquisition of multidisciplinary knowledge and skills” (School 1200) and through the emergence of an “interdisciplinary outlook” (School 2400).

Most of the schools emphasised that they would admit degree students from a variety of backgrounds to assist them in contributing towards identifying, solving, managing, and evaluating health and health system problems. These backgrounds include sociology, anthropology, health statistics, demography, biology, food science, epidemiology and health information sciences, medicine, nursing, engineering, law, economics, sociology and theology. School 1600 described itself as “[a]n institute for learning with ears and doors open to all kinds of health workers and all those who can contribute to better health”, whereas School 2100 referred to its MPH programme as “a multi-faculty, university-wide degree course”. With such a multidisciplinary and interdisciplinary approach one would also expect to find different approaches to gender in the official public health curriculum.

5.1.3 Modes of delivery and duration of MPH studies

The modes of delivery and the duration of the MPH degree varied from school to school as shown in Table 5-1. These modes included full-time, part-time and distance education, with some schools offering both full-time and part-time options. The duration of the full-time MPH degree ranged from 12 months to a maximum of four years. This finding differs from the findings of a study by the Health Resources and Services Administration (HRSA) in the United States (US), where the length of time to complete a full-time public health programme ranged between 11 months to two academic years (HRSA, 2004). In my enquiry the duration

of the part-time MPH degree ranged from two years to a maximum of six years, while those schools that offered the MPH through distance learning indicated it would take two to six years to complete the degree. HRSA (2004) comments that currently US schools of public health have the leeway to determine the length of time to complete the MPH programme, which appears to also be the case in sub-Saharan Africa.

Table 5-1: Modes of delivery and duration of the MPH degree by school

School	Full-time studies	Part-time studies
1200	2 years	Not offered
1500	2 semesters (length not specified)	Not offered
1600	2 years	33 months (maximum 6 years) (distance learning)
1700	12 months	Not offered
1800	4-6 semesters (length not specified)	Not offered
2100	Maximum 3 years	Maximum 3 years
2200	18-24 months (only Health Economics track)	2-3 years (only General and Epidemiology track)
2400	Duration not specified	
2500	1 year	2 years (distance learning)

5.1.4 MPH course structure

An examination of the structure of MPH programmes in terms of the “volume of learning” (DoE, 2007, p.8) required and their various components revealed much variation in the composition of the curriculum. This variation was attested to by School 2100, whose curriculum document stated that “*MPH degree programmes around the world vary widely in terms of intensity, scope and depth*”.

The structure of the MPH curriculum in terms of the volume of learning and the components of the curriculum is discussed below.

5.1.4.1 Volume of learning required for the MPH degree

The term “volume of learning” in reference to the quantification of the MPH degree was derived from the South African Department for Education (DoE) policy document on the National Qualifications Framework (NQF):

The design of programmes makes assumptions about the volume of learning that is likely to be necessary to achieve the intended outcomes. Currently within the higher education system, this measure of volume may be expressed in terms of study time, for example the number of academic years of study required, or the number of notional hours of study, expressed as credits. (DoE, 2007, p.8)

In the analysed curriculum documents, the structure of the MPH programme differed from school to school in terms of the volume of learning required. We took a keen interest in the language used to describe the volume of learning as, according to Ornstein and Hunkins (1998), curriculum is written and presented in language form and language should therefore be taken seriously. We found that diverse language was used to quantify the volume of learning and that there was a particular way of ‘naming’ this volume of learning as “*course*”, “*module*”, “*credit*”, “*unit*”, “*thesis*” and “*dissertation*”. Kabira and Masinjila (1997) state that recognising what is named or not named in a text is important, since it shapes our perceptions and attitudes towards the object that is named or not named.

Three schools (1600, 2200 and 2400) used the word “*courses*” to quantify volume of learning required for the MPH degree; two schools (1200 and 1800) used the word “*units*” and three schools (1500, 2100 and 2500) used the word “*modules*”. Some schools (1600, 1700 and 2100) referred to “*credits*” allocated to units, modules and courses to quantify their weight in terms of volume of learning. However, it was not possible to determine whether all schools had the same understanding of each of these terms. They certainly quantified them differently in terms of hours required and number of courses, units and modules required.

5.1.4.2 Components of the MPH curriculum

From the analysis of the documents, the following emerged as the key components of the MPH curriculum that were common to six of the schools (1200, 1700, 1800, 2100, 2200 and 2500):

- Core courses;
- Courses in an area of specialisation (also called field of study, track or stream);
- Electives; and
- Research: thesis, mini-thesis, dissertation, mini-dissertation.

Schools 1500 and 1600 differed from the other schools in that all their courses were compulsory and therefore not broken down into any component. School 2400 had only three

of the above components (core and area of specialisation courses and a research report), while School 2100 had an additional component, namely integrative case studies. Schools 1700 and 2200 had one area of specialisation and another general MPH degree. The structure of the MPH curriculum in School 2500 was quite unique to the rest of the schools in that one had to first complete a Postgraduate Diploma in Public Health before proceeding to the MPH programme, and all courses taken at the diploma level were credit-bearing towards the MPH degree. The components of the MPH curriculum for School 2500 were structured as follows:

- Postgraduate Diploma in Public Health;
- Two electives; and
- Mini-thesis.

It is the Postgraduate Diploma in Public Health that was composed of areas of specialisation, core and elective courses. For the purposes of this inquiry, since the Postgraduate Diploma in Public Health in School 2500 formed part and parcel of the MPH degree, the course descriptions of the Postgraduate Diploma in Public Health were also analysed.

Since this study is interested in the use of language in the construction of reality, it was noted that there was variation in the ‘naming’ of research outputs of the students – some schools used the term “*thesis*”, others “*dissertation*” and others still “*research report*”. (See Table 5-2.)

The curriculum was arranged through the use of special language that ‘named’ “*areas of specialization*”, “*core courses*”, “*electives*” and “*mini-dissertation*”.

a) Areas of specialisation

The discourse of ‘areas of specialisation’ was used in the official curriculum documents to “*represent some of the major areas of practice in the public health field and therefore, possible career paths*” (School 2500).



Table 5-2: Components of the MPH curriculum by school

School	Areas of specialisation	Core courses	Electives	Research thesis / dissertation / Report	Integrative case study	All courses compulsory/ general MPH
1200	X	X	X	X		
1500				X		X
1600				X		X
1700	X [§]	X	X	X		X
1800	X	X	X	X		
2100	X	X	X	X	X	
2200	X*	X	X	X		X
2400	X	X		X		
2500 [#]	X	X	X	X		X

[§] School 1700 had only one area of specialisation – Social and Behavioural Science. The other MPH degree is a general one that is composed of core and elective courses.

* School 2200 had only one area of specialisation – Epidemiology. The other MPH degree is a general one that is composed of core and elective courses.

[#] School 2500 had several areas of specialisation as well as a general MPH degree. Courses in the Postgraduate Diploma in Public Health were also included in the analysis.

Several observations were made in the use of the discourse of ‘area of specialisation’ to construct the public health curriculum. Firstly, area of specialisation was ‘named’ in the following ways in the different schools of public health: area of specialisation (Schools 1200 and 2200); field of study (Schools 1700 and 2400); track (School 2100); and stream (2500). This variation illustrates how the public health curriculum was socially constructed, resulting in multiple ways of conceptualising the term ‘areas of specialisation’. Secondly, the curriculum in different schools depicted the areas of specialisation differently, although there were also commonalities. Table 5-3 indicates that the most common areas of specialisation were health management and epidemiology, followed by health promotion, occupational health, and safety and environmental health. Maternal and child health and human nutrition appeared as areas of specialisation in only two schools. Two schools (1500 and 1600) did not offer any specific area of specialisation but instead offered a general public health degree. Each area of specialisation in each school had a set of its own compulsory or required courses or modules that were specific to that area.

Table 5-3: Areas of specialisation common to most schools

Areas of specialisation	SCHOOL								
	1200	1500	1600	1700	1800	2100	2200	2400	2500
Health management – of policy, services, systems, hospitals	X				X	X		X	X
Human resources development									X
Health information systems									X
Health research									X
Epidemiology in all its forms*	X				X	X	X		
Health promotion	X				X	X			X
Occupational health and safety/occupational hygiene	X				X			X	
Environmental health	X				X	X			
Maternal and child health	X							X	
Human nutrition/reproductive health nutrition	X				X				X
Social and behavioural science				X					
General public health		X	X	X			X		X

* Pure epidemiology, with disease control, applied, field, laboratory management, and biostatistics

b) Core courses or modules

Core courses or modules are compulsory for all students – they “provide an overview of the essential disciplines of health systems and public health” (School 2100). Not all schools had core courses. In Schools 1500 and 1600 students had to take all courses on offer. Schools with core courses ‘named’ them in the following ways: “*foundation*” courses (Schools 1700 and 2400); “*fundamental*” or “*compulsory*” courses (School 2100); and “*core*” courses (Schools 1200, 1800, 2200 and 2500). These findings are similar to the discourse of ‘core course’ found in the general education system discourse. The emphasis here is on compulsory and in relation to the qualification in question, thereby ensuring that the purpose of the qualification is achieved (DoE, 2004).

There were six core courses that were common to most of the schools. This is depicted in Table 5-4. Again, each course varied in the way it was described. Braine (2007a; 2007b) and the HRSA (2004) reported a similar trend with regard to the core disciplines of most schools

of public health in the world and the US respectively. However, in their case, environmental health was among the core courses, while it was not the case in our findings – some of the schools offered environmental health as an area of specialisation, but not as a core course.

Table 5-4: Focuses of core courses common to most schools

Focus*	SCHOOL								
	1200	1500	1600	1700	1800	2100	2200	2400	2500
Public health (introduction, principles, learning in public health)	X	X				X			X
Epidemiology (principles, applied) and health measurement (and health needs assessment)	X	X	X	X	X	X	X	X	X
Biostatistics (basic, applied) and informatics	X	X	X	X	X	X	X		
Health care organisation, management and planning	X	X	X	X	X	X			
Social and behavioural dimensions of health (society, determinants of health, culture)	X	X	X	X	X	X		X	
Research methods (unspecified, quantitative)	X	X	X	X	X		X	X	
Research thesis / dissertation / report	X	X	X	X	X	X	X	X	X

* Appendix 4 contains details of course names

c) Elective courses or modules

According to the South African Department of Education, “[t]he elective learning component allows the learner to reinforce the core area of study, to study something for specialisation purposes, or to study something unrelated for personal interest and enrichment” (DoE, 2004, p.15). While some of the schools used the common term “*electives*” for courses or modules that were not compulsory and which students could choose to do, others ‘named’ them “*optional*” (Schools 1200 and 1700) or “*Capita Selecta*” (School 2500).

The nature of electives is illustrated by the wide variety of topics found in the curricula, with very little duplication across schools. (See Appendix 11 for more detail). This variety demonstrates the social construction of electives in the public health curriculum and is also a reflection of the diversity of thought and expertise residing within and outside schools of

public health. These findings resonate with Braine's (2007a; 2007b) presentation of a wide range of courses offered by schools of public health all over the world. (See also Section 2.2.2.5 and Table 2-1.)

In general, and as was evident from the findings, areas of specialisation, core and elective areas of learning seem to be important components of any academic programme. The South African Qualifications Framework (SAQA) states that a core curriculum and optional courses in a programme together make up the different ways that a student can choose to arrive at the degree (SAQA, 2000). The South African Department of Education and Council on Higher Education (CHE) emphasise that all taught higher education programmes should be constructed from core and elective elements in order to achieve the purpose of the qualification and the required number of credits (CHE, 2004; DoE, 2004; DoE, 2007).

In the next section the findings on the representation of gender in the structures of the public health curriculum are presented.

5.2 Representation of gender in the structures of the public health curriculum

As gender was the key construct for this study, it was important for us to explore how it was located and represented within the structures of the public health curriculum described in the previous section. Accordingly, our analysis was guided by the research question on how gender was represented in public health curricula in sub-Saharan Africa. The analysis mapping emerging discourses in the spectrum of mainstream and marginalised discourses and the role of these discourses in producing new discourses or reproducing conventional constructions of gender. An attempt was also made to identify how language was used in these texts to frame or situate gender in public health curricula, and how these representations could be a reflection of circulating discourses on gender. In the subsections that follow the findings from the analysis on the location of gender on the surface and beneath the surface of the public health curriculum are discussed. Attention is given to explicit and implicit representations of gender and 'gender layering'.

5.2.1 Location and representation of gender at a glance

A ‘bird’s eye view’ of the public health curriculum and the overall picture of gender that emerged is summarised in Table 5-5. Appendix 6 contains the more detailed presentation that was used in the analysis. The interpretations of the representations of gender as explicit and implicit were derived from the Gender, Education and Training (GET) project already described in Section 2.2.2.7b. The more direct representations of gender are referred to as **explicit**, when gender is mentioned directly, for example “*gender, sexuality and health*” and “*gender and health*”. There are two types of **explicit** representations: **domain** representation when gender is addressed in a much broader and holistic way; and **issue-based** representation where gender is represented in terms of a specific issue. For the indirect representations, **implicit (proxy)** representation is used to refer to instances where other names are used as proxies to refer to gender, for example “*reproductive and family health*” and “*maternal and child health*”. In the **implicit (submerged)** representation, gender is submerged under broader public health discourses; for example, “*social dimensions of health*”. There was **silence** on the representation of gender in some of the courses. This interpretation forms part of the graphical depiction in Figure 5-1.

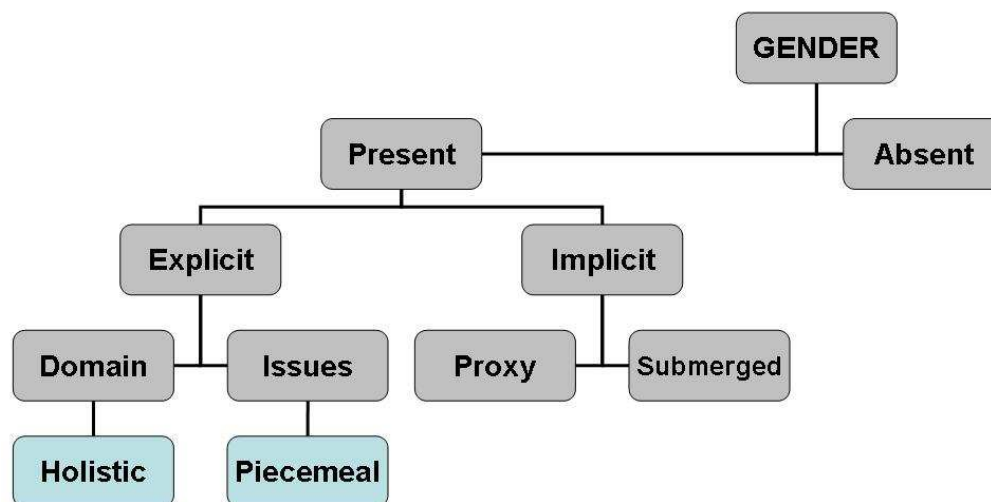


Figure 5-1: Representations of gender in the official public health curriculum

Table 5-5 gives an overview of the representation of gender in public health curricula. The pattern was that in the description of areas of specialisation and core courses gender was implicitly represented (with a prominent focus on reproductive, maternal and women discourses), whereas it was more explicit in some of the elective courses (three schools). The literature review in Section 2.2.2.5 revealed a similar international trend and only one reference was found on gender issues in health offered as an additional course (Thankappan,

2007). In the GET project only two schools in sub-Saharan Africa reported directly on gender courses (Section 2.2.2.7b). In conclusion, at a glance, the representation of gender in the official public health curriculum documents suggests that gender is mainly an implicit discourse beneath the surface.

Table 5-5: Representation of gender in the public health curriculum

School	Area of specialisation	Core courses	Electives
1200	Maternal and child health (implicit – proxy)	Social dimensions of health (implicit – submerged)	Gender, sexuality and health (explicit)
1500	No area of specialisation	Social and behavioural determinants of health (implicit – submerged)	Silent on gender
1600	No area of specialisation	Social and behavioural determinants of health (implicit – submerged)	Silent on gender
1700	Social and behavioural science (implicit – submerged)	Silent on gender	Silent on gender
1800	Population and reproductive health (implicit – proxy)	Public health and society (implicit – submerged)	Silent on gender
	Reproductive and family health (implicit – proxy)	Silent on gender	
2100	Silent on gender	Society and health (implicit – submerged)	Reproductive health epidemiology (implicit – proxy)
			Ethical issues in women's health research (implicit – proxy)
2200	Silent on gender	Silent on gender	Gender and health (explicit)
2400	Maternal and child health (implicit – proxy)	Silent on gender	Silent on gender
2500	No area of specialisation	Silent on gender	Gender and health (explicit)
			Women's health and well being (implicit – proxy)
			Maternal and child health (implicit – proxy)

5.2.2 Representation of gender beneath the surface of the public health curriculum

In the previous section, a ‘snapshot’ of the overall public health curriculum was taken to reveal gender representation. This section looks at the findings of a deeper analysis of gender-related content, according to explicit and implicit representations.

5.2.2.1 Explicit representations of gender

The explicit representations of gender were divided into two types of knowledge, ‘domain’ gender knowledge and ‘issue-based’ gender knowledge.

a) Gender as a domain area of knowledge

In domain knowledge, gender was constituted as a domain area of knowledge in its own right with its own set of components that addressed gender in a much broader way. I interpreted this as a ‘holistic’ approach to gender. (See Figure 5-1.) The Asian Development Bank (ADB) explains that a “... gender-focused approach seeks to redress gender inequity through facilitating strategic, broad-based, and multifaceted solutions to gender inequality” (ADB, 2010, p.1). The representations of gender as a domain area of knowledge in the compulsory courses of areas of specialisation, core and electives courses are attached as Appendix 7.

School 1700 was the only one that included gender as a domain area of knowledge as a compulsory course in the area of specialisation. Three other schools (1200, 2200 and 2500) had electives with this type of focus. The best example of gender as a domain area of knowledge is the excerpt below in the compulsory Gender and Health course description of School 1700. Firstly, it acknowledges the role of gender in health, and then moves on to examine the construction of gender by social systems and how these in turn impact the health of men and women. Secondly, the importance of considering both social and medical perspectives when looking at gender and health is acknowledged, while at the same time gender is emphasised as a lived experience shaped by different societal forces. Finally, various concepts guiding the teaching of gender are listed.

The main aim of this course is to provide Public Health and Development Workers with the relevant understanding of the role of gender in health and welfare of the populace. The course examines the interrelationship of gender and health. It examines

the socio-cultural, socio-political and socio-economic constructs of gender and how these constructs impact on women and men's health in the developing world. The central idea of the course, however, is to move beyond a description of specific health problems to critically analyze how women and men's health problems develop, are perceived, and are responded to both medically and socially in contemporary society. In this context, an important theoretical aspect of the course is the development of a socio-medical perspective on health and, specifically, the analysis of women and men's health in relation to their lives and how these experiences are shaped by culture, social institutions and social policies. Some topics under this course are gender concepts; patriarchy; gender, experience, culture, power, and health; poverty, health and health care, gender and men's health. (School 1700)

Several gender discourses that emerged from the explicit representations of gender as a domain area of knowledge will be discussed in Section 5.3. They include: the social construction of gender; social and biomedical discourses on gender; gender concepts and theories (patriarchy and matriarchy, femininity and masculinity, power, gender and men's health); and gender as a silent discourse.

b) Gender as an issue

In the representation of gender as an issue, gender knowledge was singled out to be addressed – for example “*sexual harassment*” and “*women in management*” or by ‘twinning’ gender with social issues and inequalities, with empowerment, and with environment. I describe this as a ‘piecemeal’ approach to gender. (See Figure 5-1.) These types of gender representations resonate with liberal feminist perspectives that focus on themes of equity in schools (Weiler, 2008) by raising questions related to specific gender issues such as sexual harassment at place of work or in management and gender inequalities. (See also Section 3.2.2.1a.)

Six schools did not have gender as an issue in any of their course descriptions. Schools 1600 and 1700 described gender in relation to environment and violence respectively. Only School 1200 used all the issues described in this section in a variety of course descriptions.

Gender discourses emerging from explicit representations of gender as an issue in the public health curriculum are: gender and work (sexual harassment, women in management, gender

aspects in the health profession); gender and environment; gender and empowerment; gender equality; gender and sexuality; and gender and violence. All these discourses will be presented in more detail in Section 5.3.

5.2.2.2 Implicit representations of gender

Appendix 8 contains a summary of the implicit representations of gender in the compulsory courses of areas of specialisation, core and elective courses. Gender was represented implicitly as a proxy in a predominant way in the components of the public health curriculum. (See also Section 5.2.1 and Figure 5-1). Most of these representations occurred in the elective courses. In summary, the main gender discourse emerging from the implicit representations of gender was the discourse of ‘women’, supported by various other discourses: women’s reproductive and maternal roles; women as a vulnerable group; women’s productive roles; and women in the life cycle.

5.2.2.3 ‘Gender layering’

In Section 5.2.1, I took a ‘glance’ at how gender was represented on the surface of the public health curriculum. At this first level of analysis, it appeared on the surface as if there was very little gender-related content, particularly in the areas of specialisation and core courses. However, as I investigated gender representations further I realised that I had to go deeper than the surface to ‘unearth gender’ – in other words, some references to gender, both explicit and implicit were ‘buried’ in the deeper layers of the public health curriculum. The pattern that emerged led to the coining of the metaphor ‘gender layering’ to refer to the ways in which gender was embedded in layers beneath the surfaces of course descriptions, sometimes up to three layers deep. This brought to mind Van Dijk’s (2004) proposition of analysis of discourse that goes deeper than the surface, in order to unearth underlying assumptions that lie deeper than what is evident on the surface. I therefore took the curriculum documents and peeled away layer after layer to find out whether and how gender was represented in each particular layer. The metaphor of ‘gender layering’ was also inspired by Appignanesi and Garret (1994), who likened discourse analysis, and particularly deconstruction, to peeling away the layers of an onion. They explain:

This is deconstruction – to peel away like an onion the layers of constructed meanings. Deconstruction is a strategy for revealing the under-layers of meanings in a text that were suppressed or assumed in order for it to take its actual form – in

particular the assumptions of presence (the hidden representations of guaranteed certainty). (pp.79-80)

Figure 5-2 below is one illustration of the embeddedness of gender at the third level or layer in School 1200. Gender issues, specifically sexual harassment and women in management, were embedded in the topic “*personnel management*”, which was incorporated in the module Human Resources Management in the area of specialisation of Hospital Management.

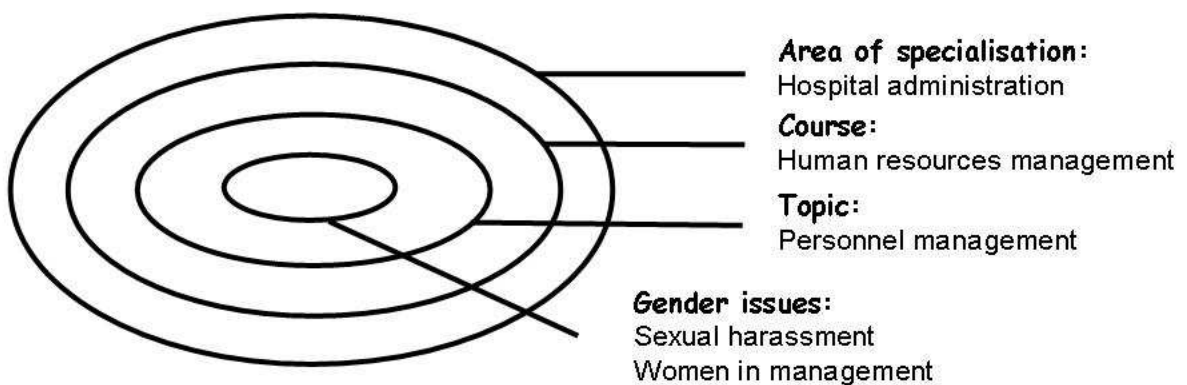


Figure 5-2: Layering of gender at three levels in School 1200

A detailed description of the different levels of gender layering and representation in the areas of specialisation, core and elective courses is given in Appendices 9, 10 and 11.

5.3 Gender discourses emerging from the public health curriculum

In the previous sections, the ways in which gender was represented both explicitly and implicitly in the public health curriculum were presented and summaries of emerging gender discourses from these representations were provided. In this section, the gender discourses that emerged from both the explicit and implicit representations are presented in more detail from the point of view of the social construction of gender.

5.3.1 Discourses emerging from gender theory

Annandale (2004) posits that feminist theory is essential for an adequate understanding of both gender inequalities in health and women’s experience in contemporary society. In our analysis references to aspects of gender theory were found, particularly the framing of gender

within social and biomedical discourses, the construction of gender, sex and sexuality, binary masculinity-femininity and patriarchy-matriarchy discourses, and discourses on power.

5.3.1.1 *The social construction of gender*

The curriculum texts of School 1700 had the most prominent locations of gender within certain theoretical frameworks to “*explain the concept of gender and give meaning to gender constructs and terminologies.*” In its Gender and Health course, this school took what appears to be a social constructionist position by including “*the socio-cultural, socio-political and socio-economic constructs of gender and how these constructs impact on women and men’s health in the developing world*”. This approach to gender and health aligns with current social constructionist discourse that dismisses the taken-for-granted expressions of gender as based in natural or biological difference and instead maintains that gender is shaped and given meaning by the social structures of a society, which inevitably leads to gender inequalities (Alsop et al, 2002; Lorber, 1997). (See also Sections 3.1.2.2 and 3.2.1.1c.) The course’s focus on the impact of these constructions on the health of men and women is in line with the Africa Gender Institute’s (AGI) view that a major obligation for public health practitioners is to increase the visibility of the social and gender differentials in health (AGI, 2002).

By locating gender and health within broader social systems, the descriptions of the Gender and Health course also projects the image of gender as a dynamic process, as well as a lived experience: “*the analysis of women and men’s health in relation to their lives and how these experiences are shaped by culture, social institutions and social policies*”. By using these broader ‘lenses’, School 1700 seems to have espoused some of the key features of a reconceptualised curriculum, and accordingly, reflecting a shift from curriculum development to understanding curriculum (Ornstein & Hunkins, 1998; Pinar et al, 1995). (See also Section 3.3.3.1.)

The health sector has been accused of paying more attention to the biological aspects of diagnosis, treatment and prevention, to the exclusion of more social approaches (Hartigan, 1999; Klugman, 2004; Simms & Butter, 2002; WHO, 1998; Wong, 2003). Our findings showed that there was a conscious effort on the part of some schools to link gender to social discourse. For example, in Table 5-5, it was illustrated how several schools addressed gender under the umbrella of social aspects of health. It therefore appears that gender was

acknowledged in some schools as one of the social determinants of health, along with other social factors. In other detailed descriptions, School 1700 aimed to “*cover the impact of cultural and religious beliefs on reproductive health and contraception* (Course: Women’s Health in Sub-Saharan Africa), while School 2100 sought to “*identify and develop an understanding of the different cultural and social frameworks diverse communities of women carry in the context of their participation in research*” (Course: Public Health, Ethics and Human Rights).

There was also an attempt by some schools to locate gender within both social and biomedical discourses. School 1700 employed a “*socio-medical perspective*” to explain “*how women and men’s health problems develop, are perceived, and are responded to both medically and socially in contemporary society*” (Course: Gender and Health). School 1800 described “*policies, rights issues and management: societal, biological, political linkages between the epidemic in the three groups*” (Course: HIV Infection in Women, Children and Adolescents).

5.3.1.2 Gender, sex and sexuality

The course descriptions of only two schools (1200 and 2500) referred to gender, sex and sexuality. School 1200 presented “*the principal theory underpinning our understanding of gender/sex*”, while School 2500 sought to provide an understanding of “*the difference between sex and gender*”. The concern of the two schools about providing this clarity on the distinction between sex and gender is possibly linked to the complaints by some organisations that there is often confusion or conflation of the terms ‘sex’ and ‘gender’ (Sections 1.1.1, 3.2.1 and 3.2.1.1c), as expressed by Kriegler (2003) as follows:

Open up any biomedical or public health journal prior to the 1970s, and one term will be glaringly absent: gender. Open up any recent biomedical or public health journal, and two terms will be used either: (1) interchangeably, or (2) as distinct constructs: gender and sex. (p.652)

Kriegler (2003) adds that it is crucial to clarify the concepts of sex and gender and to pay attention to both of them in population-related health research. However, despite the course description by School 1200 that hints towards an understanding of the difference between sex and gender, in the description of the Principles of Epidemiology course in the same school, “*sex*”, instead of gender, was lumped with other social markers of difference such as ethnicity, social class and occupation. This conflation of sex and gender could be expected, as

epidemiology courses are often very biomedical in approach. Or, it could be a representation of different views on gender by different staff members responsible for different courses, thereby giving an indication of multiple representations in one school.

With regard to gender and sexuality, Schools 1200 and 2500 were also the only schools where gender and sexuality appeared in a course description that differed considerably from the predominant discourses of reproductive and maternal health. (See Section 5.3.2.1.) School 1200 foregrounded the role of theory in the “*understanding of gender/sex, sexual identity and sexual health*” by referring to biomedical (biological), behavioural (psychoanalysis and psychology) and social (feminism and political science; philosophy and social construction) theoretical discourses in its course Gender, Sexuality and Health. As a biological concept, sexuality was framed as “*the relationship between sex and health; sex behaviour surveys*”, and was linked mainly to disease in the “*epidemiology of HIV/AIDS and other sexually transmitted diseases*”. As a social discourse, sexuality was framed in terms of HIV and its relation to gender as the “*prevention and control of AIDS in relation to gender and the importance and place of community based response in relation to gender and health*”. School 1200 wondered about the “*unanswered questions: Gender power, notions of desire, social and sexual networks, personhood and power of language and community*”. Many scholars and researchers contribute to some of these “*unanswered questions*” by claiming that in Africa, sexuality is often cast as a problem associated with risk, danger, violence, reproduction, and disease but never about desire and pleasure (Correa, 2002; Jolly, 2007; Klugman, 2000; Petchesky, 2005; Tamale, 2005). (See also the latter part of Section 2.1.4.) In this regard, Jolly (2007) is emphatic that:

We need to move to more positive framings of sexuality which promote the possibilities of pleasure, as well as tackling the dangers at the same time. The promotion of sexual pleasure can contribute to empowerment, particularly but not only for women and marginalised groups. The pleasures of safer sex can be promoted to tackle HIV/AIDS and improve health. (p.24)

School 2500 viewed sexuality and sexual orientation as forming part of many other issues affecting women’s health and well-being. (See Section 5.3.2.2.) The two schools’ inclusion of sexuality could be linked to second wave feminism, particularly radical feminism, which brought private issues in the domestic sphere such as sexuality into the limelight (McLaughlin, 2003; Saulnier, 1996).

5.3.1.3 Other binary gender discourses

With regard to gender theory, School 1700's course descriptions examined “*in detail, theoretical frameworks of femininity and masculinity, patriarchy and matriarchy and how these apply to gender health and development particularly those that apply to gender, health, development and gender research*” (emphasis added).

Theories of femininities and masculinities are dominant discourses that reportedly define men and women's health risks, and their morbidity and mortality (Courtenay, 1998; Courtenay, 2000; Sabo, 1999). According to Sabo (1999), masculinity is often associated with characteristics such as aggressiveness, competitiveness, dominance, strength, courage and control, while femininity is associated with characteristics such as sociability, fragility, passivity, compliance with male desire, and sexual receptivity. There is concern that if men and women conformed to these societal prescriptions, it could translate into attitudes and behaviours that could put both men and women's health at risk, particularly in relation to HIV/AIDS (Sabo, 1999).

Although the binary discourses of “*patriarchy and matriarchy*” also appear in School 1700's course description, there was lack of further information in the description. The theory of patriarchy resonates with radical feminism that was able to highlight the subordination of women and their relegation to the private sphere and the elevation of male power and privilege over women (Arnot & Fennell, 2008; Connell, 2005). In doing so, radical feminists were able to expose harmful practices resulting from a patriarchal society such as sexual harassment, rape and violence (Lorber, 1997; Saulnier, 1996). These are public health concerns and could point to why the theory of patriarchy was included by this school. School 1700 included the discourse of matriarchy in its descriptions, whereas feminist literature is somewhat silent on this theory. In the literature review in Section 3.2.1.1 we saw that patriarchy was the feminist watchword. The inclusion of matriarchy by School 1700 could possibly serve as a binary opposition to patriarchy, as explained below.

The presentation of “*femininity and masculinity*” and “*patriarchy and matriarchy*” as binary categories brought to mind Derrida's (1998) assertion about the role of binary oppositions in constructing meaning through language. According to Derrida, one of the meanings that could be inferred from binary oppositional categories is that of ‘self’ and ‘other’, where one of the

categories is assumed to have more power and privilege over the other. Webb and Macdonald (2007) reinforce Derrida's argument by explaining that mechanisms of dualism explain the powerful workings of gender, where femaleness and maleness are constructed as different and in opposition to each other, with maleness being marked as physically strong and skilled and femaleness as weak and unskilled.

School 1700's course description uses the singular form of "*femininity and masculinity, patriarchy and matriarchy*". Many writers are in agreement that speaking of femininities and masculinities in the singular portrays an essentialist, totalising perspective that assumes unitary and static feminine and masculine entities located within a homogeneous culture (Cheng, 1999; Craig, 1993; Donovan, 2006; Munro & Stychin, 2007; Person, 2006; Skelton & Francis, 2006). Donovan (2006) refers to singular forms of masculinity and femininity as metanarratives that do not account for the complex, lived reality of gender. It has been proposed that instead, masculinities and femininities should be spoken of in the plural as a way of drawing attention to the fact that there are many different ways of being feminine and masculine within and across cultures and that, therefore, gender is a dynamic cultural construct (Cheng, 1999; Craig, 1993; Donovan, 2006; Munro & Stychin, 2007; Person, 2006; Skelton & Francis, 2006).

5.3.1.4 Gender and power

Another discourse central to gender theory was that of power (Kabira & Masinjila, 1997; Skelton, 2007). Power was mentioned by School 1700 as one of the gender concepts in the compulsory course Gender and Health in the area of specialisation, Social and Behavioural Aspects of Health. School 2500 had an elective course, Women's Health and Well-being, which referred to "*how health issues intersect with power relations in different cultural contexts*". The discourse on gender power relations is of great importance because social gender relations are maintained by dominant power structures that come out clearly in texts. In terms of 'gender' at least, feminists agree that what needed emphasis in professional development courses are power dynamics and differentials (Skelton, 2007).

5.3.2 The ‘women’ discourse

The ‘women’ discourse was the most dominant discourse permeating all the components of the public health curriculum, although it was more predominant in the elective courses. (See Appendices 8 and 12 and Tables 5-7 and 5-8.) Moreover, it was particularly prominent in School 1200, where representations of “*women in management*”, “*health care for women and children*”, “*women, minors, adolescents*” and “*work and women*” permeated the text. In addition, this school had a dedicated topic on “*women’s health*” in its Population, Health and Development course. In other schools (including School 1200), women were ‘spoken’ of implicitly in terms of their reproductive and maternal roles.

The dominance of the ‘women’ discourse in the components of the public health curriculum could unconsciously project the view that gender in this text was predominantly about women, thereby promoting and perpetuating the dominant discourse of gender as being equated to women (EngenderHealth, 2000; WHO, 1998). The ‘women’ discourse also seems to be a mainstream discourse in the health sector and in society at large, perhaps due to the stance taken that women are disproportionately affected by the negative impact of gender on women’s health; for example, that they have more limited access to, and less control over resources to protect their health (Phillips, 2005; WHO, 2010).

The prominent focus on women in the public health curriculum is a reflection of the women in development (WID) approaches that tend to treat women as a special target group of beneficiaries in projects and programmes (World Bank, 1994). Although it may not have been the intention of the public health curriculum developers, the unintended consequences of treating women as a special category have been well documented. Targeted and segregated women-only projects marginalise and isolate women from the mainstream of development. Further, they treat women as a homogeneous category divorced from the rest of their lives and from the relations through which such inequalities are perpetuated and reproduced (ADB, 2010; Arnot & Fennell, 2008; Elmhirst & Resurreccion, 2008). Cornwall (2007) refers to this as “gross essentialism” (p.71), where women are treated as a unitary homogeneous group with a set of predefined roles that are static and virtually unchangeable and that translate into their disadvantaged social lives (Rathgeber, 1990) and where their experiences are universalised (Zein-Elabdin, 1996). Jackson (1993) proposes that instead, women should be treated as a disaggregated group of subjects to reflect the social and historical construction of gender roles

that are continually reformulated. We only found one example in a non-compulsory course in which School 1200 disaggregated a sub-category of vulnerable women as “*rural women*” (Course: Critical Issues in Health Research in the area of specialisation of Health Research Ethics).

In general the ‘women’ discourse departs in a major way from the domain gender and health discourse discussed earlier, which took into account both men and women, their lived experiences and the social processes that helped to shape gender. (See Section 5.2.2.1b.)

In our analysis the ‘women’ discourse was supported by several other discourses such as reproductive, maternal and productive roles and the vulnerability of women. These are discussed in the subsections that follow.

5.3.2.1 *Reproductive and maternal roles of women*

Health Canada (2002) maintains that equating gender to women’s issues often results in a focus on reproductive health and women’s maternal roles, a trend that also was observed in my analysis, and which might unintentionally have served to frame women’s health in the public health curriculum as being about reproduction and motherhood. From the course descriptions, it appears as if the course content had a special focus ‘**on**’ women (their bodies), ‘**for**’ women (services and programmes) and less ‘**about**’ women’ (their different contexts) of reproductive age.

The ‘**on**’ **women discourses** focused ‘on’ women’s bodies in relation to conception, pregnancy and labour, HIV and sexually transmitted infections (STIs), as illustrated by the following excerpt:

Maternal health indicators: ANC, conception, pregnancy – diagnosis, high risk; family planning; maternal nutrition; HIV/AIDS; STI. Abortion and ethics: Labour – induction, caesarean section, maternal mortality. Perinatal health indicators: Care of mother during delivery and puerperium. Labour management: Infective in the puerperium. Psychological problem, puerperal, psychosis. Post-natal depression: Care of the newborn; resuscitation perinatal care of the mother and baby prematurity

low birth weight, birth trauma, congenital malformation. (School 1200; Course: Applied Clinical Practice in MCH)

The above excerpt with its focus on women's bodies resonates with the Africa Gender Institute's (AGI) assertion that the discussion of sexuality and African women is disturbingly dominated by what is starkly medical, painful and pathological rather than on women's psychic well-being (AGI, 2002). In this way, when women are removed from their social contexts, they become constructed merely as reproductive bodies and subsequently their roles in conception, gestation and birth become increasingly devalued and marginalised (Raymond, 1993). (See also the latter part of Section 2.1.4.) Although there were attempts to locate gender within social discourses, the public health curriculum remained biomedical in content.

Since this inquiry has a special focus on language, the highly medicalised language used in the course description in the excerpt above was also noted. Although phrases such as "*infective in the puerperium*", "*puerperal psychosis*" and "*post-natal depression*" sound so 'normal' in medical (and public health?) terms, the question is, are these medical phrases neutral? 'Medical jargon' was found circulating in public health curriculum texts and could have been more a reflection of the dominant position of the biomedical discourse persisting in the curriculum (IJsselmuiden et al, 2007).

The '**for**' **women discourses** focused on services, programmes, policies and strategies 'for' women in the reproductive health and maternal and child arena and are illustrated in the excerpt below:

Development of MCH services: organization of MCH services; global; national; urban; rural; peri-urban; district approach to MCH service delivery. Needs assessment; planning – goal setting; budget; work plan formulation; funding; staffing; cost benefit analysis. Implementation of MCH programs, Monitoring and evaluation of MCH programs. (School 1200; Course: Organization and Management of MCH Services)

The 'for' women discourse resonates with a radical feminist approach focusing on developing services that centre on women's needs (Saulnier, 1996). In the analysed curriculum documents the focus on women's bodies and on programmes, services, policies and strategies

placed reproductive health within the broader WID discourse with its aim of establishing programmes and projects to improve the condition of women and to deliver development to women (Moser, 1993). In doing so, women are positioned as passive recipients of resources (ADB, 2010). The United Nations Children’s Fund (UNICEF) supports this position by stating that many women in developing countries have no say in their own health-care needs (UNICEF, 2009).

The language ‘**about**’ **women** and their reproductive roles was somewhat limited, with a few schools trying to provide some knowledge ‘about’ women and their social contexts in relation to reproductive health. For example, “*rights issues*” were alluded to in the Sexual and Reproductive Health course of School 2100, while School 1700 included “*the impact of cultural and religious beliefs on reproductive health and contraception*” in its elective course, Women’s Health in Sub-Saharan Africa. Therefore, it appears as if the discourses on women’s reproductive health were lodged more within the biological functions of women than in their social realities, thereby evoking an essentialist view of women (Butler, 1990). In this regard UNICEF (2009) comments that most reproductive health programmes hardly consider the underlying causes of ill health that may lie in women’s disadvantaged position in many societies and cultures.

The equation of gender with ‘women’, resulting in a focus on reproductive health and women’s maternal roles (Health Canada, 2000), was also apparent in the analysed curriculum documents. It has been reported that such an approach excludes women of non-reproductive age and fails to recognise the critical role of men in decisions regarding women’s lives (ADB, 2010; Health Canada, 2000; UNICEF, 2009).

Another observation from the analysis was the inextricable link between women and children, as was evident in the maternal-child and women-children word pairs. (See also Appendix 13.) The mother-child dyad appeared several times in the documents of Schools 1200 and 2400 that offered maternal and child health courses. School 1800 again referred to “*public health problems in mother and newborn*” in its course description on Population and Reproductive Health Nutrition.

The mother-child and women-children pairs are global mainstream discourses that are largely lodged in, amongst others, development discourses. According to King et al (2006), the health

needs of pregnant women, mothers and children have received special attention and priority, as is evident in the many different treaties, policies and programmes that have been developed over time, including Health for All (HFA) and the Millennium Development Goals (MDGs). In focusing on maternal and child health discourses with an emphasis on programmes and services, the schools of public health could have been responding to reports about increasing rates of maternal and child mortality (UNICEF, 2009) and the need to prioritise maternal and child health in response to the demands of the treaties mentioned above. (See also the end of Section 1.1.1.)

5.3.2.2 Counter-discourses to reproductive and maternal roles

A few discourses inhabited the public health curriculum text and unintentionally served to show that women's health was not only about women's reproductive and maternal roles. School 1700 addressed other periods of **women's health in the life cycle** in its course, Ageing and Health, in which the emphasis was placed on improving the health of ageing women due to their ability to act as resources for their families and communities: *"There is a very significant scope for improving the health of ageing women and thus ensuring that they remain a resource for their families and communities"* (School 1700).

The construction of ageing women by School 1700 seems to portray ageing women in a more positive light. The depiction of women as a *"resource"* in old age seems to be in agreement with Araba's (2002) position that older people both want to and do contribute economically and socially well into old age. Araba sees age as a social construction that sometimes depicts older people as "victims, objects of pity and burden" (p.40). Although not intentionally, this depiction isolates men and leaves it open to an interpretation that women are resourceful in old age, but not necessarily men.

School 2500 was the only school to give a **comprehensive view of women's health** in the description of its course Women's Health and Well-being, without getting locked into the reproductive and maternal and child health discourses. The course is about *"[t]he concept of well-being and the values associated with it, in relation to women's physical, social and mental health"*. This description seems to provide a comprehensive and affirmative view of health by including the term *"well-being"*, implying that health is not necessarily always a problem. Even though reproductive health was mentioned as one of the women's health

issues, it was mentioned alongside other health issues such as mental health, HIV/AIDS, sexuality, and women's bodily integrity and social well-being. The course description furthermore reflected on how particular aspects of women's health and well-being were enhanced or compromised by the local context.

Conceptualizing and analysing women's health and well-being in relation to parameters of: race, class, age/generation, geographical context, historical context, cultural contexts and sexual orientation. (School 2500)

5.3.2.3 Women as a vulnerable group

Another discourse accompanying the 'women' discourse was the discourse on women as a vulnerable group. In the description of the Health Services for Displaced Persons course offered by School 1200, "*women, minors and adolescents*" were identified as the most vulnerable during times of disaster. The way this discourse is framed by placing a focus on women, minors and adolescents appears quite normal, but it could unintentionally serve to exclude men and older persons from accessing health services during times of disaster.

School 2100's description of the course, Critical Issues in Health Research, the focus is on women as a vulnerable group: "*Challenges to informed consent in vulnerable communities of women. Challenges to recruitment and retention of diverse and vulnerable communities of women in the research process*". In this excerpt, nothing more is, however, revealed on the nature of the vulnerability.

The discourse of vulnerability is also a mainstream gender discourse. According to Jolly (2005), vulnerability is a measure of an individual's or community's inability to control the circumstances in which they find themselves. It is normally ascribed to gender inequality and its many structural, social and sexual manifestations (Persson & Richards, 2008). However, it has been pointed out that vulnerability analysis often focuses on structural constraints only, which could lead to the portrayal of people as hopeless victims of circumstances over which they have no control, unable to find solutions to their problems themselves (Jolly, 2005). Therefore, the vulnerability paradigm downplays agency by obscuring women's strengths and resourcefulness (Jolly, 2005; Persson & Richards, 2008). Vulnerability assigned to women in

the public health curriculum could unintentionally connote a victim status to the women mentioned and especially so in the absence of other alternative empowering discourses.

5.3.2.4 Violence against women

One of the areas in which women's vulnerability is very visible is that of violence against women. The discourse of gender and violence emerged from School 1200 and was grounded in social discourse to "*analyse the impact of cultural and religious beliefs on gender issues as they relate to violence*". The course description addressed the "*prevalence of violence by intimate partners*" and 'named' the types of violence as, "*physical, emotional and sexual violence*". The use of the ambiguous term "*intimate partners*" was noted and could have served the purpose of deconstructing the dominant male-female relationships. However, it seems as if the gender and violence course was mainly a 'women' issue when the description focused on

... women's coping strategies and responses to physical violence, demographic factors associated with violence, women's violence against men, women's attitudes towards violence ... association between violence by intimate partners and women's physical, sexual and reproductive health, women's self-reported health and physical symptoms, injuries caused by physical violence by an intimate partner and mental health. (School 1200)

Although the excerpt above focused on women in relation to violence, it was 'about' women and did not position women as victims *per se*, but rather, recognised that they possessed some agency through the use of phrases such as "*coping strategies*", "*responses*" and "*attitudes*" towards physical violence. It was also 'about' women and their "*self-reported injuries*". Women were not viewed as passive recipients of violence, but their views were taken into consideration.

5.3.2.5 Women's productive roles

The discourse on the productive roles of women was a predominant discourse in the official curriculum text of several schools, although each addressed different aspects of the reproductive roles of women.

Although School 1200 referred to “*gender issues*” in its Human Resources Management course, the issues that were listed relate closely to women (sexual harassment and women in management), thereby framing gender issues as women issues. Within the same description, the discourse on gender and work once again appeared as “*gender aspects in the health profession*”. School 1200 also referred to “*maternity benefits; day care*” and “*the recursive relationship between women’s reproductive and productive roles and their health and status*” in its description of the Population, Health and Development course. The reference to recursive relationships possibly alludes to the ‘double burden of women’ as reproducers and producers and its effect on women’s health. There were further reference to “*women, work and health*” and “*gender and work*” in modules presented in Schools 2200 and 2500.

The discourse on the productive roles of women is also a common discourse in the wider society. (See Sections 2.1.2 and 2.1.7.) It echoes liberal feminist ideals that aim to transform the sexual division of labour and the provision for domestic labour and childcare outside of the nuclear family (Weedon, 1997).

5.3.3 “Buzzwords” underpinning gender discourse

According to Cornwall and Brock (2005), “buzzwords” are an “... ever present part of the worlds that are made and sustained by development agencies” and therefore, “making sense of what they do for development calls for closer attention to be paid to the discourses of which they form part” (p.3). Buzzwords that will be discussed below are: ‘gender and environment’; ‘gender/women and empowerment’; ‘gender mainstreaming’; ‘gender [in]equality’ and ‘equity’; different forms of ‘rights’; and ‘ethics’. Although some of these buzzwords had their origins in social and feminist movements, they are now “to a greater or less extent, mainstreamed across international development agencies” (Cornwall & Brock, 2005, p.4). Morley (2010) views these “buzzwords” as the goals and the theoretical underpinnings of gender mainstreaming – although she also adds other words such as “social justice”, “transformation”, and “sameness/difference” (p.536).

5.3.3.1 Gender and environment

In School 1600 gender was twinned with environment in the core course, Environmental Health, as “*gender and environmental health*”. Although there was scant information on

gender and environmental health in the curriculum documents, it is a current discourse that is increasingly receiving attention in the health sector due to a growing awareness that the environment and related factors may play a role in creating health status differences between men and women. Setlow et al (1998), for example, maintain that various factors, such as genetics and hormones, may account for gender differences in susceptibility to environmental factors.

5.3.3.2 *Gender and empowerment*

According to Oxaal and Baden (1997), the word ‘empowerment’ is used in many different contexts and by many different organisations, including the health sector. Furthermore, what is seen as empowering in one context may not be in another. In the official curriculum text, School 1200 identified empowerment as a “*key concept in public health*” (Course: Principles of Public Health). However, due to scant information, it was not possible to make sense of what this discursive framing of empowerment as a key concept was supposed to accomplish in public health. Who was to be empowered? School 1500 alluded to the “*empowerment of women*”, which was a specific approach focusing on women (Course: Special Public Health Issues). In two other instances “*gender and empowerment*” was mentioned (Schools 1200 and 1700), indicating ambiguity in who was to be empowered. Oxaal and Baden (1997) report that a number of development programmes, such as micro credit, political participation and reproductive health, have become closely associated with the promotion of women’s empowerment.

Terms are not neutral and in this study the twinning of the words “*women/gender and empowerment*” was identified. Cornwall and Brock (2005) argue that “[t]he way words come to be combined allows certain meanings to flourish and others to become barely possible to think with” (p.iii). When the terms ‘women/gender’ are combined with the term ‘empowerment’ they seem to mirror words used in development discourse. The cryptic use of these terms in the curriculum documents made it impossible to decode the reality they meant to construct.

5.3.3.3 Gender equality and equity

Gender [in]equality was constructed by School 1200 as one of the “*key concepts in health promotion*” in the Principles of Public Health course. This course description was aligned with development discourse by the description of an “*overview of the genesis of the ICPD and Beijing and specifically to understand the historical development from population control to the current rights approach and the significance of this to the promotion of equity*”.

Although no further details were provided about the gender equality and equity discourses used in the public health curriculum they could be linked to development discourses presented in Section 1.1, which pointed out how international conferences and forums such as the International Conference on Population and Development (ICPD), the Beijing Conference on Women and the United Nations Millennium Summit, exerted pressure on governments to incorporate issues of gender, equality, equity and empowerment of women in their policies and programmes and the need for women’s freedom to make reproductive choices. The ‘key’ words “*equality*” and “*equity*” found circulating in the official curriculum text are common development buzzwords. However, without further details, it was not possible to make sense of the importance of these terms as used in public health, or whether they were just other buzzwords aligned to development discourses on gender.

5.3.3.4 Gender mainstreaming

Schools 2200 and 2400 referred to changing practices and mainstreaming gender, but again without giving any further details. But its inclusion in the public health curriculum could perhaps be linked to the acknowledgement that gender mainstreaming (GM) is a dominant development discourse that is widely recognised and promoted as a policy approach for achieving gender equality (Jahan, 2007; Lyons et al, 2004; Rönnblom, 2005). Interview participants reported on a gender-mainstreaming course that had been offered by their institution to increase their understanding of gender. (See Section 6.2.2.1 in the next chapter.) However, in Section 2.1.9.3 several authors were reported as having raised the concern that in most cases, GM does not serve the feminist objective of transforming gender relations and institutional culture, but rather, has been turned into a technical operation.

5.3.3.5 *The rights discourse*

There was a little more detail in the curriculum texts on “rights”, compared to some of the other buzzwords. The various ways in which the discourse of rights was positioned around gender in the text is presented in Appendix 16.

DeLaet (2008) contends that human rights discourse does not emerge in a vacuum, but rather, “concrete actors with specific interests and ideas on the subject of human rights make choices about whether or how to frame certain subjects as human rights issues”. In this study, some schools made a choice to frame gender within a broader, general human rights framework; others within a women’s rights framework; and still others within a sexual and reproductive rights framework. This is graphically depicted in Figure 5-3.

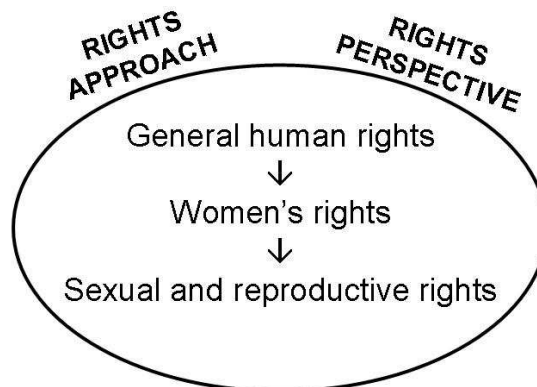


Figure 5-3: Representation of gender and human rights

Women were singled out with regard to “women’s” rights and rights issues in HIV infection. In this case, rights were associated with a particular category of people and “women, children and adolescents” were constructed as subjects with rights. Such a focus is useful as it highlights and negates the predominantly traditional view that women and children have no rights and aids in identifying the underlying structures of inequality. For example, a focus on women’s rights could be used to bring attention to men’s oppression of women through violence. In this respect, Hall (2004) maintains that violations of the human rights of women render them prey to high-risk sexual behaviour and concludes that respect for women's human rights might lead to AIDS as a controllable disease rather than a pandemic.

The language of sexual and reproductive rights was also used in the text and was linked to the key reproductive rights-related concepts such as: gender equality and equity; empowerment; life cycle approach; and a holistic approach. While mobilisation around sexuality issues is not new, linking different sexuality issues together into a broader framework of sexual rights is a strategy that is only now gaining strength and visibility. This link was made visible particularly in School 2100. According to the World Health Organization (WHO), sexual rights “... mean that everyone should have the right to personal fulfilment, and to freedom from coercion, discrimination and violence around sexuality, whatever their sexual orientation or gender identity” (WHO, 2002, p.2). This language means that women have more autonomy and decision-making rights on matters related to their sexuality and reproductive health, thereby deconstructing the commonly held view that women are passive and have no decision-making role in these matters. The gender/women empowerment discourse already discussed was also partly about the empowerment of women in the sexual and reproductive health area.

5.3.3.6 *The discourse of ethics in research*

Although observation of ethical codes is common in most professional organisations, the word ‘ethics’ in academic circles is often linked to the research ethics committees or institutional review boards. In the official curriculum text, the term “*ethics*” was framed mainly as a women issue in health research in the following excerpts:

Equip students with an awareness and understanding of the ethical issues associated with gender inequity in research as a violation of the principle of justice and also as an affront to women’s rights to self determination; Identify and discuss the ethical issues associated with the conduct of research in pregnant and lactating women; Identify and discuss the ethical issues associated with studies in women for the development of agents for conception and contraception. (School 2100; Course: Ethical Issues in Women’s Health Research)

Be able to argue for and against ethical dilemmas in resource allocation; Identify the ethical issues that form the basis for the inclusion of both genders in biomedical or behavioural research in a way that reflects a thorough understanding of the distrib-

utive justice system; Explain the ethical issues in research in vulnerable and diverse populations of women and demonstrate means whereby unscrupulous and unethical research in this class of women can be prevented. (School 2100; Course: Public Health, Ethics and Human Rights)

School 2100 was the only one with a reference to ethics in two of its course descriptions, both of them referring to ethical issues related to women in research. The two pertinent issues emerging from the above excerpts are the under-representation or exclusion of women in the selection of research topics and the exploitation of women in research. These two findings seem to concur with the views of the Institute of Medicine (IOM) that, because of the greater focus on the health problems of men compared those of women and the exclusion of women from clinical studies, women have been denied access to advances in medical diagnosis and therapy (IOM, 1999). Further, the IOM (1999) argues that if women are excluded or under-represented in research, it might lead to information deficit, especially for conditions that affect exclusively or primarily women, for example breast cancer and osteoporosis, resulting in significant gaps in knowledge and in health services for women.

Taking a departure from research ethics, School 1200 referred to “*ethical consideration of abortion*” as a social issue in its Social Dimensions of Health core course.

In this section, we looked at the discourses of gender/women empowerment, gender equality and equity, rights, ethics and their use in the public health curriculum. These are discourses that have been universalised in development and research discourses until they appear quite normal. According to Cornwall and Brock (2005), hard questions need to be asked about whether these discourses have been emptied of their meanings and relegated to the “buzzwords” of development discourse.

5.4 Dominant, marginalised and silent discourses on gender in the public health curriculum

A summary of the dominant discourses discussed in this chapter is given in Table 5-6, while marginalised discourses are summarised in Table 5-7. Dominant and marginalised discourses were identified in order to demonstrate how they become entrenched and legitimised as gender knowledge and through this, other discourses are marginalised and silenced in the production

of knowledge (Cheek, 2000; Ornstein & Hunkins, 1998; Pinar et al, 1995; Usher & Edwards, 1994). Ferfolja (2007) also argues that silences authenticate particular discourses and herald others as illegitimate. (See also Section 3.1.3.3.)

5.4.1 Dominant discourses

The most dominant discourse identified in the official public health curriculum was gender as ‘women’, supported by strong discourses of their reproductive and maternal roles. These discourses tended to focus **on** women’s bodies and the programmes, policies and services **for** fulfilling reproductive and maternal roles. In very limited ways the social circumstances **about** women’s reproductive and maternal roles were also addressed. Other discourses that supported the ‘women’ discourse were the productive roles of women and the vulnerability of women in different circumstances (in times of disaster and as research participants). These discourses are summarised in Table 5-6.

In order to confirm the dominance of the women discourses in the public health curriculum, we applied the strategy of ‘gender naming’ by identifying the characters that were named in the text. According to Kabira and Masinjila (1997), textbooks present a gendered picture of the world: “any written, visualized or/and spoken text contains within it a gendered perspective that purports to mirror the reality of that which is written about, that which is spoken about and that which is visualized” (p.10). According to Ferfolja (2007), the categories we use for naming are not neutral. Therefore, through naming, certain social subjects are constructed and, consequently, the process of becoming subjects is inseparable from the discursive production of sexual and gender identities. Tables 5-7 presents the various gendered discourses in which people in the official curriculum text were variously positioned.

Women were ‘named’ the most in the public health curriculum, followed by the combined category of women with children in their maternal roles and then the category of family. The naming of men and women together, and men alone, appeared in relatively fewer course descriptions when compared to the naming of women. Adolescents were named the least. The ‘naming’ of different gendered categories is presented in Table 5-7 and was derived from Appendices 12 to 15.



Table 5-6: Summary of dominant discourses in the public health curriculum

Component	Dominant discourse	Supported by	Issues
Area of specialisation (compulsory courses)	<ul style="list-style-type: none"> • Women discourse 	<ul style="list-style-type: none"> • Reproductive health discourse • Maternal and child health discourse • Productive roles of women • Women as vulnerable group 	<ul style="list-style-type: none"> • On women, for women, about women • Sexual harassment • Women in management • Vulnerability in times of disaster and during the research process
Core courses	<ul style="list-style-type: none"> • Reproductive health discourse • Maternal and child health discourse 	<ul style="list-style-type: none"> • Women’s bodies • Services, programmes • Social and biological discourses 	<ul style="list-style-type: none"> • On women, for women, about women
Electives	<ul style="list-style-type: none"> • Women discourse 	<ul style="list-style-type: none"> • Reproductive health discourse • Maternal and child health discourse • Women’s health in the life cycle • Women’s health in sub-Saharan Africa • Women and research • Women’s health and well-being 	<ul style="list-style-type: none"> • On women, for women, about women • Women and ageing • Stratification – women’s health in a specific geographic region • Vulnerability during research • Holistic view of women’s health

Table 5-7: Overview of gender naming in the public health curriculum

Gender naming	Number of times named according to an issue		Number of schools	
Women only	●●●●●●●●●●●●●●	14	●●●●●●●●	8
Women and children / Maternal and child health	●●●●●●●●●●	10	●●●●	4
Family	●●●●●	7	●●●	3
Men and women	●●●●	4	●●	2
Men only	●●●●	4	●●●	3
Adolescents	●●	2	●	1

5.4.2 Silent and marginalised discourses

Gender was a silent and marginalised discourse in some schools, which is an important representation to be noted. Secondly, some important discourses commonly found in gender theory, such as gender identity, were missing altogether. The official public health curriculum documents assumed a binary gender identity of male and female and did not consider other gendered identities such as intersex and transgender people. By extension, it also assumed heterosexual relationships as the norm, since only one school tackled the topic of sexual orientation in its curriculum. Table 5-8 provides a summary of the marginalised discourses in the public health curriculum.

Table 5-8: Summary of marginalised discourses in the public health curriculum

Marginalised discourse	Component	Issues
Men's health	Compulsory course (in an area of specialisation)	<ul style="list-style-type: none"> • Gender and men's health
	Electives	<ul style="list-style-type: none"> • Male reproductive epidemiology • Men's health in relation to public health • Men, gender and health
Sexuality and sexual health	Elective	<ul style="list-style-type: none"> • Sexual identity and sexual health • Sexuality and sexual orientation
Gender power relations	Compulsory course (in an area of specialisation)	<ul style="list-style-type: none"> • Power as a gender concept
	Elective	<ul style="list-style-type: none"> • Gender power

When compared to the predominance of the women discourse, the 'men's' discourse appeared to be a relatively marginalised discourse in the public health curriculum. The under-representation of men's issues seems to concur with several reports about the conspicuous absence of men from gender equality projects, including health (Greig et al, 2000; Lorber, 1997; Phillips, 2005; Sabo & Gordon, 1995; UNICEF, 2009; White, 1997).

Gender is often overlooked as an aspect of men's social identity. Yet, significantly, men continue to be implicated rather than explicitly addressed in development programmes focusing on gender inequalities and the advancement of women. (Greig et al, 2000, p.3)

Although it was not clear why there was little reference to men and their health in the public health curriculum, reasons have been advanced that ‘men’ are often missing in gender equality projects in health because male characteristics and attributes are usually viewed as the norm, while those of women are considered as a variation from the norm (Knudsen, 2003; Kuzmic, 2000). Allandale (2004) adds that men are often constructed as strong, resilient, robust and above all healthy, which could easily be construed to mean that in general, men do not become ill. (See also Section 2.1.8.)

The marginalisation of the discourse of sexuality and sexual health has been discussed in Section 5.3.1.2. The silences around and marginalisation of issues relating to sexuality, sexual orientation and gender identity are a reflection of how issues of sexuality and sexual orientation are perceived in the wider society and in the academy – including hostility towards homosexuals in most countries of sub-Saharan Africa. (See also Section 2.1.4.)

Finally, the silence around the discourse of power could be related to the claim by the Population Council (2001) that for many decades the public health field considered gender power relations as belonging to the “private sphere” and consequently “skirted issues of gender power relations and avoided acknowledging the effect of differential power relations on sexual and reproductive health” (p.5). This organisation adds that silence around issues of power relations was ended by the emergence of the HIV epidemic and the ICPD that focused attention on how gender power relations influenced sexual relationships and reproductive health decision making. (See also Section 1.1.1.)

The dominant, marginalised and silent discourses on gender are interpreted further in Chapter 7 through a poststructuralist lens.

5.5 Conclusion

This chapter started by giving a broad overview of the structure of the MPH curriculum that was under investigation. It served in preparing the reader to understand the location and representation of gender in this curriculum. An exposition of the representation of gender as an explicit and implicit discourse in the public health curriculum was given, with the conclusion that gender was represented more as an implicit discourse in the public health curriculum. It was found that where gender was represented implicitly, the focus tended to be

on women. Where gender was represented explicitly, the focus seemed to be on structural differences between men and women and this representation of gender was very limited. The representation of gender as women was the most dominant discourse in the public health curriculum.

The exposition described above was then followed by a more detailed presentation of how gender was represented in the structures of the public health curriculum and again, the representation of gender as women emerged as being prominent, while representations of men and masculinities were limited. The potential effects of these representations were also discussed. The emerging gender discourses from the compulsory courses of areas of specialisation, the core and elective courses were identified and potential effects of these discourses were also discussed. The chapter ended with a summary of the dominant and marginalised discourses in the public health curriculum.

Although this chapter focuses on findings from the analysis of official curriculum documents, the researcher acknowledges the limited information available in official texts and that often, what appears in the official curriculum is not necessarily what is taught in the classroom. It is further acknowledged that public health curricula have most certainly undergone many changes since the time of data collection for this study. These limitations have been discussed in more detail in Section 4.5.

The next chapter will present the findings from the interviews with staff in the two schools selected as case studies.

Chapter 6

Lived experiences of gender and curriculum

In this chapter I will provide an interpretation of the texts from the transcripts of in-depth interviews that were held with academic staff in two selected schools of public health in sub-Saharan Africa (Schools 1600 and 2500). The sample selection and case-study design have already been described in Chapter 4. The following questions, which were directly linked to the research questions of this inquiry, guided my interpretation in this chapter:

What are the perceptions of public health academic staff in sub-Saharan Africa with regard to gender?

- (a) What resources have shaped these perceptions?
- (b) How are forms of subjectivity constituted and taken up within these discourses on gender?
- (c) How do academics' own perceptions and experiences contribute to the construction of current discourses on gender in the public health curriculum?

Participants from both schools possessed diverse educational backgrounds and qualifications, ranging from Medicine, Dentistry, Nursing and Science to Social Sciences and Arts. With regard to rank, the directors of both schools were interviewed, as well as four senior lecturers, two lecturers, four assistant lecturers, one curriculum developer and one researcher. The biographic profiles of the participants are captured in Table 6-1 and include the areas in which participants were teaching and their levels of training in gender. The sample reflected sufficient diversity to elicit a wide range of responses.

Contrary to my expectations, most of the participants had received some training on gender or had been exposed to gender-related issues. Seven reported that they had received some form of training on gender, with four of these participants, all from School 1600, reporting to have attended a gender-mainstreaming (GM) course. Two of the participants had been exposed to gender indirectly, through carrying out gender-related work, while five participants had not been exposed to any previous gender training at all. One aspect for analysis was therefore how the previous exposure or non-exposure to gender had aided in shaping the constructions



Table 6-1: A biographic profile of research participants

Code	Sex	Rank	Education	Teaching area	Formal training in gender
1600:1	F	Assistant lecturer	<ul style="list-style-type: none"> • BSc (Technology) • Master of Public Health 	<ul style="list-style-type: none"> • Epidemiology • Research methodology • Biostatistics • Computer applications 	Gender mainstreaming
1600:2	M	Assistant lecturer	<ul style="list-style-type: none"> • BSc (Statistics) • MSc (Statistics) 	<ul style="list-style-type: none"> • Statistics • Computing 	Gender orientation
1600:3	M	Assistant lecturer	<ul style="list-style-type: none"> • Bachelor of Medicine • MPH 	<ul style="list-style-type: none"> • Health policy and economics • Reproductive health 	<ul style="list-style-type: none"> • Training – around ICPD issues – analysed issues from a gender perspective • Exposure through research evaluating ICPD, Post-Beijing – family planning issues with a focus on women’s choice
1600:4	M	Director of School	<ul style="list-style-type: none"> • Bachelor of Medicine • MPH 	<ul style="list-style-type: none"> • Infectious disease • Epidemiology • HIV/AIDS 	Gender mainstreaming
1600:5	F	Lecturer	<ul style="list-style-type: none"> • Bachelor of Medicine • MPH • Diploma in Family Health 	<ul style="list-style-type: none"> • Environmental health • Ethics and law 	Gender mainstreaming
1600:6	M	Lecturer	<ul style="list-style-type: none"> • BSc (Botany & Zoology) • MSc (Water Resource Management) • PhD (Environmental Toxicology) 	<ul style="list-style-type: none"> • Environmental health 	None
1600:7	F	Assistant lecturer	<ul style="list-style-type: none"> • Bachelor of Dentistry • MPH 	<ul style="list-style-type: none"> • Epidemiology • Biostatistics 	Gender mainstreaming



Code	Sex	Rank	Education	Teaching area	Formal training in gender
2500F:1	F	Curriculum materials developer	<ul style="list-style-type: none">• Diploma in Adult Education• BA (Honours)	<ul style="list-style-type: none">• Curriculum development	<ul style="list-style-type: none">• Gender and population education• Methodology for studying gender issues – offered by the women and gender studies
2500:2	F	Senior lecturer	<ul style="list-style-type: none">• Bachelor of Nursing• BA (Social Sciences)• MPH (Public Health Nutrition)• PhD (Public Health)	<ul style="list-style-type: none">• Nutrition• Monitoring and evaluation	None
2500:3	F	Senior lecturer	<ul style="list-style-type: none">• Bachelor of Nursing• MPH• PhD (Epidemiology and Biostatistics)	<ul style="list-style-type: none">• Maternal and child health	No training, but did something gender related – working with the women and gender studies unit – supervising a PhD student
2500:4	F	Senior lecturer	<ul style="list-style-type: none">• Bachelor in Social Sciences• PhD (Education)	<ul style="list-style-type: none">• Human resource development	None
2500:5	F	Researcher	<ul style="list-style-type: none">• Bachelor of Nursing• Honours (Public Health)	<ul style="list-style-type: none">• Non-communicable diseases	None
2500:6	M	Senior lecturer	<ul style="list-style-type: none">• Bachelor of Medicine• MPH	<ul style="list-style-type: none">• Health management• Epidemiology	No training, but exposure to gender issues through related work – organising a workshop, working with a consultant on gender issues, and through a research project
2500:7	M	Professor & Director of School	<ul style="list-style-type: none">• Bachelor of Medicine• PhD (Public Health)	<ul style="list-style-type: none">• Primary health care	None

of gender at both a personal level, in their teaching and in the construction of public health courses. This topic will be presented in greater detail in Sections 6.1.3 and 6.2.

The findings of the analysis of the in-depth interviews will be discussed from the following angles: the ways in which conventional representations of gender were reproduced or resisted through participants' narratives; the resources which participants relied on to shape their constructions of gender; and the ways in which gender was constructed in academic discourses.

6.1 Staff members' constructions of gender

In the analysis of staff members' understandings of gender three dominant discourse groupings emerged: biological, societal and academic. Two themes recurred throughout these discourses like a golden thread: gender as the male-female dichotomy ('two different coins') and gender as lived and situated experience. The metaphor of the 'two different coins' was borrowed from one of the participants who said, "*You cannot address really a problem just by looking at one side of the coin. You need to look at both sides of the coin*" (1600:1F). However, because of the way male and female were constructed as two distinct entities, with sex differences highlighted, I chose to use the term 'two different coins' as a useful metaphor to understand how, in a variety of ways, participants represented gender, men and women, as two different coins.

6.1.1 Biological discourses on gender

This section highlights the presence of discourses in participants' talk that emphasised sexual or biological differences between men and women. These discourses are linked to biological determinism (Alsop et al, 2002), essentialism (Harding, 1997) and natural difference discourses (Pauw, 2009). The term 'sexual differences' will be adopted for the purposes of reporting in the subsections below.

6.1.1.1 On "chromosomes" and "genital organs" – gender as sexual difference

With regard to the biological discourses, gender was constructed as sexual difference between male and female with a heavy emphasis on this difference. This is illustrated by the statement,

“Gender to me, I will take it to mean sexual differences... Whatever happens there is a difference between male and female; that’s automatic... Naturally that is what it is” (1600:2M). This participant, with a statistical educational background and exposure to a gender-orientation course embraced the discourse on sexual differences without questioning the implications of such a stance. In doing so, he seemed to (intentionally or unintentionally) be magnifying and perpetuating the sexual differences between men and women, implying that men and women are always two different coins. Further, the participant’s use of strong language to explain the sexual differences seemed to constrain the production of any other view on gender. This participant’s sentiments on sexual differences have resemblances with first wave feminisms and the women in development (WID) approaches that emphasised the sexual differences between men and women and accordingly, developed programmes that addressed the needs of men and women separately.

Most participants constructed gender as a dichotomous male-female category based on the assumption of sexual difference. For example, the comment, *“Gender to me, it means what sex are you, a female or a male”* (2500:5F) represents gender as an entity and essence, which promotes an essentialist view on gender. According to Alsop et al (2002), discourses on sexual differences assume that gender is an essence and that differences between men and women are natural, innate, fixed and not amenable to change. Our participants insisted *“that’s automatic... Naturally that is what it is”* (1600:2M) and you are *“female or male”* (2500:5F). The expressions of these participants seemed so normal and common-place and resonated with Pauw’s (2009) argument that “the natural difference discourse is a discourse that calls on the commonsense notion that women and men are naturally different and that these differences cannot be explained away” (p.163). Participants’ strong focus on sexual difference points towards a taken-for-granted status that is rarely questioned within public health circles. (See also Gavey, 1997; Pauw, 2009; Shaw & Bailey, 2009; Van Dijk, 2004).

6.1.1.2 *“Males ... are also gender” – the invisible coin*

Even though most participants were categorical that gender was about the sexual differences between male and female, it seemed that in reality, men as the ‘other coin’ or as the ‘one side of the gender coin’ were either missing or were invisible. Instead it was the female differences that had been put on the agenda. A number of participants expressed through their use of language their rejection of and resistance to the predominant view held by society that gender

represented only one of the coins by means of a discourse of ‘self’ (“I”) and other (“people”):

First, I will start with what I don't like, because I have had many people talking about gender and they have always narrowed this to women issues. The broad aspect of gender, to the extent that gender [is narrowed down] to femininity or issues related to women, which I think is wrong. (1600:3M)

But I know that when you think about gender studies, people often think of it as women gender studies, when obviously it shouldn't just be. (2500:3F)

Even in a bid to distance themselves from the predominant viewpoint, these participants constructed women as a homogeneous, universal category, thus perpetuating an essentialist view about women. Further, in the act of distancing themselves from the dominant stereotype of gender as women, participants also offered a counter-discourse which should include men as ‘the other side of the coin’ by advocating that in gender mainstreaming (GM), “*The males are just outside and they are also gender – they also belong to gender issues*” (2500:5F). In this way these participants deconstructed the dominant views of gender as ‘women’. A male participant offered an even stronger view on this, using a metaphor of male partnership in gender issues and pointing to the vulnerability of men. He seemed to be in agreement with the previous two female participants (2500:3F & 5F) with regard to gender not being only about women when he said:

...where a man needs to be brought up more into a discussion, because they actually – well a lot of research anyway showing us that many of the issues that are gender issues, men are strong partners and therefore leaving them behind is not helpful, but also there are areas where men themselves are worse off. (1600:3M)

One participant used a plural form when talking about men: “*Obviously there are going to be male gender constructs as well*” (2500:3F). This conscious or unconscious acknowledgement of differences among men seems to be a departure from the essentialist perspective on men as a homogeneous group that was present in most of the participants’ constructions.

There was a trend among some participants to discursively distance themselves from the conventional construction of gender as women towards a framework that also included men.

However, there appears to be a contradiction in that the official curriculum documents still reflect a status quo, dominant discourse of gender as women. (See Section 5.3.2). According to Pauw (2009), such contradictions are hard to reconcile. On the one hand they open up space for resistance, but on the other hand they provide the space for the discourse of men to remain invisible yet present. When confronted with a number of possible discursive frames, the discursive frame that ends up carrying more weight – in this case gender as women – illustrates how subjectivity is a site of conflict (Weedon, 1997). Consequently, the different discourses and the contradictions between them may support the status quo (Pauw, 2009).

6.1.2 “Roles that are given to men and women” – societal discourses on gender

From the analysis of interviews, “*gender is the social construction of roles that are given to men and women*” (1600:5F) emerged as a dominant discourse – “*It’s mainly looking at maybe responsibilities, the role of both men and women in society*” (1600:1F). This resonates with a structuralist approach that emphasises the shaping of meaning by sociological structures (Bush, 1995; Lye, 1997). “*Gender is the differentiation between males and females*” (1600:6M) highlights the sex difference discourse co-existing with the fixed and static societal discourse that ascribes roles and responsibilities based on sex differences. According to Pauw (2009), the sex role discourse justifies structural inequalities and requires subjects to submit to its descriptive and prescriptive capacities and its effect is the unequal distribution of domestic labour and the maintenance of structural inequalities in social systems.

The acceptance of sex roles is often accompanied by an assumption that females/women and males/men are singular categories that share similar innate characteristics. Courtenay (2000) asserts that the sex role theory has been criticised for assuming that gender represents dichotomous, mutually exclusive categories of men and women with fixed, static roles. He adds that the theory also assumes that women and men have innate characteristics and also fosters the notion of a singular female or male personality that obscures the various forms of femininity and masculinity that women and men can and do demonstrate. Despite some attempts to unpack the complexities of gender, participants’ social construction of gender was generally based on the original concept of sex differences and assumed a natural or biological difference between men and women. The implication of such a perspective is that it would be difficult to break down boundaries on sex so that roles could converge, because roles were originally based on biological sex. In addition, confusion and tension could arise at theoretical

and practical levels due to the depiction of gender as a fluid multiplicity of concepts on the one hand, and the opposing view of sex as an essentialist, fixed and unchangeable essence on the other hand. Kabeer (1994) argues that role differentiation based on sex differences is often the main cause of inequalities, with women's roles being greatly undervalued, thus greatly reducing the status of women in society and denying them power over decision making on issues that affect their lives.

In the foregoing participant talk, gender seemed to generally reside in “*male and female*” and “*both men and women*”, leaning towards a binary, essentialist approach. This tends to lead to an emphasis on differences that are not problematised. In this regard, Gavey (1997) posit that it is quite easy to create the male/female binary category but that in itself does not address the complexities of gender adequately.

However, in contrast to the predominant sexual difference discourse discussed above, participants from School 2500, the school that had not had formal exposure to GM, positioned gender beyond sex differences and in terms of power relationships. Participant 2500:6M sought to make a clear distinction between sex and gender, arguing that gender went beyond sex differences to embrace social aspects of gender. Participant 2500:4F went further and problematised the role of women in society in terms of power relations.

Well my understanding of, when one talks about sex, it's about purely biological definition of what sort of genital organs that people have. But gender is much more as well. I think about a social definition of what is a man and what is a woman and I guess it's like the social and legal framework within which we live and identify ourselves.
(2500:6M)

But I find it a quite difficult concept to grasp, because I think it's about much more than women doing the job and it clearly talks very much about women's roles in society and how society, I suppose, culturally and in terms of its power allocation and so on, thinks about women and brands women and puts women in certain places. (2500:4F)

The latter participant's sentiments support the position of several gender researchers who maintain that gender is not about two static categories but is instead a dynamic social structure that involves a dialectic process that produces and reproduces gender continuously through

people's actions and interactions (Connell, 1995; Courtenay, 2000). Courtenay (2000) adds that gender does not reside in the person, but rather in social transactions.

6.1.3 Academic discourses on gender

The ways in which some of the participants constructed gender fell within an academic discourse. Some of the main categories that emerged were gender as: a social construct of roles and responsibilities; equality of outcomes; a statistical/demographic variable; and gender issues in the community.

6.1.3.1 “Gender is more of a social construct” – roles and responsibilities from an academic perspective

The societal discourse on gender as prescribed roles and responsibilities (sex role discourse) as was discussed in Section 6.1.2 emanated from one school. Even though the interview questions did not include the word “construct”, the participants from School 1600, which had received a GM intervention (see Table 6-1), used the gender construction jargon in very similar ways. Their responses probably emanated from this exposure.

Viewed from a poststructuralist perspective, this is a good example of a universalising ‘grand narrative’ (McLaughlin, 2003), which has been circulated and perpetuated through academic discourse. This type of discourse would be questioned by poststructuralists since it seems to advance the structuralist view that gender (roles and responsibilities) are shaped by sociological structures and held together firmly by underlying social systems (society and culture), implying a static situation for men and women over which they have no control, and from which they cannot escape (see also Bush, 1995; Lye, 1997). A universalising theory also does not take into account the different contexts and subjective positions of both men and women (for example, that roles and responsibilities have changed and that there are women who have taken on male-dominated roles and responsibilities, or that there are single mothers and fathers).

6.1.3.2 “But we are slowly getting into mixing the gender” – discourses of access and participation

Some participants represented gender in terms of the achievement of equal outcomes with regard to numbers between male and female staff and students in their schools, also known as formal

equality (Health Canada, 2000). In School 1600, one staff member indicated that there were more male than female students, while in School 2500, the reverse was true, with more female than male students. In terms of staff, both schools indicated that there were more male academics than females. This is how these participants described equality of outcomes:

First of all I would like to see that both men and women are given an equal chance when it means being admitted into the programme. We would like to see at least, you know there is the same number of both men and women. Most of our programmes, it's mainly the men or the boys – particularly in the post-graduate – it's mainly the men that are the most. But now like for instance in the class I was we were only nine women to about 26 men. There is that difference. I would like to see that and then for instance, the teachers who are involved in lecturing the students are also mainly men. So I would like to see a fair ratio here and there at least at the different levels. (1600:1F)

Okay. I would say because health profession as such, it's dominated by females. So I would say we are seeing more females than males in public health. We have got more females than males. We are attracting more females than males, although we do have males, but they are very few, because when we have got our winter and summer schools, it's usually maybe 80 percent female and 20 percent male. But we are slowly getting into mixing the gender. (2500:5F)

We have got about three female professors now, which is very rare. If you talk about a professor in a university, you know it's a male. Now it wasn't. But I don't think it was because of being gender sensitive. It just happened that it was their time. It was not just - it was promoted, that let's also have females. But what I like more about our faculty as such, sciences, because that our dean is a female. (2500:5F)

The discourse of equality of outcomes advanced by the participants resonates the women in development (WID) and liberal feminist approaches that emphasise gender issues in terms of access and equality related to equal numbers (Aikman & Unterhalter, 2005) (See also Section 2.1.1.) This does not always translate into gender equity, as it ignores the different conditions from which men and women emerge (Arnot & Fennell, 2008).

6.1.3.3 Gender is “one of the demographical characteristics”

A few members of staff constructed gender in very formal and scientific terms as a statistic and variable where one participant “...looked at whether you are female or male, the gender issues ... It's one of the demographical characteristics” (1600:7F). In this case the participant’s construction made gender appear as if it was an object rather than a subjective position. The other participant talked of “... whether actually there is a big deviation between males and females and that is similarly given to any statistic” (1600:3M), which made gender appear as a statistic that could be manipulated to show statistical differences between men and women. According to Schulze and Angermeyer (2003), the construction of gender as a statistical variable reflects a positivistic approach that treats its participants as objects. These authors argue that the findings from a positivist approach are often limited in scope since the findings fail to take human subjectivity into account and are normally disconnected from the context in which research was carried out, thereby hindering a better understanding of social problems.

6.1.3.4 Discourses of intersectionality

Through analysis of her use of language, it became apparent that one participant from School 2500 (5F) was actually highlighting some of the gender issues that might arise while carrying out academic community outreach programmes. The issues may possibly not be so apparent when teaching students inside the university. Through her narrative, the participant showed that intersections with gender and age and gender and race were important factors in determining the success of her programmes in the community. Perhaps, without even being consciously aware of it, she was underscoring the point that sometimes gender alone might not be the sole determining factor, but that there were other factors that were also markers of difference and that might equally have an impact on public health interventions.

a) Gender intersection with age

For participant 2500:5F age was important in making her programme successful. She did not consider women and men as a homogeneous group but, rather, she acknowledged that the group of women and that of men were differentiated by age (the younger and the older) and that each age group had its own peculiar need. For example, while the older women attended the programme with much enthusiasm and commitment, the younger women and men needed an incentive in order to participate.

We have negotiated with them to donate some equipment so that at least, because even the females that are coming, it's old females, not young females. So now in trying to attract young females and young males we have adopted a style of – we have negotiated with [Company A], so they have donated equipment in [Township X] for us. So after that we are seeing a great difference. We are seeing more males and females and what is surprising, as it's more males now than – it's more young males than young females that are coming to be trained. I think the equipment has promoted our health promotion side, in bringing now more males than females. They are more into coming to gym. (2500:5F)

Based on this observation, the participant was able to develop an appropriate intervention, particularly for the younger women and men.

b) Gender intersection with race

In the same case, our participant demonstrated the intersection between gender and race by referring to black women and black men. The importance of doing so was to indicate that she did not consider all women and men as a homogeneous group, but rather, the issue she was dealing with was specific to “black women” and “African males”, and therefore it would not necessarily have been applicable, for example, to white women and men.

And again we have been having a study with students, on the perception, attitude and knowledge of black women about fat and then they said that their husbands like fat women. Their husbands are more pleased and then after that study we also got money and then we further went to do a study now on African males' attitude, knowledge and beliefs ... towards fat [women], tying it to gender ... we also want to know what do they think, the males, because we know now what the females think. So in that we are addressing the gender in [it]. (2500:5F)

Our participant talked about age and race in very practical terms in working with the community. In the official curriculum text age, sex, ethnicity, social class and occupation only appeared as formal epidemiological variables covered as part of epidemiology modules or courses (Section 5.3.2.1.)

c) Gender reflexivity in research

Creswell (2003) calls on qualitative researchers to systematically reflect on their biographies, their biases, values and interests, and to highlight how these could shape the study, an action known as *reflexivity*. The same participant referred to her dilemma as a female working with males in the community and vice versa. In the Non-communicable Diseases course, she constructed gender in terms of gender identity and gender biases and went on to explain how the identity of the researcher as male or female posed a dilemma for the researcher and also in clinical practice. In the excerpt below we find a greater emphasis on the self-awareness and identity of the researcher.

But now when we had the research study about perceptions of black men to interview we had a great problem because there are questions that we could not ask, because of being female. So we said, “Oh, we need a male now here”. And again I have seen it when we are doing interviews with clients in one clinic, that clients who are females would prefer to be or to say their problems to a male, because they preferred [assumed] that a male has got confidentiality. If a woman has got STI, he is not going to talk about her at tea time. If it's a female nurse she is going to know not to be ... [inaudible]. And me as an African female, there are questions that I would not ask them. I would just say let me show them respect; let me not ask the question. (2500:5F)

The above brings a new focus to the researcher-subject relation. In this case the participant was ‘unbracketing’ her own subjectivity as a researcher – and by doing so, challenging the objectivist ideology associated with bracketing one’s own beliefs, assumptions, tastes and preferences – in order to acknowledge how deeply these enter into knowledge constructions and power relations (Peters, 2004).

6.2 Resources that shaped participants’ constructions and understandings of gender

We also used the transcribed interview text to explore how participants relied on specific resources to shape and give meaning to their constructions of gender. It emerged that their representations of gender were largely informed by and entrenched in societal, academic and institutional systems, practices and processes and personal experiences. There were often

overlaps and tensions between these discourses. It is important to report that there was probing on religion and culture where this information was not forthcoming.

6.2.1 Discourses embedded in societal systems

Society has a strong influence on people's constructions of their reality (Gergen, 1994). The staff members' constructions of gender were embedded in their socialisation experiences of family, culture and religion.

6.2.1.1 "Probably it starts off in the family and ... in one's culture" – culture and socialisation

Both male and female participants from the two schools drew from their cultural and early childhood socialisation experiences to shape their current understandings of gender and gender roles. However, the experiences of the participants from School 1600 and those of School 2500 were markedly different. The differences in the cultural constructions of gender by participants from the two schools appear to be based on geographical, historical, social and racial differences. Participants from School 1600 came from an African background that is still very patriarchal, while participants from School 2500 were of diverse races: white, black and Indian, with some of the white participants raised in the West, where the notion of equality between men and women had been accepted and promoted for a much longer time. The findings therefore demonstrate multiple constructions of gender that differ between cultures.

For participants from School 1600, culture and early childhood experiences shaped their construction of gender into a *discourse of difference*, in which gender roles and expectations, based on sex differences, were fixed and unchangeable.

I think culture is the first thing that lets you know what gender is. You may not know that the term is gender, but culture lets you know that this is, what a girl does, this is what a boy does; this is what is expected of a woman and this is what is expected of a man. And then through school and all, it keeps changing. I think it has an influence as in it's the first point of contact probably that you know about gender, even your mother will tell you as a girl you can't do that. (1600:7F)

The culture has had an influence, like you think when you are still young they tell you don't do this; the man doesn't do that, the woman does that. So you grow up knowing this is supposed to be like that. Don't cry in public because a man doesn't cry in public. (1600:6M)

The potential conflicts and tensions between these cultural prescriptions and socialisation processes with the notions they advance of what is feminine and what is masculine, on the one hand, and the personal beliefs and feelings of the participants on the other are also noteworthy. There are some hints of feeling like a prisoner to societal prescriptions – “*this is supposed to be like that*” (1600:6M). Our female participant in the excerpt above, however, hinted at the possibility of change as one goes through school, implying that constructions of gender were fluid and were shaped by context.

The above findings are linked to the discourse on sex roles where sexual differences are another dominant public health discourse on gender. (See also Sections 6.1.2 and 6.1.3.) Views such as these reinforce the paradox of the sex/gender system where gender as a social construct is derived from sexual differences. The potential effect of such a construction is the confusion and conflation of sex as gender and gender as sex that is so prevalent in the biomedical paradigm. (See also Section 1.1.1.)

In direct contrast to the experiences of participants in School 1600, three participants from School 2500 narrated how culture and the process of socialisation helped in shaping for them a more positive and flexible rather than prescriptive view of gender. They talked about how the environments and types of cultures in which they were brought up encouraged women to get out of stereotyped sex roles and promoted equality between men and women. These processes helped shape gender as a *discourse of sameness and equality of opportunities*.

I think for myself I was fortunate. I had a father who was non-traditional, I think, in how he viewed gender roles. He had a very strong mother and my father wished for me to be the first woman astronaut. So that was from when I was very little, so I was pushed that way. (2500:3F)

I suppose it's a mix of own experience and what I have seen around me and it's been quite interesting, because I mean, I have certainly grown up in an environment where

women were expected to – there was comparably little branding of women in a particular role. So I and sort of my peers and also my sister and so on, we had a lot of pretty much the same opportunities as boys and men around us. (2500:4F)

I think people develop ideas about gender. Probably it starts off in the family and how one's parents interact. Also in one's culture. So I grew up in Canada and it's a very social-minded kind of country and has very firm, both legal and, I think, cultural principles around equality of men and women. And I grew up with a very strong mother who defended women's rights, and three sisters. And so I have always been a defender of women's rights. (2500:6M)

In their narratives, these participants alluded to several factors that were favourable to achieving this sameness and equality of opportunities. Firstly, there was need for a non-traditional environment where obstacles in the way of women were removed, where women were not branded, and which had strong legal frameworks. Secondly, there was a need for ‘gender champions’ such as strong mothers and defenders of women’s rights. The cultural discourses on gender emanating from School 2500 seemed to be transformatory and liberating as opposed to the discourses emanating from School 1600, which appeared to be fixed, rigid and imprisoning. In addition, the discourses offered by participants from School 2500 seemed to be congruent with the notion of substantive equality, which advances the view of equality of opportunities and benefits (Health Canada, 2000).

The sex role discourse was repeated over and over in the participants’ talk in School 1600, not only with reference to their academic life, but also in everyday cultural life. According to Gergen (1997), discourses grow from the language used within a culture. Van Dijk (2004) also refers to the reproduction of dominance through subtle, routine, “natural” (p.302) everyday forms of text and talk. The academic discursive framework in School 1600 enabled the production of sex roles as a dominant gender discourse transmitted through ideology (GM course) and had become rooted in the ways of speaking, writing and representing (Hodgson & Standish, 2009). This same action could have constrained other ways of thinking about gender (see Cheek, 2000). In contrast, some participants from School 2500 were able to deconstruct the discourse on sex roles as a result of their upbringing, showing that through change agents or ‘gender champions’ such as a “*non-traditional father*” and “*a strong mother*”, it was possible to break through the rigid sex-role structures. This raises a fundamental question about

gender: are gender norms so deeply entrenched and rigid (Coen et al, 2004; Klugman, 2004) that ‘gender champions’ were needed to free up the discursive sex-role trap? The language participants used portrayed the image that gender equality was very difficult to achieve and that it took a very special kind of person to intervene in order for equality to be realised.

6.2.1.2 “Even religion yes, that can have a big influence” – religious systems

While most of the participants said that religion had no influence on their construction of gender, a few of them viewed religion as a resource on which they drew to shape their understanding of gender. It was also interesting to note that it was only female participants who acknowledged the role of religion in giving engendered meaning to their lives. They gave personal accounts of how religion had shaped their constructions of gender, either positively or negatively.

a) “In God’s eyes both a man and a woman are equal” – religion perceived as promoting gender equality

On one side of the coin, religion was seen as constructing gender in terms of equality between men and women. One participant was a firm believer and ardent follower of her religion and its teachings and accepted that her perceptions of gender had their source in her church.

Now like for, instance, my religion. I am an Anglican. And you know the way we are taught they look at both men and women equally and the Bible says that in God’s eyes both a man and a woman are equal really. (1600:1F)

Framing men and women as equal through God’s eyes gave this construction of gender some sort of unquestionable divine authority and legitimacy that is passively accepted without questioning. This kind of reasoning resonates with Weedon’s (1997) assertion that when one is confronted with constructed reality, “the individual becomes its bearer by taking up the forms of subjectivity and the meanings and values which it proposes and acts upon them” (p.34).

b) “A second class citizen in your own faith” – religion perceived as perpetuating gender inequality

On the other side of the coin religion was depicted as being complicit in perpetuating gender inequality. In contrast to the previous participant who accepted the teachings of her church

without question, another participant from the same school actively resisted, rejected and reconstructed her church's representation of gender. Her talk alludes to a perpetuation of gender inequality through a religious discourse of disempowerment of women based on a sex-difference construction of gender, with women being treated as the 'weaker sex' of lower value and position. Through the institution of marriage women are constructed as objects required to be humble, obedient and subservient to their husbands. The reactions of this participant's children to religion open up other spaces for reconstructing God in a discourse of spirituality instead of sexual differences.

I am a Christian of the Roman Catholic faith and the Bible and the teachings have always taught women to be humble, to be obedient to men. Even God is a male... that we all grew up with him and the important people, the important angels like Gabriel who brought the news, the people who wrote the Bible, the apostles – all of them were men. You find that you are a second class citizen in your own faith. And this is not only Christianity, it's in Islam. If you are a woman and you are in your period you are not supposed to go into the mosque. And I think up to the – a long time ago – even Christian women were not supposed to go to church if they were having their period.

But the whole concept of marriage, ownership, you put on the white veil and you walk around like an angel and this man takes you for his wife. And the tradition, you are supposed to love and obey. And like the Catholic Church you have the women being sisters and the men being priests and they can reach to the highest level. You have been seeing all these issues of women, issues of women priests bringing in so many misunderstanding, and everybody forgetting the simple message of Jesus that you love yourself, you love your neighbour and you love your God. But how come your partner who is [a] woman be subjugated and you say, you love God? So these are the issues as far as religion is concerned.

Of course it's all about power, giving men the power over the women and women are being in a lower social position, and it's very difficult to convince the children today. I have got two daughters. They don't go to church, they say: "What is this?" Yes, they say: "Mummy, you have gone to school, [so] how do you explain this? I cannot go to a church where I am a second class citizen. I cannot go to the church that does not respect women. Women of different gender, equally before God, and I cannot go to a church that

thinks God is male, who gives them the right to think that it's him, it's a spirit, it has no sex.” You know all these issues and they do affect the way people live and their health. (1600:5F).

6.2.2 Discourses embedded in academic systems

Training, research, networks, role models and the feminist movement were some of the academic discourses that were common in the participants’ talk and which seemed to have kick-started the exposure, interest and, later, the shaping of their understanding of gender. On further analysis, these discourses were divided into two categories: academic discourses acquired by design; and academic discourses acquired by default.

6.2.2.1 “Until this gender mainstreaming came about” – academic discourses acquired by design

Discourses acquired by design refer to the ‘social engineering’ of gender discourses by means of deliberate academic workshops or training on gender that were offered to academic staff to increase their understanding of gender. The majority of the participants from School 1600 referred to the GM unit that had just been established and from which they had received training. (See Table 6-1.) The GM unit was established to train members of staff across all faculties on gender issues. A detailed background of the unit, including its objectives and functions, is described in Appendix 1. One participant credited the unit for having contributed to the academic staff’s awareness and understanding of gender issues as follows:

But we do actually have ... a gender-mainstreaming committee that is actually throughout every institute or faculty in the university and that is something. But it has increased our understanding of gender issues. There is a gender-mainstreaming policy at the university and there is actually a department of gender studies. But there is one there and they have been very strong advocates of these issues too ... We have seminars on these issues and it has increased our awareness. (1600:4M)

Other participants from School 1600 also narrated how the GM training had advanced their knowledge of gender. They explained how the training had exposed them and sensitised them to gender issues and, in doing so, aroused their interest. One participant also talked of how the training had helped her know how to identify gender issues in the curriculum. The ways in which

these mainstreaming workshops shaped their own understandings and constructions of gender have already been discussed in Section 6.2.2.1 above. These participants' experiences relate to a technical GM curriculum with an integrationist approach. There was no evidence to show that the training had enabled the participant to address the political question of transforming gender power relations in their curriculum. (See Section 2.1.9.3.)

Another participant from School 1600 who did not attend the GM course talked of how he had received training on gender from elsewhere. Although he had heard about the institutional GM, he was not quite sure how to understand it – to him it sounded like abstract, ambiguous jargon.

And I think when you do talk to the people, you will find that there are some initiatives going on. I don't know what kind of – it looks like it's really another project, most likely some resource. It's called “gender mainstreaming” and they elected some people. They actually elected senior staff and one of the staff they appointed to be gender mainstreaming, whatever. What is champion, whatever it is, they appointed two people to be in charge of. (1600:3M)

Only one participant from School 2500 reported having received some formal training on gender, which enabled her to consciously incorporate gender in her area of work.

And so we learned or we developed a way of incorporating gender into our popular education practice. So ever since then, and then I worked in that department later and we always incorporated it into that and then I did a module with women and gender studies here. (2500:7F)

School 2500 as a whole, however, seemed to have taken a gender-equity approach in contrast to the mainstreaming approach. Participants from this school talked about having a gender-equity unit and how the ethos and the core philosophies of the university reflected human rights and equity. The core functions of the gender-equity unit and the sensitivities around gender revolved around mentoring women academics, harmonising their working conditions amid a predominantly male presence at the top of the hierarchy.

I would say it is yes [that the gender-equity unit has had any impact]. I would say quite strongly because they have had a gender-equity unit for a long time, with a strong

person. The evidence is seminars and visiting academics who have worked with women as academics, to re-write their CVs, to think about salaries. I never looked particularly hard at it, but I think there is sensitivity. At the same time there is awareness that the hierarchy is hugely male, white and so-called coloured male, black women, if you look at the staffing statistics. It's got a long way to go. Black and coloured women are probably more on contract than – I mean I am on contract, that's just one of the things. But in the mainstream I would say it's still very skew. And I think there is consciousness of it but I am not sure what measures and I have seen stats going around. So yes on policies, I am not too sure on practice. (2500:1F)

6.2.2.2 “And that is how by default, I became a sort of expert” – academic discourses acquired by default

Academic gender discourses which were acquired “by default” were those that participants had picked up indirectly by being involved in gender-related work. At School 2500, all but one participant fell into the category of acquisition by default. The reverse was true for School 1600 where one member also acquired gender knowledge by default, while the majority received formal gender training. Therefore, while the experiences of staff members in School 1600 were more similar in relation to the academic discourses that they encountered on gender, the ones for School 2500 tended to be more nuanced and diverse due to different avenues of exposure to gender issues.

As I said, I learned it more from having organised this training course, workshops and then involved in this gender consultant and then through the work that I did with this research project on micro finance and AIDS and gender. (2500:6M)

So I was called in., I told my director I know nothing about gender and he said, “But you are a woman”. I said well if that is the qualification, you know, I joined that team and we were trained. We went to the reproductive health and gender; that was my first exposure. And since then I started working with our different aspects of gender and health, and that is how by default I also became a sort of expert. (1600:5F)

Another participant from the latter school, for example, indicated that she had had no formal training in gender, but had worked with the institute of gender studies on gender-related issues.

6.2.2.3 Institutional discourses on gender and institutional role models

Academic members of staff talked about how their schools had institutional policies and gender units in place to address and redress gender issues. They also talked about how these policies, units and some role models from certain institutions had increased their understanding of gender. The GM unit associated with School 1600 and the gender-equity unit associated School 2500 have already been discussed in the preceding sections.

a) Affirmative action discourses

Participants from both schools confirmed that there was “*affirmative action towards women*” (1600:4M) in their institutional policies and constitutions, “*in their hiring and in their promotions and in their support of woman professors*” (2500:3F). The assumption behind affirmative action is the notion of substantive equality that takes the conditions from which men and women emerge into account – diversity, difference, disadvantage and discrimination (Arnot & Fennell, 2008; Bennet, 2002a). The primary aim of affirmative action is to level the playing field for women by considering the alleged previous disadvantaged and discriminatory circumstances in various areas of their lives (Aikman & Unterhalter, 2005; Arnot & Fennell, 2008; Barnes, 2007). (See also Sections 6.1.3.2 and 6.2.1.1.)

Despite confirming institutional gender-sensitive policies in place, some participants felt that there was some tension between policy and its implementation.

Oh, they have gender sensitive policies, yes. Practice is a different matter, which I think is quite common. No, I mean I think gender issues have been addressed and we have had a gender-equity unit for at least in our last 15 years. You see the practices are much subtler, and also much more complex. (2500:4F)

The above participant’s sentiments on the gap between policy and implementation of gender policies seem to be congruent with arguments advanced by other gender researchers in Africa (Longwe, 2002) and South Africa (Pauw, 2009). (See also Sections 1.1.1 and 2.1.2.) Her reflections on institutional practices on gender, being much more “*subtle*” and “*complex*”, are a replica of Morley’s (2006b) findings that discrimination against women in higher education occurred in subtle and complex ways, even in institutions where equity policies

were in place. Ducklin and Ozga (2007) also claim that there is dissonance between the rhetoric of equality of opportunity and the practices of everyday social relations and organisational life.

When our participant pointed to the fact that gender-sensitive policies and the gender-equity unit were in place in her institution, her words seemed to portray a static or fixed impression of the gender policies and the gender-equity unit since, according to her, practice or implementation seemed to be problematic. This sentiment seems to echo the contention of Hodgson and Standish (2009) and Nudzor (2009) that when policy is constituted as a fixed entity in institutions, it makes practice and change impossible.

b) Institutional role models

Another participant talked about a role model based in a certain institution and who had inspired her as a woman to strive to rise to higher levels than women were expected to do in those days.

So I had a different sort of thing and interesting, when you talk gender, I don't know if you know Dr X. I don't know if you know her name, but she is the head of Y. Okay. I don't know if she still is, but she was and of course she is from, I think, Bangladesh or Pakistan. She is from a very [conservative background] you know, cultural women are ... It's very difficult for women especially to rise to be a prominent doctor, to become a doctor at all, to become a prominent doctor, to become international, to become a head of an agency such as Y. And I once attended a – she was receiving an award for Public Health, which I was involved in and I remember asking her, because I was curious, how someone coming from, where I knew where she came from, sort of become, you know, as a woman. I asked her what did she think that had allowed her to do that. And her response was actually her father ... [who] felt that the girls in the family should have the same education and the same culture, even though that wasn't necessarily the predominant culture ... her father felt that she should also be educated and also pushed her to think. And I thought that was an interesting situation. Ways that you can look at, broader context of the way that women can then come up, having the support, even a microcosm of support. (2500:3F)

The above narrative encompasses examples of two different role models. The one is the woman academic being a role model for one of the participants. A secondary role model is presented by this woman's role model, namely the role of her own father. This complements the discussion in Section 6.2.1.1 where reference is made to the role that participant 2500:3F's own father played in the socialisation processes that shaped her constructions of gender, wanting her to become the first female astronaut. Both the academic role model and her own father as role model served as an inspiration for this participant to break through the cultural mould to reconstruct gender as a transformative process rather than a fixed entity, as illustrated by expressions such as “*rise*”, “*become*” and “*come up*”.

Another important point our participant seemed to be making was that gender stereotypes were so deeply seated (Shackleton, 2006), that to break out of this cultural mould, one needed some kind of “*support, even a microcosm of support*”. In her own case and in the case of her academic role model this type of support materialised through their fathers who acted as ‘gender champions’, or change agents. This enabled the participant to take up a position of agency in shaping her life. This idea of support and agency was reported at the University of Botswana where a masters-level specialisation course on gender and education could be developed as a result of the support of male colleagues and the presence of a female vice-chancellor (AGI, 2002). Finally, the educational opportunities given to the participant and to her academic career against a strong cultural background of disadvantage seems to be another reflection of substantive equality – providing equal opportunities for the attainment of equal benefits (Bartlett & Harris, 1998).

6.2.3 “*Rich*” and “*loud*” discourses embedded in history

Two women participants from School 2500 drew on the women's liberation movement to explain how their understanding of gender was shaped. For one, feminist ideas informed her training curriculum, while for the other, the feminist movement enabled her to construct notions of equality. The latter described these historic periods nostalgically as being “*rich*” and “*loud*” to the extent that she “*wanted to become equal*” (to men?).

That came later in the eighties but in the seventies I was reading that. I had some good feminist lecturers at Unisa. So maybe that influenced [me], but there was awareness from early on. I did have a strong sense that I wanted to be equal quite early. So

maybe that shaped it to an extent and I suppose that's cultural. The seventies were quite rich for women. It was in our vision, it was all possible. Whereas I would say for those who grow up through the eighties and nineties, it has taken a much lower profile, except maybe in the development context. But you don't have the same loud discourse as we had in the seventies. (2500:1F)

The undertone of this participant's construction of gender was a process of 'political activism' that would lead to change. Her nostalgic narrative of the seventies seems to resonate with the 'feminisms' described in Section 3.2.1, which showed how gender theory was deeply rooted in feminism and how feminist theory had played a significant role in shaping the concepts of gender as they are understood today (Lorber, 1997; McLaughlin, 2003; Weedon, 1997; Wyckoff-Wheeler, 2002). The participant's descriptions seem to be particularly congruent with the second-wave feminism of the late 1960s and early 1970s that dealt with the liberation of women from gender-imposed roles and expectations (Jackson & Scott; 2002; McLaughlin, 2003; Wyckoff-Wheeler, 2002) and in which "the personal became political" through activism (Weiler, 2008, p.1).

The participant then contrasted the seventies with the eighties and nineties, which she claims took a "much lower" not so "loud" profile with regards to gender. AGI (2002) provides a similar argument that donor agencies de-politicised gender by focusing on bringing more women into development without necessarily challenging existing power structures or gender relations, and in this way scholarship on gender lost its political edge and transformative potential.

6.2.4 Discourses on gender as lived experience

Some academic staff members drew from their situated experiences to shape their understandings of gender. This 'situatedness' was located within their specific lived experiences and knowledge in their material world. It was difficult for some participants to come up with concrete constructions of gender. Instead, they chose to explain these through narratives of their own lived experiences, thus emphasising the reality and materiality of gender as a lived experience. Some of the narratives reflecting gender as lived experience go back to the childhood years, whereas others relate to women's experience as academics. (See also Sections 6.1.3 and 6.2.1 and their subsections.)

One participant's narrative illustrated the consequences of a dominant sexual difference discourse arising out of the socialisation process while at school and how she resisted it.

I know for instance, this is now some years way back, I was in a mixed boarding school. We were both boys and girls. So you know with the way we were brought up I know each time – I mean that school in particular – each time boys would always look you down, down. With all that exposure kind of it made us ... try to stand up and try to tell this, “Hey, we are, why don't you treat us like we are the same level”. There is no difference, apart from you being a boy and me being a girl. We are the same. (1600:1F)

The description of how boys “*look you down, down*” reflects a construction of gender in terms of power relations based on sexual differences that result in an inferior status for women. This participant's opinion mirrors the sentiments of another participant who claimed that society “*brands women and puts women in certain places*” (2500:4F). (See Section 6.1.2.) However, this participant challenged the discourse of sexual difference and instead reconstructed her own notion of gender based on ‘sameness’, regardless of sexual differences between boys and girls. This reconstruction was emancipatory and enabled her to survive in that environment, as it emphasised the sameness and “*no difference*” philosophy.

In the following narrative the participant narrates how growing up in a polygamous home and a patriarchal society enabled him to construct polygamy as an oppressive gender system for women:

Well, first I am the sixth born in a family of seven, so nearly the last but one. And there were only two girls, the rest were boys, but we did not really grow together very much. So I grew up mainly with my aunt and that aunt of mine, that... aunt was married to a guy who had four wives and I think the experience I saw there and this was a unique character. He had the four wives in [under] one roof and each of these women had children, except my aunt. She was barren and she was the one who was officially married. But because maybe she didn't produce, so the man had three others to make sure he fills up. So my aunt used to collect relatives like me to go and be around full time, to fill up, because there were some roles we were supposed to do: cultivate food, pick coffee and all those things. So growing in this family you could see squabbling every day amongst the children, amongst the women. It was just something that I grew up thinking I

don't think I want to be. Because some of the things really, I even was where you have four or five people, all trying to capture the attention of this man who had so many people to take care of. So that upbringing I think that is the one I can say exposed me a lot to some issues that shaped the way I look at things. (1600:3M)

This gendered lived experience of the participant contributed to his current view of gender as a system with fixed roles for women as reproducers and children as the labour force that “*I don't think I want to be*” part of. The excerpt above turns our attention to the view of women as reproducers and fighters for attention within a discourse of motherhood that could lead to the marginalisation of those who did not fit the expectations created by this dominant discourse (the “*barren*” aunt). His aunt tried to conform to this dominant discourse by “*fill[ing] up*” with relatives.

Apart from drawing on childhood experiences, some women participants raised issues regarding the material conditions of women’s academic experiences to highlight how these had shaped their understanding of gender. It also lends credence to the fact that gender is ‘embodied’ and emphasises the need to address both the practical and strategic needs of women.

But coming back to coming to work, you always realise there are challenges for you to come to work as a woman. First of all there are some simple things like our toilets. They are not separate. You know that in our toilets we don't even have bins for sanitary towels and this is public health. Then we have young girls with babies, we have a little type of crèche where you can have a trained person for these girls, even young men who want to bring their babies and look after them. Then of course at the end of the day, there are the issues during the day, the child sick, you are rushing home to take it to hospital. The man has already got somebody to take care of them. Then residential workshops. You know academia, workshop after workshop after workshop, you know these hotels. A man goes to a workshop, no question. For us women, every time we go for a workshop, you negotiate at home. The husband feels that you have to negotiate for him to be co-operative about your going and him having to look after the family while you are away, and always asking: What are you going to do from there that you should leave your home? So that I do every time having to negotiate everything, while the man takes it for granted. It can be very very stressful.

Then in the evening when we leave here all the men go to doctors' club or academic meeting. That is where they discuss all the projects that are coming here, promotion, everything to do with the career guidance [?]. For you from here you go to fetch the children, to the market, to prepare the meal. Sometimes your husband has brought visitors without telling you, so you are preparing the meal for the visitors. By the time you go to sleep it's like midnight and yet you still have more work to do. You have to prepare for the classes, mark reports, assignments et cetera, you have to access your e-mails, so you see the men progressing and I admit where they are working hard that they have good opportunities. So that is where you see the difference, when you look at the lowest cadre of academia, the women. If you look at the highest, it is the men. (1600:5F)

In this narrative, gender is constructed as a lived experience in terms of sex roles, where there is a perpetual struggle for women in which their practical needs are neglected, in which they are always negotiating, and in which they have to work round the clock in order to catch up with their male counterparts in the workplace. It shows a firsthand experience of the construction of gender roles in the workplace and how these privilege men over women. This highlights the convergence of women's productive and reproductive roles and how these could act to perpetuate patriarchal structures and as a barrier preventing women from 'breaking through the glass ceiling' in the workplace. This construction of sex roles seems to align with assertions by many feminists that traditional gender roles are oppressive for women and that the female gender role is constructed as an opposite to an ideal male role – "*at the lowest cadre of academia, the women,... at the highest, it is the men*". Sex roles are projected as socially determined, with our participant trapped in dual sex roles, resigned to a fixed situation without much evidence of active engagement by her individual agency to challenge or change her situation. Although our participant seemed to have recognised and problematised the negative effects of the construction of sex roles in the workplace, she seemed quite helpless in doing anything about it. Trigiani (1999) captures some of the potential pitfalls and limitations of the sex role discourse narrated by our participant: its rigidity; failure to recognise that traits deemed masculine by a particular society are valued more highly than those labelled feminine; 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 its failure to acknowledge the role of agency in constructing gender roles.

The participant's construction of gender also appears to be foregrounding the issue of the 'double burden of women'. Her sentiments seem to be in agreement with the reference of School 1200's description of the recursive relationship between women's productive and reproductive roles in Chapter 5. The participants' constructions of the double burden of women also support the views of Tamale and Oloka-Onyango (2005) that 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.

Further, the participant's narrative seems to be congruent with standpoint feminism that critiques the absence and marginalisation of women from knowledge making and research and situates women's specific experiences and knowledge in their material world (Harding, 1997; Olesen, 2000). In this case the participant was able to show that her situated experience and thus her 'voice' was different from men's, and it must be heard if women are to challenge hegemonic values (Lorber, 1997). (See also Section 3.2.1.1b.)

6.3 The construction of gender in academic courses

After exploring how the participants constructed gender and what resources they relied on to shape these meanings, the next issue I sought to understand was how they then used their personal constructions to represent gender in the courses and modules that they taught. The following sub-themes emerged from the analysis of this text: courses or modules in which gender was incorporated; gender content of courses and modules; the status of gender in the public health curriculum; and obstacles experienced in the incorporation of gender in curricula.

6.3.1 The taught (operational) curriculum

According to Posner (1995), the operational curriculum refers to the content of the curriculum – what is actually taught by the teachers or the taught curriculum. (See also Section 3.3.2.). In Chapter 5 the findings from the official written public health curriculum were presented, while in Section 6.2.4, the participants' lived experiences related to the hidden curriculum were referred to. Although my inquiry did not include observations of classroom teaching by participants, the operational or taught curriculum was indirectly accessed by means of

participants' reports on their teaching related to gender. Table 6-2 shows the taught courses with gender-related content as reported by the participants.

A few participants did not incorporate gender in any of their courses. In School 1600, where most of the participants had undergone a GM course, only one participant (1600:1F) did not incorporate gender in her courses, while School 2500 had three who did not. Since the participants taught different public health courses, gender was incorporated across this spectrum of courses. These findings differ from the official curriculum where gender was mostly tipped in favour of reproductive and maternal and child health courses (Section 5.3.2.1). In general, gender was mainly addressed as an issue (Section 5.2.2.1b) rather than being incorporated in a common approach to teaching gender. Secondly, it appeared as if most of the participants located their gender content within social discourse, with only a few locating gender within biomedical discourse, as would be expected in statistics and non-communicable diseases. This finding differs slightly from the official curriculum findings, which indicated a much stronger biomedical approach. It also appeared as if participants who were mainly teaching biomedically oriented public health courses found it difficult to incorporate gender into their courses.

However, even though it seemed as if most of the interviewed participants incorporated some gender content in the courses they taught, they reported some challenges they experienced while in this process gender incorporation in the public health curriculum. This is the subject of the next section.

6.3.2 Status of gender within public health curricula

From the way the participants talked about how they dealt with gender in the courses and modules they taught, three sub-themes emerged: gender was not taught by some participants in their courses; gender received low priority; and gender was insufficiently addressed in the public health curriculum. These sub-themes are discussed below.

6.3.2.1 "In my teaching I have not been doing that" – gender as an absent discourse

Some participants from both schools indicated that they did not address gender in the courses and modules they taught.



Table 6-2: Courses with gender content taught by participants and approaches to the teaching of gender

Participant	Course in which gender is incorporated	Gender-related content	Approach
1600:1F	None	None	Not applicable
1600:2M	Statistics	Gender as a statistical and demographic variable – based on male/female differences	Biomedical
1600:3M	Health policy and economics	Gender-responsive policies	Social
1600:4M	Reproductive health Public health programmes	Including men in reproductive health issues Including gender when implementing public health programmes	Social Not clear
1600:5F	Environmental health Ethics and law	Different aspects of gender and health	Social
1600:6M	Environmental health	Gender roles and their impact on the environment	Social
1600:7F	Community health	Reproductive health	Not clear
2500:1F	Health promotion	Gender violence against women and children Gender and HIV – gender issues that affect prevention, PMTCT and stigma	Social Social
2500:2F	Nutrition Monitoring and evaluation	None	Not applicable
2500:3F	Maternal and child health	Not clear but collaborates with gender institute	Not applicable
2500:4F	Human resource development	None	Not applicable
2500:5F	Non-communicable diseases	Obesity and gender power relations Gender and race Gender reflexivity Gender and age Gender and sex	Social Social Social Biomedical Biomedical
2500:6M	Health management Epidemiology	AIDS and gender	Social
2500:7M	Primary health care	Gender equity	Social

In the department not even done that, even as an institute we do not. We do have plans of having a workshop where we try to look at our courses that we all have under the various departments. (1600:1F)

This finding is similar to the finding from the analysis of the official curriculum where gender was also absent, or there was silence on gender in some courses. (See Figure 5-1 and Table 5-5.)

6.3.2.2 Gender “for my thinking, has too low a priority”

The language used by some participants indicated that gender received very low priority in their teaching. They expressed sentiments that showed that gender was glossed over, was not deeply reflected upon in a conscious and systematic way and that there was a lack of conscious effort to address gender – “we do it as a matter of reflex” (1600:4MD); “it didn’t come automatically” (1600:4M); “through some little issues that were raised” (1600:1F); and “we had a bit of brushing around some of these issues of gender” (1600:3F). Assumptions uncovered in such statements are that either gender was not an important discourse in public health, or that staff lacked the know-how to enable them to venture into more depth and in a more systematic way on inclusion of gender in their teaching. Two participants supported these sentiments by saying:

I think we need to think a little more what it means and okay you are designing an implementation programme, public health implementation programme. In the process of designing it, are you thinking about gender issues in order to be able to be more effective? (1600:4M)

Something we know, we take it [gender] for granted as one of the determinants, so if it was important like anything else, we haven’t really come out, because we know it is an important determinant of health. (1600:7F)

The portrayal of gender as a focus with low priority in public health was also supported by findings in Chapter 5, which revealed that gender was neither a core course nor an area of specialisation in the public health curriculum, except in Schools 1700 and 2500. This may

explain why no interview participants from School 2500 related to the idea of gender having a low priority in the curriculum.

6.3.2.3 Gender “seems almost to be the air you breathe and therefore it's not much addressed”

Participant 2500:1F referred metaphorically to the “*air you breathe*” to illustrate the ‘taken-for-grantedness’ of gender in a nutrition module. To this participant, gender issues should come naturally just as nutrition comes naturally. However, the participant’s assertion could lead to insufficient attention to gender in courses.

Other participants expressed similar views about “*the way the content is brought out, they don't try to look at gender issues in a number of things*” (1600:1F). One pointed out that “*[w]e haven't done as much with that since X left, but I think that we would see gender as a structural issue that's very important*” (2500:3F). Another participant acknowledged that gender is an important determinant of health and “*it was something we maybe go into*” but, nevertheless, she confirmed that “*I don't think we really address that [gender]*” (1600:7F).

6.3.3 Approaches to the teaching of gender

Another major issue that emerged when participants talked about teaching gender was about the various approaches they used to incorporate gender in their courses. From the text, it emerged that they used three major approaches in the teaching of gender: gender-embedded or gender-implicit approaches; gender-oriented or gender-related approaches (gender perspective, gender lens); and gender-collaborative approaches (work together, join forces, team up, cooperate with).

6.3.3.1 “It's more embedded than explicit” – gender-implicit curricula

Gender-implicit curricula in which gender was not addressed directly and specifically as an independent course or module were referred to in a variety of ways. Apart from terms such as “*embedded*” or “*implicit*”, one participant used the metaphor of infusion to present issue-based gender knowledge in relation to violence against women.

So that [gender] is infused into the health promoting schools module, into the health promotion module and then I would say there is another person in health promotion, HIV

AIDS, there is a very strong view on violence against women and it's infused in that way.
(2500:1F)

This participant elaborated further that only one of their courses, Gender and Health, was more explicit on gender, while in courses in health and human resource management, “*I think it's tacitly acknowledged*” (2500:1F). Other participants echoed their sentiments by using other phrases such as “*not in a specific way*” (1600:1F) and “*I don't have a deliberate curriculum to teach gender issues*” (1600:3M). By using this language, academic staff members constructed gender as a hidden and invisible discourse.

Two participants also had specific views on the desirability of having gender so visible in the curriculum:

I think it will be more welcomed if it's sort of tacit and embedded, than if it's explicit, although there is no opposition to X's course being brought in. (2500:1F)

I wouldn't think that there should be a special module..., but it's not necessarily having a special module for gender. (1600:2M)

In trying to comprehend why gender was constructed as an implicit and invisible discourse, one can link this to the fact that gender is an underlying rather than an immediate determinant of health, which is deeply seated and therefore not readily visible on the surface. In public health, it is often easier to address the more immediate and readily visible determinants of health, such as those related to reproductive health.

Some participants actually expressed the difficulty of addressing gender in some specific courses. “*Particularly in some courses that are disease related ... in a way it [gender] would come out but not so direct*” (1600:1F). One participant did not see the need for including gender (constructed as sex differences) in all courses:

But you know the other courses I teach, we don't really bring it out. Not that they should come out, but I don't feel there is a need for it to come out. ... Now I am teaching environmental pollution. I don't think there is any need ... to bring out the differences between the sexes, that kind of thing. (1600:6M)

The narratives of the above participants suggest that there are some courses in which it is difficult to teach gender, especially the biomedically oriented courses. This raises the question of whether it is necessary to incorporate gender into all public health courses. (See also the discussion on add-on and integrationist approaches in Section 7.1.2.)

6.3.3.2 *“I would work or go across to gender studies and collaborate” – gender-collaborative approaches*

Participant 2500:3F pointed out that due to her lack of knowledge on gender, she normally joined forces with the gender studies unit to help her out with gender issues. By doing so she introduced an alternative way of teaching gender – through collaboration.

In the above subsections we have seen how participants used different forms of language to express how they dealt with gender in their courses. The participants, however, also raised pertinent barriers to the teaching of gender.

6.3.4 Barriers to teaching gender

When the participants talked about how they dealt with gender in curricula, it became obvious, through the language that they used, that they were pointing out some obstacles that hindered them from effectively teaching gender – *“sometimes people find it hard to really operationalise them”* (1600:3M). The obstacles were categorised as: lack of knowledge, resources and commitment; resistance; and competing priorities.

6.3.4.1 *“Lack of knowledge, skills ... resources and commitment”*

Participants from School 1600 acknowledged that gender was a new concept and they were struggling with conceptual understanding – *“the issues of gender have been a little bit confusing to me”* (1600:4M). Participant 2500:3F acknowledged that the understanding of gender is *“sometimes skewed”*. She listed barriers to the teaching of gender as *“lack of knowledge, skills and resources and commitment”* and expressed specific concern about commitment to the implementation of gender in curricula by arguing that if resources were put aside for the teaching of gender, then it *“would tell me more about their commitment”* (2500:3F).

6.3.4.2 “We cannot introduce change without resistance”

Participants from both schools felt that resistance was a barrier to incorporating gender in curricula. “So they really would like to see that issue being addressed, but of course you can't have something without resistance” (1600:1F).

To incorporate gender one also needed to see to sensitisation and provide convincing arguments for this position. This entails hard work, “a bit of a push”, and perseverance.

What I know is that people support something if they are convinced. If somebody doesn't present a good case, that case is likely to lose. That's what I know. (1600:2M)

I would say it will take a bit of a push ... So I do think that if you raise consciousness, people respond ... But I would say it's a relatively responsive environment, but there probably has to be some quite hard work too. (2500:1F)

6.3.4.3 Competing priorities

A participant from School 2500 gave a detailed account of how other competing priorities in curricula made gender to be relegated to the backburner:

So I would say it's a need, but I also – I can see the tension that we face, because a generic curriculum has been put forward under a lot of pressure and in a way the dust is just settling. We have had a first evaluation by a public health expert who pointed to some gaps around communicable diseases. A lot of the African country users that are using our course, are needing malaria, are needing a stronger orientation to communicable diseases in our curriculum. So, in a way that's one of the first responses. And the mother and child issue was also identified as a gap and that will be gaining from them in the next couple of years. Issues of equity and moving from the medicalised model to the health promotion, preventive model, were the priorities and embedded in that equity move is gender. But in the South African context where the curriculum was formulated to try and change the health system for the South African black population at large, another agenda gained priority and I would say the next 10 years might be when one can refine and actually look at issues like gender more consciously and try and pull

in, because we have a gender-equity unit on campus and we have a women and gender studies grouping on campus, who run a post-graduate course and with who[m] we talk quite a lot, because we suffer similar problems. (2500:7M)

6.4 Conclusion

The findings presented in this chapter have shown the importance of ‘mini-narratives’ in the production of gender knowledge and how forms of subjectivity were constituted and taken up within discourses on gender. It also showed how, to a large extent, gender is a lived experience shaped by different contexts, and that gender sensitivity does not automatically mean that gender will always be included in the curriculum.

In the next chapter, the findings of this chapter and Chapter 5 will be interpreted and discussed within a poststructuralist framework.

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.

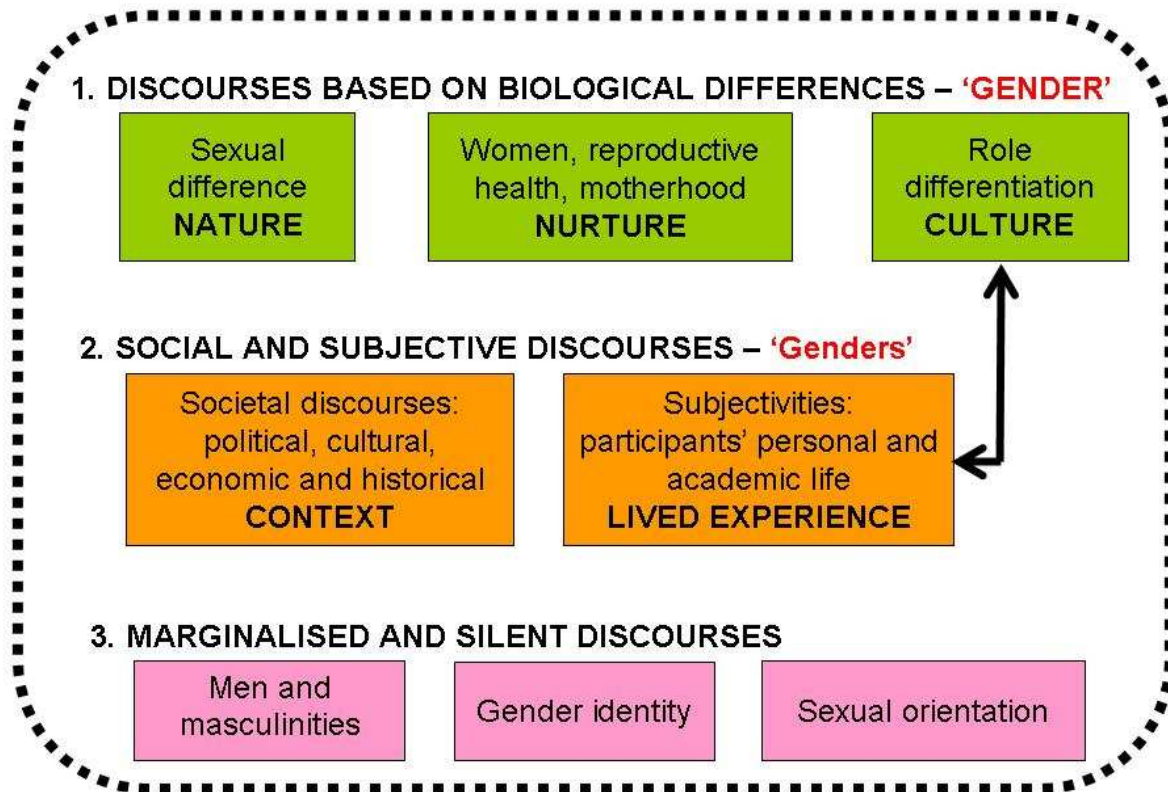


Figure 7-1. Emerging gendered discourses

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*.

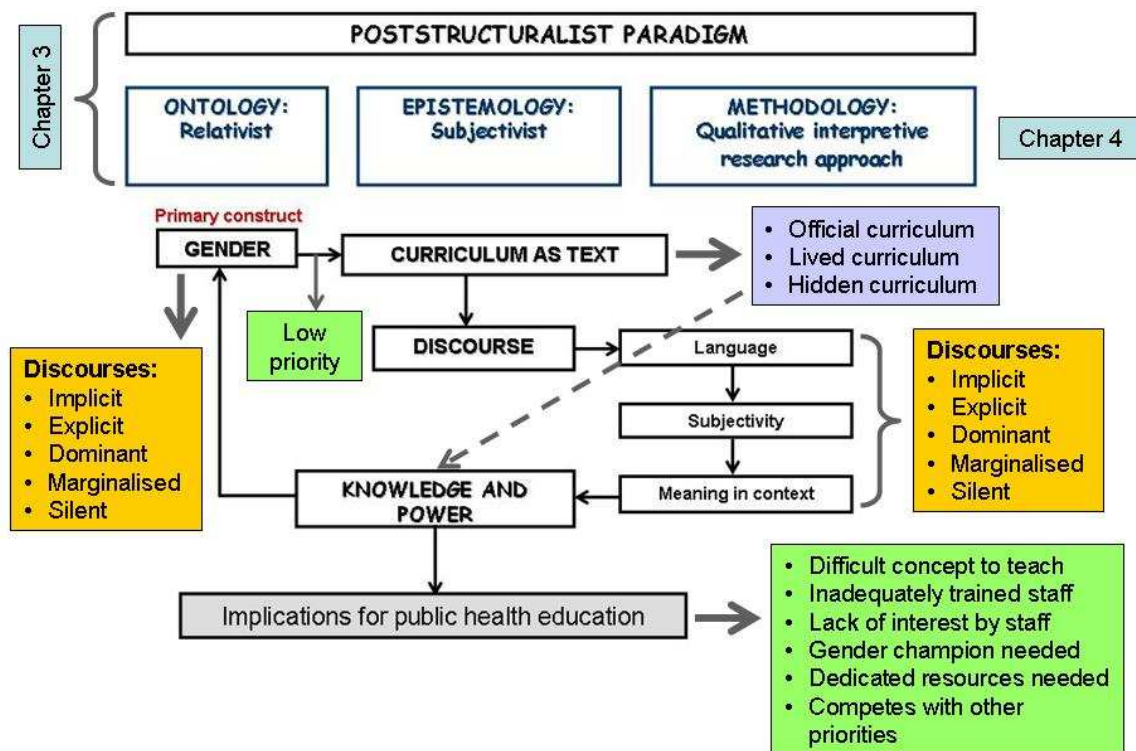


Figure 7-2: The bricolage

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”.

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Appendix 1: Description of schools used as case studies

1 Summary of the two schools

The table below gives a summary overview of the characteristics of the two schools of public health selected as case studies in this enquiry. The table is followed by a more detailed description of these characteristics.

Characteristic	School 1600	School 2500
1. Country background	<ul style="list-style-type: none"> • In Eastern Africa • Women-friendly government • Gender-sensitive constitution • Ministry of Gender BUT society is <ul style="list-style-type: none"> • male dominated • deeply rooted in patriarchal tradition 	<ul style="list-style-type: none"> • In Southern Africa • Strong and gender-sensitive constitution • Gender Commission • Equity and transformation policy • History of racial and gender discrimination
2. University policies	<ul style="list-style-type: none"> • Gender mainstreaming 	<ul style="list-style-type: none"> • Gender equity and transformation
3. Departments & programmes related to gender	<ul style="list-style-type: none"> • Department of Women and Gender Studies 	<ul style="list-style-type: none"> • Women and Gender Studies Programme
4. School of Public Health	<ul style="list-style-type: none"> • A School of the College of Health Sciences • Five departments: <ul style="list-style-type: none"> - Health Policy Planning and Management - Epidemiology and Biostatistics - Disease Control and Environment Health - Community Health and Behavioural Science - Community Health and Behavioural Science - Centre for Quality Health • Only one qualification, a Masters of Public Health (MPH) 	<ul style="list-style-type: none"> • A School of the Faculty of Community and Health Sciences • Seven streams: <ul style="list-style-type: none"> - Health promotion - Health research - Health information systems - Health management - Human resources development - Nutrition - General public health • Seven MPH qualifications offered in the above streams
5. Interview participants	<ul style="list-style-type: none"> • 3 females • 4 males 	<ul style="list-style-type: none"> • 5 females • 2 males

2 School 1600

2.1 Country background in relation to gender

School 1600 is located in an East African country that is perceived to have a women-friendly government and a gender-sensitive constitution that commits the country to affirmative action in the workplace, freedom from sexual discrimination, and economic rights for women. In addition, the government has established a Ministry of Gender, although it is said to have far less financial resources than other departments. However, it is also perceived that all these efforts are all for political expediency, as there seems to be little evidence of gender justice delivery. In general, the society is said to be male dominated and have a deeply rooted patriarchal tradition, a situation that hampers the implementation of gender equality policies. The women's movement in the country has been reported to be episodic and erratic, organised in terms of an issue-based and crisis approach, leaving it vulnerable to co-optation.

2.2 The university and its gender-mainstreaming policy

The university in which the school is located is one of the oldest and most prestigious universities in Africa. It became an independent national university in 1970, offering its own undergraduate and postgraduate courses. The university has adopted an institution-wide gender-mainstreaming (GM) approach for the attainment of gender equality on the campus. The enactment of the GM policy is attributed to the establishment of the Women's and Gender Studies Department in 1991, which lobbied for such a policy by engaging national policy-makers, university managers and other stakeholders.

At this university, GM is regarded as a strategy for making women's as well as men's concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes for development. The reported ultimate goal of GM is gender equality and women's empowerment.

In this regard, the university launched the Gender Mainstreaming Programme in 2001 with the key objectives of promoting and advocating for the enactment and effective implementation of gender-responsive policies in the various functions of the university to include teaching and learning, research, knowledge transfer, partnerships and networking,

governance and administration, students and staff welfare, data management and the organisational culture. Two key GM policies that were developed and implemented in 2006 were the sexual harassment policy and the 1.5 points scheme. The sexual harassment policy is a regulatory framework through which sexual harassment against students and staff can be prevented or redressed in case it occurs. It is aimed at tackling acts of sexual harassment at all levels within the structures of the university. The 1.5 point scheme is an affirmative action policy where 1.5 points are awarded to female A-level applicants to the university in order to increase the participation of females admitted to the university.

Some of the reported challenges experienced by the GM unit at this institution are that there are few staff on the ground and the workload is overwhelming, leading to backlogs. Due to this there is an over-reliance on consultants and donor funding, which is not sustainable. In order to expand and increase the visibility of the unit it will require an increase in personnel in the right numbers, qualifications, and interest in gender in order to address these challenges. Other challenges include the commitment of actors involved and the attitudinal change, both at individual level and collectively for the institution

One of the main objectives of the GM unit is to support GM in teaching and learning through engendering of the university curricula. Therefore the University's GM combines both academic and institutional interventions.

2.3 The Department of Women and Gender Studies

The university also has a Women and Gender Studies Department. It was established in 1991 as a department of the Faculty of Social Sciences. The Department of Women and Gender Studies is a multidisciplinary academic unit that strives to address gender and development issues from an African perspective at both the academic and community levels. The department offers undergraduate and postgraduate degrees in women and gender studies, as well as a number of short or tailor-made courses to the local and international community.

2.4 The School of Public Health

At the university, the School of Public Health (SOPH) is located in the College of Health Sciences, which is headed by a dean and two deputies for research and education,

respectively. The faculty employs problem-based learning and community-based education and services in its teaching activities.

The SOPH evolved from the Department of Preventive Medicine in the medical school into the Institute of Public Health in 1974. In 2000 it became a fully-fledged autonomous Institute of Public Health with five departments: Health Policy Planning and Management; Epidemiology and Biostatistics; Disease Control and Environmental Health; Community Health and Behavioural Science; and Regional Centre for Quality Health. In 2007 it became a School of the College of Health Sciences.

With regard to gender, the School responded to the Gender in Education and Training (GET) questionnaire. (See Section 2.2.2.7c.) It indicated that it did not have a gender course and on this basis was chosen for a case study. (See also Section 4.2.2.2 and Figure 4-2.) However, during the time of the interviews, it was discovered that the university had just introduced the gender-mainstreaming policy and that most of the respondents had attended a GM course with the aim of sensitising them to gender issues and encouraging them to mainstream gender in their teaching. However, at the school, there was no established gender course in public health and the lecturers were trying to incorporate gender according to the limited knowledge they had, as described in Section 6.3.2. From the interviews it seemed as if they found GM an abstract construct that they were unable to apply in their own courses.

2.5 The interview participants

A profile of the participants was given in the introduction to Chapter 6. (See also Table 6-1.)

3 School 2500

3.1 Country background in relation to gender

School 2500 is located in Southern Africa. The country's history was steeped in institutional racism where rights, life chances and the distribution of goods and services were predicated along racial lines. More importantly, it is reported that respect for the dignity of individuals was determined by the colour of their skin and, further within the various racial groupings, by their gender designation. In contrast to the country of School 1600, there was thus a double layer of discrimination along race and gender lines. The socio-cultural dictates of all groups defined women to be inferior to men and, as such, assigned to them the position of minors in both the public and private spheres of life. In the private sphere, women were less likely to lead in decision making. In most interpersonal relationships men had more power. This historical legacy of patriarchy influenced essential informal and formal human relationships with a marked impact at the workplace.

The country has a strong constitution that is also gender sensitive. It established a Commission on Gender Equality, whose role it is to advance gender equality in all spheres of society and make recommendations on any legislation affecting the status of women. The Commission aims to transform society by: exposing gender discrimination in laws, policies and practices; advocating changes in sexist attitudes and gender stereotypes; and instilling respect for women's rights as human rights.

Because of its history, this country adopted an intense equity and transformation policy for the achievement of gender equality or transformation rather than mainstreaming adopted by the previous case study. The country has an Employment Equity Act to monitor appointments in order to redress imbalances of race and gender.

3.2 The university and its gender-equity policy

The university in which the School of Public Health is located was established in 1959 along racial lines for a designated racial group. In 1970 the institution gained university status and was able to award its own degrees and diplomas. In line with its country policy, the university also adopted a gender equity and transformation approach rather than mainstreaming, with the

express purpose of redressing past injustices along race and gender lines. A campus-wide Gender Equity Unit was established to redress these injustices, some of which included fighting for the participation of black women in academia and the improvement of their terms and working conditions.

3.3 The Women and Gender Studies Programme

The university also has a Women and Gender Studies (WGS) Programme, which was founded in 1995. It is an interdisciplinary programme based in the Faculty of Arts and aims to promote scholarship on gender issues in the country and to contribute to the challenge of gender transformation in the university and in society at large. The WGS Programme grew out of the university's staff and student opposition to gender inequalities and gender-blind teaching and research in the early 1990s. At the time, radical women staff and students, through the Gender Equity Unit, coordinated activities such as an annual gender studies winter school and lobbied for university policies and procedures that address gender discrimination on campus, campus-wide awareness, and response to gender-based violence.

The WGS Programme offers both undergraduate and postgraduate tuition. Students may enrol for elective undergraduate modules or major in Women's and Gender Studies. The WGS Programme also conducts a wide range of research with particular focus on sexualities, cultural representations of gender, femininities and masculinities, and feminist pedagogies.

3.4 The School of Public Health

The School of Public Health (SOPH) is located in the Faculty of Community and Health Sciences, which comprises a multi-disciplinary team whose aim is to advance the transformation of existing health and welfare services in the country. The SOPH postgraduate programme aims to equip health and social service professionals with the knowledge and research skills to understand the determinants of the health of populations, and to be competent to plan, implement, manage and evaluate health and social programmes.

The SOPH was established in 1993 as the Public Health Programme to strengthen education and research in public health and primary health care at the University and to build capacity in the health services. In 2000, the SOPH staff refined the educational programme into a four-

level Postgraduate Programme in Public Health offered through contact and distance learning. It comprises of a Postgraduate Certificate (PG Certificate), a Postgraduate Diploma (PG Diploma), a Masters (MPH) and a PhD in Public Health. The Programme is accessible to students from all the provinces of the country, countries on the African continent and even from other continents. To date, students have registered from South Africa, Namibia, Malawi, Uganda, Swaziland, Lesotho, Zambia, Zimbabwe, Botswana, Niger, Kenya, Nigeria, Burkina Faso, Somalia, Central African Republic, Senegal, Rwanda, Tanzania, Cameroon, Ethiopia and countries beyond Africa.

With regard to gender, the school had responded in the Gender in Education and Training (GET) questionnaire. (See Section 2.2.2.7c.) It indicated that it had a gender course and on this basis was chosen as one of the case studies. (See also Section 4.2.2.2 and Figure 4-2.) However, during the interviews it became apparent that even though this school had a gender course on paper, there was no person to teach it at the school and they got somebody else from a sister school to teach for them. Some of the lecturers were trying to incorporate gender according to the limited knowledge they had that was informed by their own gendered lived experiences. (See Section 6.3.2.)

3.5 The interview participants

A profile of the participants was given in the introduction to Chapter 6. (See also Table 6-1.)

Appendix 2: Information leaflet and informed consent

AUTHORISATION TO PARTICIPATE IN A RESEARCH PROJECT

TITLE OF STUDY: A DISCOURSE ANALYSIS OF GENDER IN THE PUBLIC HEALTH CURRICULUM

1) THE NATURE AND PURPOSE OF THIS STUDY

We are doing a study on the representation of gender in the Master of Public Health curriculum in Africa. The aim is to gain a deeper insight into the different ways in which gender is conceptualised, experienced and thus represented in the public health curriculum. We kindly request your participation in this study

2) EXPLANATION OF THE PROCESS

This study involves interviews with key informants at your institution regarding their understanding of public health and gender, and the courses and modules they are teaching. If you give permission, we would like to audiotape the interview in order to ensure that we capture all the important information that you share with us.

We will also request copies of your course outlines, detailed descriptions, and any other curriculum documents you may have at your disposal.

3) RISK AND DISCOMFORT INVOLVED

Normally there is no risk and discomfort involved in interviews like this. However, we will use about one hour of your time. Should you feel any question is causing discomfort, you are not obliged to answer.

4) POSSIBLE BENEFITS OF THIS STUDY

The findings of this study will provide an overview of the way in which gender is represented in the public health curriculum in Africa. This will provide academics with valuable information for future policy decisions and curriculum development, especially with regard to the role of gender as a determinant of health status.

5) PARTICIPATION

If you do not want to participate in this study, it will in not in any way prejudice you nor your institution in benefiting from the findings of the study.

You may at any time withdraw from this study.

6) INFORMATION

If you have any questions concerning this study, please contact: Mrs Mary Mwaka. Tel: +27 12 841 3510 or e-mail: mary.mwaka@up.ac.za.

7) CONFIDENTIALITY

All information obtained whilst in this study will be regarded as confidential. Audiotapes will be kept under lock and key at our SHSPH offices, and will be destroyed after completion of the data analysis.

Results will be published or presented in such a fashion that participants remain unidentifiable.

8) CONSENT TO PARTICIPATE IN THIS STUDY.

I have read the above information before signing this consent form. The content and meaning of this information have been explained to me. I have been given opportunity to ask questions and am satisfied that they have been answered satisfactorily. I understand that if I do not participate it will not prejudice me or my institution in any way. I hereby volunteer to take part in this study.

I give permission that the interview may be audio taped: Yes/No

I have received a signed copy of this informed consent agreement.

.....
Name of participant Signature Date

.....
Name of investigator Signature Date

.....
Name of witness Signature Date



Appendix 3: Interview guide

Domain	Themes or Sub domains	Prompt Question	Probes	Other Issues to Explore/Time
Training in public health	Area of specialisation Social aspects of health - which Gender in the curriculum Training in gender	Tell me about your training in public health	<ul style="list-style-type: none"> • Where did you train? • How long ago was that? • What courses did you cover in the curriculum? • Do you think what you learnt then is still the same as what you are teaching? • If so, in what ways? • Which area of public health did you specialize in? • Did you cover what you would consider are social aspects of health? • If so, which social aspects do you remember being addressed? • Have you received any specific training in gender? • If so, which aspects or issues do you remember being addressed? 	10 min
Understanding of public health	Concept of public health Core domain of public health curriculum Other in public health	What in your view is your understanding of the concept of “public health”?	<ul style="list-style-type: none"> • What is public health? • To what extent did your training shape your understanding of the concept of public health. • Would you say your understanding of public health has changed since the time you trained? • Is so, in what ways? What factors have played a role in changing your conception of public health? • What in your opinion are the core domains of public health curriculum • What do you consider to be other relevant domains of public health? • Where in your opinion would you place gender within the public health curriculum 	10 min
Gender	Understanding of gender What has shaped this understanding	What in your opinion does gender mean?	<ul style="list-style-type: none"> • What do you think has shaped this understanding? • In what way has culture shaped this understanding / socialisation? • What about your ethnicity? • What about religion? • What about education? 	



Domain	Themes or Sub domains	Prompt Question	Probes	Other Issues to Explore/Time
	Lived experiences Institutional/departmental view and policies of gender		<ul style="list-style-type: none"> • Are there any experiences in your life that make this concept stand out for you? • Is this understanding reflected in any way in your courses/modules? How? • Do you consciously or unconsciously include /consider gender concerns when planning your teaching? • If so, what do you teach about gender? • Why have you chosen or not chosen to consider gender in your curriculum? • Would you say your institution gender promotes and supports gender equality • If so, in what ways? • In your opinion, are you aware if your institution has any gender sensitive policies and programmes? • If so, which are they? • Would you say your department promotes and supports gender equality • If so, in what ways? • In your opinion, are you aware if your department has any gender sensitive policies and programmes? • If so, which are they? • Would you say that your institution’s support of, or lack of gender sensitive policies and programmes encourages or discourages you from considering gender issues in your curriculum? 	How concept of gender has changed over time <i>10 min</i>
Gender role identity	Gender roles Masculinity Femininity “Doing gender”	What does being a woman / man mean to you?	<ul style="list-style-type: none"> • Are you always conscious of your identity as a man/woman? • What does it means to be a woman/man? • Does being a man/woman influence your course content? • As a man/woman, what curriculum content would you emphasize? • As a man/woman, would you include gender issues in your curriculum? 	<i>10 min</i>



Domain	Themes or Sub domains	Prompt Question	Probes	Other Issues to Explore/Time
Gender in curriculum	<p>Modules/courses taught</p> <p>Is gender addressed?</p> <p>Why and how?</p> <p>Why not?</p>	Tell me more about the courses which you teach	<ul style="list-style-type: none"> • Who decides on the content of your courses/modules? • Would you say that your courses/modules contain any social aspects of health? • If so, which aspects? • Would you say that your courses/modules contain any gender aspects? • If so, which aspects? • If yes why included? • If no, why not? • Have you had any experiences / problems / successes with including gender in your modules/courses? • In your opinion, are you aware if gender issues are being addressed in other courses / modules? • Are you aware of any staff member who is trying to advance gender issues in health / curriculum? 	10 min
Construction of the public health curriculum	<p>Lived experiences in the construction of the curriculum</p> <p>Dominant and alternative discourses</p> <p>Knowledge and power issues</p> <p>Organisational support</p>	Could you please take me through the process of how the curriculum is developed here.(Focus on courses and modules.)	<ul style="list-style-type: none"> • Who chairs the curriculum development committee? • Which stages does new curriculum go through? • What would you say are the core courses of public health curriculum at this institute? • Which would you say are electives? • Who decided on which should be core and which electives? • Which would you say are those that don't really have to be taken? • Have you participated in any curriculum development/review process? • Please relate your experience. • What role do you think you played? What did you argue for? • Do you think your ideas were incorporated into the curriculum? 	10 min



Domain	Themes or Sub domains	Prompt Question	Probes	Other Issues to Explore/Time
			<ul style="list-style-type: none"> Do you feel the curriculum development is participatory and takes in the view points of all? Are there any views that you think are not taken into consideration? If gender issues would be introduced in the curriculum, would you resist or support it? What position would you take? If gender issues would be introduced in the curriculum, who do you think would resist it most? Men, women, senior members of staff, junior members of staff, older members of staff, younger members of staff? If gender issues would be introduced in the curriculum, who do you think would support it most? Men, women, senior members of staff, junior members of staff, older members of staff, younger members of staff? If gender issues would be introduced in the curriculum, do you think it would receive support at organisational level – faculty leadership, institutional leadership? 	
Gender and public health	Importance of gender in health	Please tell me if you are aware of calls to incorporate gender in public health programmes	<ul style="list-style-type: none"> Are you aware of these calls? In your opinion, are these calls necessary? Are they timely? How would considering gender improve public health? Would you say that the institute in general and colleagues are aware of gender and its importance as a determinant of health status? 	10 min

END

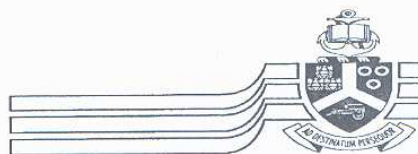
That is my last question.
Thank you for helping us with this study.
The information you gave us will be very useful.

Time end: ----- am/pm



Appendix 4: Approval letter of the Research Ethics Committee, Faculty of Health Sciences, University of Pretoria

FWA 00002567, Approved dd 22 May 2002 and
Expires 24 Jan 2009
IRB 0000 2235 IORG0001762 Approved dd Jan 2006 and
Expires 21 Nov 2008



University of Pretoria
Faculty of Health Sciences Research Ethics Committee
University of Pretoria
Date: 31/10/2006

Soutpansberg Road
MRC-Building
Room 2 - 19

Private Bag x 385
Pretoria
0001

Number : 97/2006
Title : A discourse analysis of gender in the public health curricula in Sub-Saharan Africa.
Investigators : Mary Mwaka; School of Health Systems and Public Health;
University of Pretoria; Pretoria. E: apberg@medic.up.ac.za / kirstie.rendal-mkosi@up.ac.za F: 841 5308 T: 841 3345 C: 0721940127
Sponsor : None
VAT No : None
Study Degree : PhD Public Health

This Protocol has been considered by the Faculty of Health Sciences Research Ethics Committee, on 25/10/2006 and found to be acceptable for the University of Pretoria only.

Mr P Behari	B.Proc. KZN; LLM – Unisa; (Lay Member)
Advocate AG Nienaber	(female)BA(Hons) (Wits); LLB; LLM (UP); Dipl.Datometrics (UNISA)
Prof V.O.L. Karusseit	MBChB; MFGP (SA); M.Med (Chir); FCS (SA): Surgeon
Prof M Kruger	(female) MB.ChB.(Pret); Mmed.Paed.(Pret); PhDd. (Leuven)
Dr N K Likibi	MB.BCh.; Med.Adviser (Gauteng Dept.of Health)
*Dr F M Mulaudzi	(female) Department of Nursing,
*Mrs E.L. Nombe	(female) B.A. CUR Honours; MSC Nursing – UNISA (Lay Member)
*Snr Sr J. Phatoli	(female) BCur (Et.A) Senior Nursing-Sister
*Dr L Schoeman	(female) Bpharm, BA Hons (Psy), PhD
*Prof J.R. Snyman	MBChB, M.Pharm.Med: MD: Pharmacologist
*Dr R Sommers	(female) MBChB; M.Med (Int); MPhar.Med;
Prof TJP Swart	BChD, MSc (Odont), MChD (Oral Path) Senior Specialist; Oral Pathology
Dr A P van Der Walt	BChD, DGA (Pret) Director: Clinical Services of the Pretoria Academic Hospital
*Prof C W van Staden	MBChB; Mmed (Psych); MD; FTCL; UPLM; Dept of Psychiatry

DR R SOMMERS; MBChB; M.Med (Int); MPhar.Med.
SECRETARIAT of the Faculty of Health Sciences Research Ethics Committee - University of Pretoria

* = Members attended the meeting on 25/10/2006.

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Appendix 5: Invitation letter to potential research participants



University of Pretoria

The Director
School of Public Health

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Faculty of Health Sciences
School of Health Systems and Public Health
P.O. Box 667
PRETORIA, 0001 SA
Tel: +27(0) 12-841-3240
Fax: +27(0) 12-841-3328
<http://shsph.up.ac.za>

23 November 2006

Dear

Re: Request for permission to conduct qualitative interviews with academic staff in the School of Public Health, University.

I am a senior lecturer at the School of Health Systems and Public Health, University of Pretoria. At the same time, I am also carrying out my PhD studies in the area of gender and health. My research topic is titled: "A discourse analysis of gender in the public health curriculum in Africa".

The objective of my study is to examine how gender is understood and represented within the public health curriculum by academic members of staff. In order to achieve this objective, I need to carry out qualitative interviews with academic staff in schools of public health. I have purposively selected your school as one of my study sites for these interviews.

The purpose of this communication is to kindly request for your permission to conduct these interviews with academic members of staff at SOPH. Specifically, I am going to ask them for information about their understanding of gender, what forces have shaped this understanding, and how this understanding has in turn shaped whether or not, and how they include gender in their modules/courses. I will also ask them for copies of their course outlines and descriptions, and any curriculum documents they can offer. By participating in this study and answering the questions, they will help to increase and deepen our understanding of how gender is understood and used within the public health sector. I hope that the results of this study will be used to highlight the implications of the multiple ways in which gender is understood, for public health policy and practice.

The interviews will take approximately one hour, and will be audio taped. In addition they will be carried out on a voluntary basis, and each member of staff who agrees to participate will sign a consent form to indicate their willingness to freely participate in the study.

If granted permission, I would like to conduct these interviews between 2006, and 2007, depending on the availability of staff. I would like to interview about 10

members of academic staff, including the director of the school. I have used certain criteria to select the participants, based on the staff data available on the SOPH website.

I would also like to kindly request for a focal person who can serve as a liaison person between me and members of staff, and assist me to arrange the interviews. Some remuneration will be offered in this regard.

Finally, if given permission, I would appreciate an official letter of approval, permitting me to conduct the interviews, as well as analyzing SOPH's curriculum documents, to be submitted to the Faculty of Health Sciences Ethics Committee, of the University of Pretoria.

I trust that you will assist me to achieve my academic objectives.

Yours faithfully,



Mrs Mary Nelly Mwaka
Senior Lecturer and Project Leader
Gender and Health Project
School of Health Systems and Public Health
E-mail: mary.mwaka@up.ac.za
Tel: +27 12 8413510, Cell: 0721940127
Fax: +27 12 8413328



Appendix 6: An overview of the public health curriculum by area of specialisation, core and elective courses

Areas of specialisation	Core courses	Electives
Hospital administration/management (1200, 2400) Health system/services/policy management (1200, 1200,1800, 2100, 2400) Epidemiology/Epidemiology and disease control/Applied field epidemiology/Epidemiology and biostatistics/ Laboratory management and epidemiology (1200, 2200, 1800, 2100, 1200) Health promotion (1200, 1800, 2100) Occupational health and safety/occupational hygiene (1200, 1800, 2400) Human nutrition (1200, 1800) Population and reproductive health/ Reproductive and family health (1800) Maternal and child health (1200, 2400) Disaster management and preparedness (1200) Health economics (2200) Environmental health/ Environmental and occupational health (1200, 2100) Rural health (2400) Disease control (2100) Health research ethics (2100) Social and behavioural science (1700)	Introduction/principles of public health/learning in public health (1200, 1500, 2100) Special public health issues (1500) Implementing change (1500) Principles of epidemiology/ Applied epidemiology (1200, 1700, 1800, 2200,1600)/Assessing community health needs (1500)/Introduction to health measurement (2100) Basic biostatistics (1200, 1700, 1500, 1800, 2200, 2100)/applied biostatistics and informatics (1600) Research methods/dissertation (1200, 1600, 1700, 1500, 1800, 2400) Quantitative research methods (2200) Social dimensions of health (1200)/Social and behavioural determinants of health (1600, 1500)/Behavioural science (1700)/Public health and society (1800)/Society and health (2100) Health care organization and management (1200, 1700, 1500)/Health planning and management 1600 , 2200, 2100) Computer applications in health (1200) Biological basis for public health and introduction to community (1600, 1700) Health economics and finance (1600) Field study (1600) Communicable and non communicable disease (1600) Principles of health education and training (1600) Family and reproductive health (1600)	Health policy analysis and development (1200) Principles of management (1200) Supplies management (1200) Public health aspects of sexually transmitted infections (1200) Epidemiology and public health policy (1200) Epidemiologic basis of TB control (1200) Injury epidemiology and control (1200) Clinical epidemiology (1200) Environmental and occupational epidemiology (1200) Gender, sexuality and health (1200)/Gender and health (2200, 2500) Women's health and well being (2500) Law and public health Workplace hazard monitoring and control strategies (1200) Occupational medicine (1200) Operations research (1200) Community based rehabilitation (1700) Preventive measures in HIV/AIDS control (1700, 2500) Ethics in public health (1700) Directed studies (1700) Biostatistics 11 (1700) Evidence based health care (2200) Advanced epidemiology (2200, 2500) Epidemiology of infectious diseases (2200) Epidemiology of non-communicable diseases (2200, 2500) Quantitative methods for health economics Macro economics, health and health care financing (2200) Theory and application of economic evaluation in health care (2200) Microeconomics for the health sector (2200) Public health and human rights (2200) Qualitative research methods (2200, 2500) Alcohol problems: a health promotion approach (2500)



Areas of specialisation	Core courses	Electives
General public health (1500, 1600, 1700, 2200)	Demography and population dynamics (1600, 1700)/Principles of demography (2100) Public health nutrition (1600) Health ethics and law (1600) Environmental health (1600, 2100) Occupational health (1600) Human ecology (1700) Public health practice (1700) Introduction to primary health care (2100) No core courses listed (2400)	Children, health and wellbeing: a cultural perspective (2500) Culture, health and illness (2500) Equity and financial planning (2500) Health management II (2500) Health and social change (2500) Health promoting schools: putting vision into practice (2500) Health promoting settings: a partnership approach to health promotion (2500) Health systems research for planning, evaluation and management 11 (2500) Introduction to human resources development in the health sector (2500) Managing human resources for health (2500) Maternal and child health (2500) Micronutrient malnutrition (2500) Monitoring and evaluation in health and development programmes (2500) Public health nutrition: policy and programming (2500) Qualitative research methods (2500) Quantitative research methods (2500) Surveillance of nutrition programmes (2500) Survey methods: designing questionnaires (2500) Using information for effective management (2500) No electives listed (2400)



Appendix 7: Gender as a domain area of knowledge in the components of the public health curriculum

Curriculum component	Compulsory course	Summary of gender related content	School
Area of specialisation			
Social and behavioural science	Gender and health	Relationship between gender and health Socio-cultural, socio-political and socio-economic constructs of gender and how these constructs impact on women and men's health in the developing world. How women and men's health problems develop, are perceived, and are responded to both medically and socially in contemporary society Gender concepts; patriarchy; gender, experience, culture, power, and health; poverty, health and health care, gender and men's health	1700
Core courses	Social dimensions of health – Gender and health	Men, women and children's health	1200
Elective courses	Theories and models of gender and health	Theoretical frameworks of femininity and masculinity, patriarchy and matriarchy and how these apply to gender and health, development and gender research Gender theory	1700 2200
	Gender and health	The impact of gender on health and health care. Specific topics used as examples to examine the impact of gender on health. health topics Global and local patterns in gender and health Strategic and practical approaches in mainstreaming gender	2200 and 2500
		Gender is silent as a domain area of knowledge.	1500 1600 1800 2100 2400



Appendix 8: Implicit representations of gender in the components of the public health curriculum

Emerging gender discourses	School	Area of specialisation	Compulsory, core and elective courses	Summary of gender-related content
THE WOMEN DISCOURSE				
Women and work – productive roles	1200	Health services management	Population, health and development	The recursive relationship between women’s reproductive and productive roles and their health and status
	1200	Maternal and child health	Organization and management of MCH services	Maternity benefits; day care
Women as a vulnerable group	1200	Disaster management and preparedness	Health services for displaced persons	Women as a vulnerable group during disasters
	2100	Health research ethics	Critical issues in health research	Challenges to informed consent in vulnerable communities of women. Challenges to recruitment and retention of diverse and vulnerable communities of women in the research process. Ethical issues in research invulnerable and diverse populations of women and demonstrate means whereby unscrupulous and unethical research in this class of women can be prevented
Women in the life cycle	1700		Gender and ageing	Increasing numbers of ageing women are increasing worldwide – more attention to be paid to ageing women – to ensure that they remain a resource for their families and communities.
Women’s health in developing countries	1700		Women’s health in sub-Saharan Africa	Factors that determine women’s health in sub-Saharan Africa Women’s situation and rights Public health and women’s health Feminist theories, social constructionist theories Compare the situation of sub-Saharan African women with women from other parts of the world including the United States.



Emerging gender discourses	School	Area of specialisation	Compulsory, core and elective courses	Summary of gender-related content
THE WOMEN DISCOURSE				
A holistic approach to women's health	2500		Women's health and well-being	<p>Explore the concept of well-being and the values associated with it, in relation to women's physical, social and mental health.</p> <p>Analyze and reflect upon how a particular aspect of women's health and well-being is enhanced or compromised in a local context</p> <p>Definitions and personal as well as comparative perspectives on women's health and well-being</p> <p>Ways in which women's health can be enhanced or compromised</p> <p>Conceptualizing and analyzing women' health and well-being in relation to parameters of: race, class, age/generation, geographical context, historical context, cultural contexts and sexual orientation.</p> <p>Women's health and well being in terms of : mental health issues, HIV/AIDS, reproductive health and sexuality, women's bodily integrity and social well-being.</p>
Women's reproductive and maternal roles	1200	Human nutrition	Maternal and child nutrition	Women's bodies – Nutritional requirements in pregnancy and lactation
	1200	Maternal and child health	Organization and management of MCH services Applied clinical practice in MCH	Policies and services Women's bodies – conception, pregnancy, abortion, breastfeeding, care of mother during delivery and puerperium, etc.
	1200	Health services management	Population, health and development	Family planning – policies and programmes
	1200		Social dimensions of health	Social issues – ethical consideration of abortion



Emerging gender discourses	School	Area of specialisation	Compulsory, core and elective courses	Summary of gender-related content
THE WOMEN DISCOURSE				
	1500		Special public health issues	<p>Services – maternal and child health/family planning Women’s bodies – breastfeeding, lactation and management, female genital mutilation, violence</p> <p>Adolescent sexuality and related sexual and reproductive health consequences Cultural and biological factors shaping adolescent sexual and reproductive health</p>
	1600			<p>Women’s bodies – fertility indices, effect of fertility Research – reproductive health surveys</p>
	1600		Family and reproductive health	<p>General – awareness of maternal, child health and family public health issues</p>
	1700		Global perspectives in health promotion	<p>Statistical/measurement aspects of reproductive/maternal and child health - reductions in mortality rates, but these impressive gains in maternal and child survival have levelled off in some countries; while in others, the positive trends have even reversed.</p>
	1700		Women’s health in sub-Saharan Africa	<p>Constructs of population health - early marriage, family size, population control (methods of child spacing and decision-making processes). The impact of cultural and religious beliefs on reproductive health and contraception - the main goal of the course is to let students understand a variety of health problems faced by sub-Saharan African women which are often compounded by cultural values and religious principles that undermine decision-making processes on reproductive and other health issues. Women’s bodies - health and illness issues specific to women such as Pregnancy and childbirth, maternity services, fertility in relation to women, reproductive technologies, menopause. Services - use of antenatal and postnatal health services.</p>



Emerging gender discourses	School	Area of specialisation	Compulsory, core and elective courses	Summary of gender-related content
THE WOMEN DISCOURSE				
				Gendered illnesses - risk of sexually transmitted infections, including HIV/AIDS.
	1800		Family planning policies and programs	Programmes, strategies and policies related to the development, organization and management of family planning programs, especially in developing countries. Social, economic, health. and human rights rationale for family planning.
	1800		Public health problems in mother and newborn; prevention of mortality and promoting the health of women, infants and children	Policy and programmatic interventions for preventing, reducing, diagnosing and treating the maternal/prenatal morbidity/mortality.
	1800		Maternal nutrition and reproductive health	Community nutrition in relation to population and development and reproductive health
	2100		Reproductive health epidemiology	Introduce epidemiological principles to reproductive health problems Determinants of reproductive health Maternal health epidemiology Relations between maternal reproductive health and child health Male reproductive health epidemiology Epidemiology of sexually transmitted infections Public health interventions and strategies for the promotion of reproductive health, develop and assess a reproductive health surveillance system



Emerging gender discourses	School	Area of specialisation	Compulsory, core and elective courses	Summary of gender-related content
THE WOMEN DISCOURSE				
	2500		Maternal and child health	Polices and services – comparative US policy on maternal and child health with country XX, maternity services. Women’s and children’s bodies- family planning, HIV/AIDS, prevention of child to mother transmission, maternal and child nutrition (over and under nutrition), Foetal alcohol syndrome and other alcohol related problems, Children with developmental disabilities Social issues - child welfare grants, and other social welfare and poverty alleviation programmes, ADS orphans
Gender as a biological construct	1200		Principles of epidemiology	Person – age, sex, ethnicity, social class, occupation



Appendix 9: Layering and representation of gender within areas of specialisation

Code	Area of specialisation	Module/unit 1 st layer	Topic 2 nd layer	Description with gender content 3 rd layer	Representation
1200	Hospital administration	Human resource management	Personnel management	Gender issues: sexual harassment at place of work, women in management	Explicit
	Health promotion	Theory and principles of health promotion	Key concepts in health promotion	Social and gender inequalities	Explicit
	Health services management	Population, health and development	Women's health	Demographics, health needs, indicators of health status and health care use, interactions among women's social, the recursive relationship between women's reproductive and productive roles and their health and status, economic and health rationale for family planning, implications for policies and programs on women health.	Implicit
	Disaster management and preparedness	Health services for displaced persons Rehabilitation and resettlement of displaced people	Health planning: Family health care	Health care for women and children	Implicit
			Vulnerable groups identification	women, minors, adolescents	
	Human nutrition	Nutrition and primary health care	Maternal and child nutrition:	Nutritional requirements in pregnancy and lactation	Implicit
Maternal and child health	Organization and management of MCH services	Maternal Child Health (MCH) Policy Applications	Key concepts; definitions; needs assessment; planning; organization implementation, monitoring, evaluation and sustainability. Development of MCH services: organization of MCH services; global; national; urban; rural; peri-urban; district approach to MCH service delivery. Needs assessment; planning - goal setting; budget; work plan formulation; funding; staffing; cost benefit analysis. Implementation of MCH programs, Monitoring and evaluation of MCH programs, Research in MCH service delivery (quantitative; qualitative; health systems research).	Implicit	



Code	Area of specialisation	Module/unit 1 st layer	Topic 2 nd layer	Description with gender content 3 rd layer	Representation
			<p>Social and family health aspects of MCH</p> <p>Legal</p> <p>Research</p> <p>Applied clinical practice in MCH</p>	<p>Family violence; child abuse, Parenting</p> <p>Work and women, maternity benefits; day care; maternal education and child health.</p> <p>Research in family and social aspects of MCH - Qualitative, Quantitative</p> <p>Maternal health indicators: ANC, conception, pregnancy - diagnosis, high risk; family planning; maternal nutrition; HIV/AIDS; STI</p> <p>Abortion and ethics: Labour – induction, caesarean section, maternal mortality</p> <p>Perinatal health indicators: Care of mother during delivery and puerperium</p> <p>Labour management: Infective in the puerperium, Psychological problem, puerperal, psychosis.</p> <p>Post-natal depression: Care of the newborn; resuscitation perinatal care of the mother and baby prematurity low birth weight, birth trauma, congenital malformation.</p> <p>Nutrition and malnutrition Nutrition in pregnancy, Breast feeding, Weaning practices</p>	
1500	No areas of specialisation	-	-	-	-
1600	No areas of specialisation	-	-	-	-
1700	Social and behavioural aspects of health	Gender and health	-	The main aim of this course is to provide Public Health and Development Workers with the relevant understanding of the role of gender in health and welfare of the populace. The course examines the interrelationship of gender and health. It examines the socio-cultural, socio-political and socio-economic constructs of gender	Explicit



Code	Area of specialisation	Module/unit 1 st layer	Topic 2 nd layer	Description with gender content 3 rd layer	Representation
				<p>and how these constructs impact on women and men's health in the developing world. The central idea of the course, however, is to move beyond a description of specific health problems to critically analyze how women and men's health problems develop, are perceived, and are responded to both medically and socially in contemporary society. In this context, an important theoretical aspect of the course is the development of a socio-medical perspective on health and, specifically, the analysis of women and men's health in relation to their lives and how these experiences are shaped by culture, social institutions and social policies. Some topics under this course are gender concepts; patriarchy; gender, experience, culture, power, and health; poverty, health and health care, gender and men's health.</p> <p>Additionally, it explores the various ways in which the study of gender and health helps Public Health and Development workers to understand women and men's health in a changing world.</p>	
1800	Population and reproductive health nutrition	HIV infection in women, children and adolescents: policies, rights issues and management.	-	Epidemiology of HIV and AIDS. Risk factors and social context for women, children and adolescents including harmful practices. Societal, Biological, political linkages between the epidemic in the three groups. Policy, programmatic and prevention issues. Local and regional factors/issues in control of infections	Implicit
2100	Environmental and occupational health	Environmental Endocrine Disruptors and Health	-	To give information regarding the physiological, reproductive, biochemical, and epidemiological research techniques, including exposure assessment, specific for EDCs, for use on the (sub-) continent	Implicit
	Health research ethics	Public Health, Ethics and Human Rights Critical issues in health research	- -	<p>Understand and accommodate special situations; vulnerable populations, gender and health. Be able to argue for and against ethical dilemmas in resource allocation, gender and environmental health</p> <p>Posses the knowledge and skills to uphold the integrity of informed consent in specific contexts, such as resource poor settings and in different cultures, and with vulnerable populations, for example, children, rural women, the mentally ill and institutionalized populations</p>	Explicit



Code	Area of specialisation	Module/unit 1 st layer	Topic 2 nd layer	Description with gender content 3 rd layer	Representation
	Health promotion	Sexual and reproductive health	-	<p>To familiarize students with the historical development of the reproductive health concept; to expose students to contemporary issues and debates in the field, to help them develop the ability to apply a reproductive health perspective to research strategies, policy analysis, programme planning and or evaluation design.</p> <p>To equip students with both the social science and biomedical approaches to understanding reproductive health issues, and will enable students to gain a deeper understanding of the social and biological factors that shape sexual and reproductive health</p> <p>To understand the genesis of the ICPD and Beijing and specifically to understand the historical development from population control to the current rights approach and the significance of this to the promotion of equity.</p> <p>Identify and discuss the current issues and debates in sexual and reproductive health and rights based on the life cycle approach</p> <p>To understand the social, cultural, political and biomedical dimensions of sexual and reproductive health</p> <p>The ability to plan specific preventive, educational and management strategies as well as plan and implement research in sexual and reproductive health that are gender sensitive and culturally sensitive</p> <p>Recognize the need for multi-sectoral approaches to sexual and reproductive health problems.</p> <p>Confront problems in maternal, adolescent and child health with comprehensive and integrative approaches</p>	Implicit
2200	Areas of specialisation have no gender content	No course with gender content	-	-	Absent



Code	Area of specialisation	Module/unit 1 st layer	Topic 2 nd layer	Description with gender content 3 rd layer	Representation
2400	Maternal and child health	-	-	<p>The MPH in the field of Maternal and Child Health is designed to prepare professionals working in government departments, NGOs, the private sector or academic institutions for leadership positions in the field of Maternal and Child Health. The four modules include Child Health I and II, Maternal and Reproductive Health and Perinatal and Paediatric HIV.</p> <p>The course focuses on developing student's competencies in areas such as critical and analytic thinking, management and communication, policy and advocacy, working with others (including community), and ethics and values. The course is designed to integrate the achievement of these diverse skills into the coursework and assignments. Although the course includes clinical issues (such as diarrhoeal disease, child disability or maternal mortality), the emphasis is on the programmatic dimensions of the critical issues affecting women and children, particularly in resource constrained settings.</p>	Implicit
2500	Maternal and child health and nutrition	-	-	<p>Advocacy for maternal and child health nutrition MTCT programmes for HIV infected pregnant women</p>	Implicit



Appendix 10: Layering and representation of gender within the core courses

Code	Core course	Module/unit 1 st layer	Description with gender content 2 nd layer	Representation
1200	Principles of Public Health	Principles and key concepts in public health	Gender and empowerment	Explicit
	Principles of epidemiology	Descriptive epidemiology	Sex	Implicit
	Social dimensions of health	*Gender and health Moral philosophy	Men, women and children's health, gender aspects in the health profession Ethical consideration of abortion	Explicit Implicit
1500	Special public health issues	Reproductive health and family health	Historical background, activities and organization of maternal and child health services Breastfeeding, lactation and management Women's health and gender issues: female genital mutilation, violence, income generation and empowerment of women, family planning services, family planning and breastfeeding	Implicit Explicit
		Health of school age and adolescence	Adolescence: definition markers significance, adolescent sexuality and related sexual and reproductive health consequences, cultural and biological factors which put adolescents at risk for sexual and reproductive health problems, reaching the out of school of adolescents with health promotion interventions	Implicit
1600	Family and reproductive health	-	Awareness of maternal, child health and family public health issues	Implicit
	Demography and population dynamics	-	Fertility indices, effect of fertility, mortality and migration on age distribution, reproductive health surveys,	Implicit
	Environmental health	-	Gender and environment	Explicit
1700	No gender content in core courses	-	-	Absent
1800	Community nutrition in relation to population and development and reproductive health	-	Nutrition education in child development, maternal nutrition and reproductive health	Implicit
2100	No gender content in core courses	-	-	Absent



Code	Core course	Module/unit 1st layer	Description with gender content 2nd layer	Representation
2200	No gender content in core courses	-	-	Absent
2400	No course descriptions for core courses	-	-	Absent
2500	No gender content in core courses	-	-	Absent

* Gender and health appears in the official curriculum but is not taught due to lack of gender expertise.



Appendix 11: Layering and representation of gender within elective courses

Code	Elective modules/units	Description with gender content	Representation
1200	*Gender, sexuality and health	<p>The principal theory underpinning our understanding of gender/sex, sexual identity and sexual health.</p> <p>Theories: Biological; psychoanalysis and psychology; feminism and political science; philosophy and social construction theories.</p> <p>Health: The relationship between sex and health; sex behaviour surveys, epidemiology of HIV/AIDS and other sexually transmitted diseases, prevention and control of AIDS in relation to gender the importance and place of community based response in relation to gender and health.</p> <p>The unanswered questions: Gender power, notions of desire, social and sexual networks, personhood and power of language and community.</p>	Explicit
1500	No electives	-	-
1600	No electives	-	-
1700	Global perspectives in health promotion	The course is designed to help the student examine the challenges associated with the implementation of Health Promotion activities around the globe with special reference to developing country contexts. It also provides insights into how to design effective strategies within severe resource constraints. Health Promotion interventions have contributed to substantial improvements in the health status of many nations. Systematic motivations of families clearly helped bring about the reductions in mortality rates recorded in many countries. In recent years, these impressive gains in maternal and child survival have levelled off in some countries; while in others, the positive trends have even reversed. Important lessons learned will be discussed.	Implicit
	Theories and models of gender and health	Several theories and models explain the concept of gender and give meaning to gender constructs and terminologies. This course examines, in detail, theoretical frameworks of feminism and masculinity, patriarchy and matriarchy and how these apply to gender health and development in the gender particularly those that apply to gender, health, development and gender research.	Explicit
	Ageing and health	This course aims to impel the recognition of health of ageing women and men and a major public health and development issue, based on the fact that the numbers of ageing women are increasing worldwide. Women's life course beyond age 50 extends for a significant period and is increasing everywhere in the world; that there is a very significant scope for improving the health of ageing women and thus ensuring that they remain a resource for their families and communities, Currently, more than half of the world's women aged 60 years and over are living in developing regions, 198 million compared with 135 million in the developed regions. The percentage of older women and men living in developing regions will grow dramatically in the future, since two-thirds of the women in the age group 45-59 currently live in developing countries as compared with only one third in the developed countries.	Implicit



Code	Elective modules/units	Description with gender content	Representation
	Women's health in Sub-Saharan Africa	<p>The focus of this course is to present a critical review of the various factors that determine women's health in sub-Saharan Africa. Specifically the course will analyse the various constructs on population growth, early marriage, family size, population control (methods of child spacing and decision-making processes), women's situation and rights, and share of changing lifestyles and associated health problems. The course will cover the impact of cultural and religious beliefs on reproductive health and contraception, effects of structural adjustment programs, gender empowerment and changing health care systems in sub-Saharan Africa, theoretical frameworks. Feminist theories, social constructionist theories, Health and illness issues specific to women such as Pregnancy and childbirth, maternity services, fertility in relation to women, reproductive technologies, menopause. .Public health and women's health. ·Public health and men's health, Use of antenatal and postnatal health services, Risk of sexually transmitted infections, including HIV/AIDS.</p> <p>The main goal of the course is to let students understand a variety of health problems faced by sub-Saharan African women which are often compounded by cultural values and religious principles that undermine decision-making processes on reproductive and other health issues. The course will also emphasize some of the emerging changes that have been brought about by the current economic crises as well as changes in gender perspectives in sub-Saharan Africa. Students will have the opportunity to compare the situation of sub-Saharan African women with women from other parts of the world including the United States.</p>	Implicit
	Gender and violence	<p>The main aim of this course is to analyse the impact of cultural and religious beliefs on gender issues as they relate to violence. Topics to be treated in this course include , prevalence of violence by intimate partners, physical, emotional and sexual violence, women's coping strategies and responses to physical violence, demographic factors associated with violence, women's violence against men, women's attitudes towards violence, sexual abuse in childhood, association between violence by intimate partners and women's physical, sexual and reproductive health, women's self-reported health and physical symptoms, injuries caused by physical violence by an intimate partner and , Mental health.</p>	Explicit
1800	Family planning policies and programs.	<p>Introduces issues and programmatic strategies related to the development, organization and management of family planning programs, especially in developing countries.</p> <p>Topics include social, economic, health. and human rights rationale for family planning, identifying and measuring populations in need of family planning services; social, cultural, political and ethical barriers; contraceptive methods and their programmatic requirements; strategic alternatives including and vertical programs and public and private sector services information; education and communication strategies; management information systems and the use of computer models for program design</p>	Implicit



Code	Elective modules/units	Description with gender content	Representation
	Public health problems in mother and newborn; prevention of mortality and promoting the health of women, infants and children.	Maternal and prenatal morbidity. Health care practices utilised to prevent, diagnose and treat the morbidity/mortality. Review of fundamental components of strategies to reduce maternal/prenatal morbidity/mortality including behaviour change intervention. Development of community level intervention including of Chew Tabs etc. Policy and programmatic interventions.	Implicit
2100	Principles of chronic disease epidemiology	Describe the epidemiology of common chronic diseases and the relationships between socio-economic status, age, gender, ethnicity and chronic disease occurrence	Explicit
	Critical issues in women's health research.	<p>Equip students with an awareness and understanding of the ethical issues associated with gender inequity in research as a violation of the principle of justice and also as an affront to women's rights to self determination. Assist researchers and learners to recognize and understand the challenges to informed consent in vulnerable communities of women</p> <p>Equip students with an awareness and understanding of the ethical issues associated with gender inequity in research as a violation of the principle of justice and also as an affront to women's rights to self determination. Assist researchers and learners to recognize and understand the challenges to informed consent in vulnerable communities of women</p> <p>Help learners to and understand the ethical issues associated with research during different physiological stages in the women's life.</p> <p>Identify the ethical issues that from the basis for the inclusion of both genders in biomedical or behavioural research in a way that reflects a thorough understanding of the distributive justice system</p> <p>Identify and develop an understanding of the different cultural and social frameworks diverse communities of women carry in the context of their participation in research</p> <p>Identify and discuss the ethical issues associated with the conduct of research in pregnant and lactating women</p> <p>Identify and discuss the ethical issues associated with studies in women for the development of agents for conception and contraception</p> <p>Identify and discuss challenges to recruitment and retention of diverse and vulnerable communities of women in the research process.</p> <p>Explain gender discrimination in research from a historical perspective and demonstrate an understanding of how world views shape people's conception of gender bias in health research</p> <p>Explain the ethical issues in research in vulnerable and diverse populations of women and demonstrate means whereby unscrupulous and unethical research in this class of women can be prevented</p> <p>Display fair knowledge of the barriers to recruitment and retention of women to participating in research trials and must be able to demonstrate that recruitment remains one of the most challenging and underestimated phases of the research process in women</p> <p>Display a fair knowledge of the different ethical issues associated with research at the different physiological phases in a woman's life</p>	Implicit



Code	Elective modules/units	Description with gender content	Representation
		<p>Display a sound knowledge of local and international guidelines and regulations regarding the inclusion of women in clinical research trials.</p> <p>Formulate a clinical trial protocol which would ensure similar representation of both genders and which is prospectively designed to evaluate potential gender differences</p>	
	Reproductive health epidemiology	<p>Introduce epidemiological principles to reproductive health problems.</p> <p>Topics covered will include determinants of reproductive health. Maternal health epidemiology, relations between maternal reproductive health and child health, common sexually transmitted infections, male reproductive health epidemiology, public health interventions for the promotion of reproductive health,</p> <p>Apply basic concepts of epidemiology and surveillance to reproductive health problems; calculate and interpret measures of disease frequency in reproductive health; develop and assess a reproductive health surveillance system; understand the basic principles of maternal health epidemiology; understand the basic principles of the epidemiology of sexually transmitted infections; understand the determinants of maternal health; understand the public health strategies for the promotion of maternal health.</p>	Implicit
2200	Gender and health	<p>To understand issues of gender and its impact on health and health care. Global patterns in Gender and Health; Gender and Health in South Africa; Men, Gender and Health ; Gender Theory ; Changing practices and mainstreaming gender: Strategic and practical approaches</p> <p>Specific topics will be used to examine the impact of gender on health. These include:</p> <ul style="list-style-type: none"> • Gender and HIV/AIDS • Women, work and health • Gender-based violence • Termination of pregnancy • Gender and work • Gender and mental health 	Explicit
2400	No electives	-	-
2500	*Gender and health	<p>To understand issue of gender and their impact on women's and men's health; to discuss key issues in providing gender-sensitive health services, with a special emphasis on developing countries and South Africa.</p> <p>The course will consist of the following areas:</p> <ul style="list-style-type: none"> • Understand the difference between sex and gender • Understand the impact of gender on the health of women and men: <ul style="list-style-type: none"> - Variation in patterns of health and illness - Inequalities in health status and access to health care between women and men 	Explicit



Code	Elective modules/units	Description with gender content	Representation
		<ul style="list-style-type: none"> • - How the processes shaping these biological and social realities are created and sustained • Analyzing health problems from a gender perspective • Changing practices – mainstreaming gender • Specific topics will be used to examine the impact of gender on health and on the delivery of gender-sensitive health-care services. These include: <ul style="list-style-type: none"> - HIV - Cancer of the cervix - Gender-based violence - Termination of pregnancy - Gender and work 	
	Maternal and child health	<p>A comparative policy analysis of US and South African policies and their impact on maternal and child health will be covered, including but not limited to the following issues in maternal and child health:</p> <ul style="list-style-type: none"> • Family planning • Child welfare grants, and other social welfare and poverty alleviation programmes • HIV/AIDS, prevention of child to mother transmission, aids orphans • Maternal and child nutrition (over and under nutrition) • Foetal alcohol syndrome and other alcohol related problems • Maternity services • Children with developmental disabilities. 	Implicit
	Women's health and well-being	<p>You will explore the concept of well-being and the values associated with it, in relation to women's physical, social and mental health. This exploration is intended to give the opportunity to gain a gendered perspective about health issues and how health issues intersect with power relations in different cultural contexts. You will have the opportunity to compare your views and experiences on this topic with those of other participants from your own geographic location as well as from other geographic locations. The module will culminate with a collaborative group project in which you will analyze and reflect upon how a particular aspect of women's health and well-being is enhanced or compromised in a local context. Some of the topics covered include the following:</p> <ul style="list-style-type: none"> • Definitions and personal as well as comparative perspectives on women's health and well-being • Ways in which women's health can be enhanced or compromised • Conceptualizing and analyzing women's health and well-being in relation to parameters of: race, class, age/generation, geographical context, historical context, cultural contexts and sexual orientation. <p>You will be working in a small group collaboratively to deepen your knowledge of women's health and well being in terms of the points listed above: mental health issues, HIV/AIDS, reproductive health and sexuality, women's bodily integrity and social well-being.</p>	Implicit

* Although Gender and health modules appear in the official curriculum but they are not taught due to lack of gender expertise.



Appendix 12: Naming of women as gendered category

Code	Women as a gendered category	Course
1200	Demographics, health needs, indicators of health status and health care use, interactions among <u>women's</u> social, the recursive relationship between <u>women's</u> reproductive and productive roles and their health and status, economic and health rationale for family planning, implications for policies and programs on <u>women health</u>	Health Services Management
	<u>Women</u> in management	Human Resource Management
	Vulnerable groups: <u>women</u>	Rehabilitation and Resettlement of Displaced Persons
1500	<u>Women's health</u> and gender issues, female genital mutilation, violence, income generation and empowerment of women	Special Public Health Issues
1700	<u>Women's</u> coping strategies and responses to physical violence, <u>women's</u> attitudes towards violence, <u>women's</u> physical, sexual and reproductive health, <u>women's</u> self-reported health and physical symptoms, injuries caused by physical violence by an intimate partner.	Gender and Violence
	<u>Women's</u> life course beyond age 50 extends for a significant period and is increasing everywhere in the world; that there is a very significant scope for improving the health of <u>ageing women</u> and thus ensuring that they remain a resource for their families and communities. The numbers of ageing women are increasing worldwide. Currently, more than half of the world's <u>women</u> aged 60 years and over are living in developing regions.	Ageing and Health
	The focus of this course is to present a critical review of the various factors that determine <u>women's health</u> in sub-Saharan Africa. Specifically the course will analyze ... <u>women's situation and rights</u> , <u>health and illness issues specific to women</u> such as pregnancy and childbirth, maternity services, fertility in relation to women, reproductive technologies, menopause, <u>public health and women's health</u> . The main goal of the course is to let students understand a variety of health problems faced by <u>sub-Saharan African women</u> which are often compounded by cultural values and religious principles that undermine decision-making processes on reproductive and other health issues. Students will have the opportunity to compare the situation of <u>sub-Saharan African women</u> with <u>women from other parts of the world including the United States</u> .	Women's Health in sub-Saharan Africa
1800	Educational issues in pregnancy and <u>women's health</u> .	Population and Reproductive Health



Code	Women as a gendered category	Course
2100	Equip students with an awareness and understanding of the ethical issues associated with gender inequity in research as a violation of the principle of justice and also as an affront to <u>women's</u> rights to self-determination. Explain the ethical issues in research in vulnerable and diverse populations of <u>women</u> and demonstrate means whereby unscrupulous and unethical research in this class of <u>women</u> can be prevented.	Public Health, Ethics and Human Rights.
2200	<u>Women</u> , work and health.	Gender and Health



Appendix 13: Naming of mother and child

School	Area of specialisation	Course	Content
1200	Maternal and child health (<u>MCH</u>)	Social and family aspects of <u>MCH</u> Applied clinical practice in <u>MCH</u>	<u>Maternal education and child health</u> <u>Maternity</u> benefits Research in family and social aspects of <u>MCH</u> <u>Maternal</u> health indicators: <u>maternal</u> nutrition, <u>maternal</u> mortality, care of the <u>mother</u> during delivery and puerperium, care of the <u>mother</u>
1500		Special public health issues	Historical background, activities and organization of <u>MCH</u>
1800		Population and reproductive health nutrition	Public health problems in <u>mother and newborn</u> : prevention of mortality and promoting the health of <u>women, infants and children</u> <u>Maternal</u> and prenatal morbidity and mortality Review of fundamental components of strategies to reduce <u>maternal/prenatal</u> morbidity/mortality including behaviour change intervention HIV infection in <u>Women, Children and Adolescents</u> : Policies. Right Issues and management: Epidemiology of HIV and AIDS: risk factors and social context for <u>women, children and adolescents</u> ; Biological, political linkages between the epidemic in the three groups <u>Women's status/work roles and child care/health</u>
2100	Maternal and child health (<u>MCH</u>)	Critical issues in informed consent Sexual and reproductive health	Vulnerable populations: <u>children, and rural women</u> <u>Maternal reproductive health and child health</u>



Appendix 14: Naming of family as a gendered category

School	Area of specialisation	Course	Content
1200	Maternal and child health (MCH) Disaster management & preparedness	Social and <u>family</u> aspects of MCH Health planning	Influences: <u>Family violence</u> , <u>parenting</u> ; Legal: work and women, maternity benefits, maternal education and child health. Research in <u>family</u> and social aspects of MCH. Health services for displaced persons: Care for women and children: <u>Family health care</u> .
1500		Special public health issues	Gender Issues: Reproductive health and <u>family health</u> .
1700	Social and behavioural sciences	Women's health in Sub-Saharan Africa	Specifically the course will analyze the various constructs on population growth, early marriage, <u>family size</u> , population control (methods of child spacing and decision-making processes)

Appendix 15: Naming of men as a gendered category

School	Area of Specialisation	Course/core/elective	Content
1200		Gender, sexuality and health	<u>Men</u> , gender and health
1700	Social and behavioural aspects of health	Gender and health	Gender and <u>men's</u> health
1700		Women's health in Sub-Saharan Africa	<u>Men's</u> health in relation to public health
2100		Reproductive epidemiology	<u>Male</u> reproductive epidemiology



Appendix 16: The use of “rights” in the curriculum

Code	Course	Content
1700	Women’s Health in Sub-Saharan Africa	Specifically the course will analyse ... women's situation and rights...
1800	Population and Reproductive Health Nutrition	Family planning policies and programme: Topics include economic, health and human rights rationale for family planning... HIV infection in Women Children and Adolescents: policies, rights issues and management
2100	Sexual and Reproductive Health	To understand the genesis of the ICPD and Beijing and specifically to understand the historical development from population control to the current rights approach and the significance of this to the promotion of equity; Identify and discuss the current issues and debates in sexual and reproductive health and rights based perspectives on the life cycle approach
	Public Health, Ethics and Human Rights*	Understand and accommodate special situations; vulnerable populations, gender and health. Be able to argue for and against ethical dilemmas in resource allocation, gender and environmental health
	Ethical Issues in Women’s Health Research	Equip students with an awareness and understanding of the ethical issues associated with gender inequity in research as a violation of the principle of justice and also as an affront to women’s rights to self determination
2200	Public Health and Society	The social analysis of patterns of disease and death: vulnerable groups, human rights and health

*The word “rights” appears in the course name but not in the course description.