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 (IJsselmuiden 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		Feminist activism	Academia in the North
	1970s	1980s	Mid 1990s	1960s to 1980s
Key construct	EQUALITY			Recognition of difference
Focus	• Girls and women	• Power, relations, social structures	• Transforming mindsets and actions • Changing organisational culture	• Understanding identity
Aim	• Equal numbers • Access and resources	• Removal of structural barriers	• Gender-aware policy and practice	• Questioning the stability of gender definitions and knowledge production
Methods / strategies	• Providing access and resources	• Gender policies • Restructuring of institutions • Empowerment of women • Gender mainstreaming	• Guides and toolkits • Integration • Agenda setting	• Deconstruction
Achievements	• Women recognised as important players in the development process	• 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	• Created gender awareness	• Recognised complex social identities • Affirmed subordinated identities
Shortcomings	• Ignored social structures that produce equality • Focus on public sphere and neglect of private sphere	• Measures intended to benefit women specifically can be lost when men are incorporated	• Gender treated as a unitary category • Strong focus on integrationist approach – people and institutions remained unchanged	• 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 (IJsselmuiden 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 interdiscplinarity and multidisciplinarity. 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, these 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 multi-disciplinary (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
• Communicable and non-communicable diseases	• James P. Grant School of Public • School of Health Systems and Public Health • School of Public Health	• Bangladesh • Pretoria, South Africa • Ghana
• Health financing	• James P. Grant School of Public	• Bangladesh
• Health economics • Sociology and psychology	• Schools of public health	• Switzerland
• International health • Biomedical laboratory science • Maternal and child health	• Some schools of public health	• United States
• Tropical health • Microbiology • Occupational health and hygiene • Family health	• High Institute of Public Health	• Alexandria, Egypt
• Nutrition	• High Institute of Public Health • Some schools of public health	• Alexandria, Egypt • United States
• Information and communications technology • Health communications • Research methodology in health and health surveillance	• Sergio Arouca National School of Public Health	• Rio de Janeiro, Brazil
• Health promotion • Health research ethics	• School of Health Systems and Public Health	• Pretoria, South Africa
• Population and reproductive health planning	• School of Public Health	• 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 2500	Gender issues in health Gender and health	**Explicit** representations
1700 1800 2100	Reproductive health Adolescent health Family health Reproductive and family health Sexual and reproductive health	**Implicit** representations – proxy
1200 1500 1800	Social dimensions of health Population, health and development Theories of behaviour change School health education	**Implicit** representations – submerged
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 TUHF'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.