Chapter 5
Institutional representations of gender

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

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

5.1 Structure and content of the MPH curriculum

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

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

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

5.1.1 Purpose of the MPH programme

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

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

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

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

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

5.1.2 A multidisciplinary and interdisciplinary public health curriculum

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

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

5.1.3 Modes of delivery and duration of MPH studies

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

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

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

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

5.1.4 MPH course structure

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

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

5.1.4.1 Volume of learning required for the MPH degree

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

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

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

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

5.1.4.2 Components of the MPH curriculum

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

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

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

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

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

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

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

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

a) Areas of specialisation

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

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

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

[$] School 1700 had only one area of specialisation – Social and Behavioural Science. The other MPH degree is a general one that is composed of core and elective courses.
* School 2200 had only one area of specialisation – Epidemiology. The other MPH degree is a general one that is composed of core and elective courses.
[#] School 2500 had several areas of specialisation as well as a general MPH degree. Courses in the Postgraduate Diploma in Public Health were also included in the analysis.

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

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

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

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

b) Core courses or modules

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

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

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

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

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

* Appendix 4 contains details of course names

c) Elective courses or modules

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

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

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

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

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

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

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

5.2.1 Location and representation of gender at a glance

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

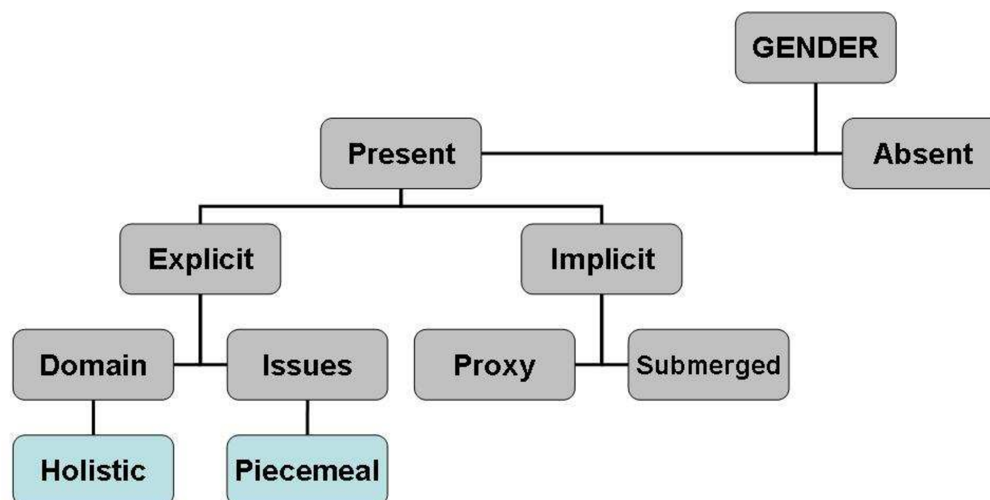

Figure 5-1: Representations of gender in the official public health curriculum

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

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

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

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

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

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

5.2.2.1 Explicit representations of gender

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

a) Gender as a domain area of knowledge

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

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

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

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

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

b) Gender as an issue

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

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

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

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

5.2.2.2 Implicit representations of gender

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

5.2.2.3 'Gender layering'

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

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

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

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

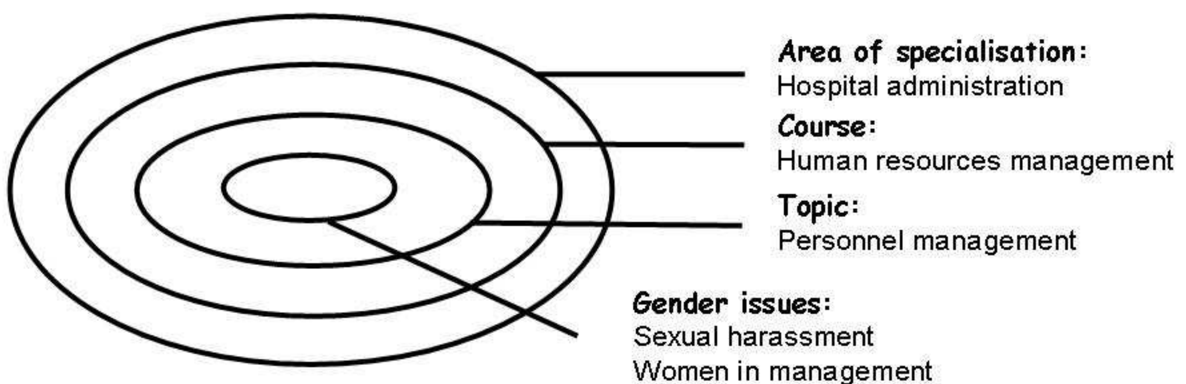

Figure 5-2: Layering of gender at three levels in School 1200

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

5.3 Gender discourses emerging from the public health curriculum

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

5.3.1 Discourses emerging from gender theory

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

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

5.3.1.1 The social construction of gender

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

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

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

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

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

5.3.1.2 Gender, sex and sexuality

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

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

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

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

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

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

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

5.3.1.3 Other binary gender discourses

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

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

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

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

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

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

5.3.1.4 Gender and power

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

5.3.2 The 'women' discourse

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

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

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

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

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

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

5.3.2.1 Reproductive and maternal roles of women

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5.3.2.2 Counter-discourses to reproductive and maternal roles

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

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

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

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

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

5.3.2.3 Women as a vulnerable group

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

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

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

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

5.3.2.4 Violence against women

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

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

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

5.3.2.5 Women's productive roles

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

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

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

5.3.3 "Buzzwords" underpinning gender discourse

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

5.3.3.1 Gender and environment

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

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

5.3.3.2 Gender and empowerment

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

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

5.3.3.3 Gender equality and equity

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

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

5.3.3.4 Gender mainstreaming

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

5.3.3.5 The rights discourse

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

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

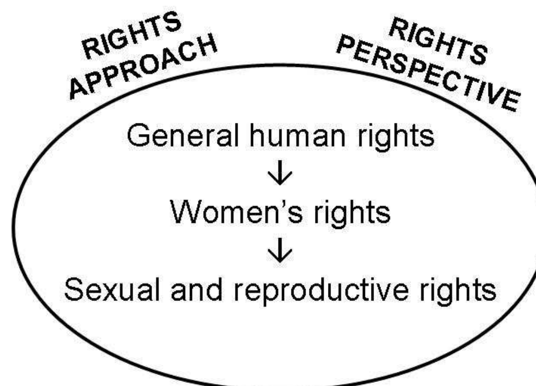

Figure 5-3: Representation of gender and human rights

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

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

5.3.3.6 The discourse of ethics in research

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

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

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

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

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

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

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

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

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

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

5.4.1 Dominant discourses

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

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

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

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

Component	Dominant discourse	Supported by	Issues
Area of specialisation (compulsory courses)	• Women discourse	• Reproductive health discourse • Maternal and child health discourse	• **On** women, **for** women, **about** women
		• Productive roles of women	• Sexual harassment • Women in management
		• Women as vulnerable group	• Vulnerability in times of disaster and during the research process
Core courses	• Reproductive health discourse • Maternal and child health discourse	• Women's bodies • Services, programmes • Social and biological discourses	• **On** women, **for** women, **about** women
Electives	• Women discourse	• Reproductive health discourse • Maternal and child health discourse	• **On** women, **for** women, **about** women
		• Women's health in the life cycle	• Women and ageing
		• Women's health in sub-Saharan Africa	• Stratification – women's health in a specific geographic region
		• Women and research	• Vulnerability during research
		• Women's health and well-being	• Holistic view of women's health

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

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

5.4.2 Silent and marginalised discourses

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

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

Marginalised discourse	Component	Issues
Men's health	Compulsory course (in an area of specialisation) Electives	• Gender and men's health • Male reproductive epidemiology • Men's health in relation to public health • Men, gender and health
Sexuality and sexual health	Elective	• Sexual identity and sexual health • Sexuality and sexual orientation
Gender power relations	Compulsory course (in an area of specialisation) Elective	• Power as a gender concept • Gender power

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

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

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

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

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

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

5.5 Conclusion

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

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

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

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

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

.