ORIGINAL ARTICLE

IMPACTS OF GENDER BIAS

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ABSTRACT

Gender bias are most obvious in the distribution of income and wealth. This reflects women's unequal position in the labour market , their less favorable treatment in most social security systems and their lower status within the household. Discrimination against women is also evident in the political sphere. Their access to power is not commensurate with their numbers, their needs or their contributions as citizens. As well as affecting women's physical and mental health, gender bias also affect the quality of the services they receive. In most developed countries, women are offered equal access to basic health care. However their use of those service may be hindered by a number of gender related factors which are likely to affect poor women in particular. In health organization, gender bias gives significant impact to the evaluation of staff performance, increase stress level and miscommunication. It is also influence the leadership style and also can create 'glass ceiling' phenomenon. Job dissatisfaction , absenteeism and high turn over are also the consequences of gender bias. Alongside the development of gender sensitive methods of routine data collection, gender bias in health research will also need to be addressed. Most biomedical research continues to be based on the unstated assumption that women and men are physiologically similar in all respects apart from their reproductive systems. Other biological differences are ignored, as are the social/gender differences that have such a major impact on health.

Keywords: *Gender Bias, Impact, Social Impact*

INTRODUCTION

Women and men are treated differently in the health sector. Sometimes ,women are treated less favorably than men. Other times women are treated more favorably than men. Although male and female employees may come to the health sector with some preexisting gender differences that provide reasonable explanations for the differential treatment they receive, often differences in the treatment of men and women are linked to the inaccurate perception of differences. For this reason, it is important to document the kinds of gender bias that occur in the health sector and the kinds of psychological processes that contribute to gender discrimination at work. However, it is also our contention that a narrow focus on documenting gender bias and gender discrimination process strictly within the temporal, physical, and social confines of the health sector masks some important differences in the way men and women experience work. It leaves us wanting with respects to explanations and solutions for well-documented differences between men and women on important work outcomes, such as compensation. Understanding variations in the experiences and outcomes of men and women at work requires that we look beyond the immediate work environment to the developmental history that people bring with them to work.

Though biological differences between the sexes are clearly important they can tell only part of the story. Socially constructed inequalities or gender differences between males and females also play a central role in determining whether individuals are able to realize their potential for along and a healthy life. This is because gender divisions have a direct impact on the health needs of the women and men as well as affecting their access to care.

All societies are divided in two along a male/female axis. Those who are defined as female are given primary responsibility for

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household and domestic labour . Conversely males have been more closely identified with the public world, with the arena of waged work and the rights and duties of citizenship. In most societies there are not just differences but inequalities inherent in the social definitions of femaleness and maleness.

IMPACT ON HEALTH CARE SERVICE

Gender bias may influences on health itself. However, we can also identified differences in the ways in which women and men are treated by the health care system. In this section we look at these issues in more depth, exploring the various factors that can lead to inequality between the sexes, both in access to health care and also in outcomes.

We have seen that women have additional needs for reproductive health care and that many face serious obstacles in their attempts to meet those needs. Are the health services women receive comparable to that of men or are there inequalities here too? Do women get services as good as those provided for men or are there inequalities here too? This question is difficult to answer because of the relative paucity of studies directly concerned with quality of care. Moreover, it is difficult to separate gender differences in quality of care from questions of class or race. However, there are consistent indications that gender divisions can be a causal factor in limiting the quality of care women receive[1.]

Women's health advocates have paid particular attention to the subjective dimensions of medical encounters, arguing that the sexism of some doctors combined with the biases inherent in the institution of medicine itself often make them demeaning experiences[2]. Medical knowledge is usually presented as superior, giving women little opportunity to speak for themselves or to participate actively in decision-making about their own bodies. This has been especially evident in the experiences of many black and ethnic minority women who may be given little respect and little opportunity to exercise their own autonomy.

Much of this criticism has focused on reproductive health services where providers are too often concerned only with controlling women's fertility. This has been reflected in failure to communicate information, lack of cultural sensitivity and dehumanizing treatment which itself has affected women's willingness to use the services[3,4]. Until recently, concern about poor quality services for women focused mostly on the personal relations involved in health care. However, this critique is now broadening.

In developed countries in particular, it is now clear that women and men are sometimes offered different levels of treatment for what appear to be the same clinical conditions[5]. In both the UK and the US there is considerable evidence to show that women are less likely than men to be offered certain diagnostic procedures or treatments for heart disease[6.] Studies have also shown that women on kidney dialysis are less likely than men of the same age to be offered transplants[7]. It would appear therefore that there are significant gender differences not only in the quality of caring relationships but also in the effectiveness of the clinical care.

IMPACT ON WOMEN'S DAILY LIVES

Every society around the world assigns gender roles which direct activities and govern behavior for women and men, girls and boys. Mediated by factors such as socio-economic level and other status differences between women and men in a given society, these gender roles exert various degrees of constraints. In general, the more rigid the gender role in a society, the sharper the gender division of labour and the lower the status accorded to women. The roles are rooted in rational responses to a lifestyle no longer adapted to the forces of social change sweeping the world.

These forces, such as globalization and urbanization, are altering the pace and style of life in even the remotest corners of the world. This requires role changes and adaptations in home and working life which have differential gender impacts, particularly as the changes needed may be significant, and the pace of role adaptation is often slow. This disjunction has a tendency to leave resource-poor women caught between two worlds, the new and the old, with responsibilities in both. Any attempt to understand the social dimensions of health and illness must therefore include a systematic analysis of the impact of gender bias on daily life, both inside and outside the home.

For instance, looking at roles inside the home, the physical health consequences of heavy domestic work have not been adequately explored. This is particularly relevant in rural settings where the need for physical weight-bearing is greatest, and women many be required on a regular basis to carry loads that would not be permitted for either sex in countries with

occupational health and safety legislation[8]. Risks from domestic exposure to chemicals in cleaning agents may be poorly understood due to lack of information or illiteracy[9,10]. Kitchens everywhere, but particularly in poor rural and urban dwellings, function as a major focus of activity for women, both in connection with domestic work and income-generating activities undertaken in the home. They pose a wide range of environmental and occupational hazards which are frequently unrecognized or underestimated . Deficiencies in water, sanitation, energy supply, food handling and storage, equipment, design and layout have large affects on women. They mainly affect women in terms of work burden and inconvenience, cuts, burns, falls, exposure to indoor air pollution, and ergonomic problems, but the impact of inadequate kitchen facilities are felt by the whole family in terms of food safety, home hygiene and risk of accidents. Indoor air pollution, a risk linked entirely to kitchen activities, is a contributing factor to acute respiratory infection in infants under five years, and is also responsible for high levels of chronic respiratory and heart disease found in women in some of the world's poorest countries[11,12]. Gender bias gives different priorities in daily life, and can be the cause of intra-household conflict. Development policy has been slow to recognize and respond to these differences, and until recently has tended to prioritize training and interventions aimed at me. This only increases the gender gaps in skills, knowledge, and income-generating power. At the household level, different priorities and decision-making power often operate to the detriment of women.

As well as exposing women to chemical hazards, domestic work itself may be damaging to health. The labour can be extremely hard, requiring intense effort sometimes in extremely difficult conditions and often during pregnancy[13]. Women engaged in subsistence agriculture for example, may have to work very long hours in severe heat with little food or water to sustain them while further domestic labours await their return.

The nature of women's domestic lives may also be dangerous for their mental health. A considerable body of evidence from developed countries indicates that depression is an occupational hazard among women who stay home alone to look after small children[14]. In community surveys many full-time 'housewives' and careers report feelings of emptiness, sadness and worthlessness. Although research is sparse, it is increasingly evident that in other cultures too, women's domestic lives are often the cause of considerable anxiety and depression[15,16]. The reasons for this are complex but include the low status awarded to domestic work, as well as isolation and lack of economic and social support [17,18].

Different evaluation for different roles means that women and men everywhere do not have equal access to the material and emotional resources needed to sustain health. There is considerable evidence to show that in some parts of the world, food, income and medical care may not be distributed according to need[19]. In many societies, cultural norms dictate that males in the household have the principal share of income and wealth as well as higher status and greater decision-making power, with women exerting influence on their decisions to a greater or lesser degree. The 'caring' role carries through to formal employment, where jobs in which women predominate, such as office work, the service industry and nursing, often have a strong caring or service component. This can require 'emotional labour' through the obligation to present positive feelings not being experienced, or to repress negative emotions, which can lead to 'burnout' and feelings of 'loss-of-self' as emotions are denied [20].

These inequalities in influence and power within the household can also affect women's reproductive lives, constraining their ability to make fully informed choices about sexual practices or about fertility control. All societies operate with a set of moral beliefs about the nature of women and men, the purposes of sexual activity and the meaning of parenthood and family life [21,22]. As a result, many women find themselves locked into complex webs of duties and obligations which may severely limit their ability to make autonomous decisions that are central to their future lives.

On top of their domestic and reproductive responsibilities, millions of women are also engaged in economic activities. Official statistics suggest that 40% of women around the world are now in the labour force but this is clearly an underestimate since so much of their work is unrecorded, especially in the informal sector which is predominantly female [23,24]. For some, this labour means an improvement in their general well-being through easier access to basic necessities, enhanced self esteem and wider social networks [25]. However, the circumstances of many women's employment places limits on these potential benefits, especially for those who

are living in poverty with few sources of economic and social support.

Continuing gender divisions in the labour market, and increasing numbers of unskilled women entering the labour force, tend to concentrate more women than men in poorly-paid jobs, many of which combine high levels of responsibility with low levels of control [26,27]. For those in the informal sector there are few controls over hours or conditions of work. Domestic workers in particular are often severely exploited or even enslaved. Even more importantly, women's entry into paid work rarely frees them from responsibility for their own domestic labour. Many are engaged simultaneously in childbearing, care of dependants and a range of economic activities. As a result, their lives in general, particularly their leisure time, are more fragmented than those of men, with the pressures of their multiple roles representing an often greater drain on their mental and physical health, strength and vitality [28,29].

It is the co-existence and co-mingling of numerous tasks which usually fall to the shoulders of women which mainly differentiate their lives from those of men. In holding together the 'double burden' of productive and reproductive activities, frequently without adequate state or family support, the consequences for women can be damaging.

IMPACT ON MEDICAL RESEARCH

There is now a growing body of evidence to indicate that medical research has been a profoundly gendered activity [30]. The topics chosen, the methods used and the subsequent data analysis all reflect a male perspective in a number of important ways [31]. Common problems that cause considerable distress for women have received little attention if they are not central to their reproductive roles. Incontinence, dysmenorrhea and osteoporosis are frequently cited as examples of such neglect [32]. In developed countries the failure to reduce the very high mortality rates from breast cancer has also led to accusations that research into the disease is not adequately funded [33]. This, however, has been changing thanks to organized advocacy efforts by women's organizations.

Gender bias is evident not only in the selection of research topics but also in the design of a wide range of studies. Where the same diseases affect both women and men, many researchers have ignored possible differences between the sexes in diagnostic indicators, in symptoms, in prognosis and in the relative effectiveness of different treatments [34]. This problem was identified in earlier sections in the context of tropical diseases and HIV/AIDS research. Coronary heart disease (CHD) also continues to be seen as a 'male' disease and this is reflected in a number of ways in research design.

Most of the major studies carried out on CHD in the UK and the US have used samples that are totally or predominantly male [35,36] . This is usually justified by reference to the fact that more men than women in these countries die prematurely from CHD. However, it is also the single most important cause of death for post-menopausal women. There are clearly sex differences in the physiology of heart disease but because of the bias in research design, not enough is known about their implications to ensure gender sensitivity either in clinical treatment or in strategies for prevention.

The exclusion of women from research studies has also been justified on the grounds that their cyclical hormonal changes make the results difficult to interpret and/or that female subjects may become pregnant and put the resulting fetus at risk. These problems certainly pose both ethical and methodological challenges but they are not in themselves arguments for the exclusion of women from either epidemiological studies or clinical trials [37]. They merely provide rationalizations for the continuation of practices that significantly limit the capacity of medicine to deal effectively with the health problems of women.

So long as researchers treat men as the norm, the medical care of women continues to be compromised. The results obtained from research on predominantly male subjects is applied with little questioning to (potentially pregnant) female patients [38] . Yet their exclusion from the original studies was grounded both in their reproductive potential and in a presumption of significant physiological differences between the sexes. The end result is that women continue to be treated on the basis of information gathered from research in which drugs may not have been tested on female bodies, in which the precise manifestation of the disease in women may not have been studied and in which women's experiences of both illness and treatment may not have been adequately explored.

IMPACT TO THE HEALTH ORGANIZATION

Impact to the Evaluation of Staff Performance

The most notable illustration that the decisions made in organizations are not systematically biased against women comes from research on performance appraisal. There are many good reasons to believe that the performance appraisals received by men and women should systematically differ (e.g. ,most supervisors are male, stereotypes of jobs usually fit men better than women). It is clear, however, that gender does not have a strong or systematic effect on performance .Performance ratings received by men are highly similar to those received by women. Similarly ,male supervisors tend to assign similar evaluations to those given by female supervisors.

Impact to the Stress Level

Although life can be tough on anybody, it seems that women generally face more stressors than men. A few years ago, a comprehensive survey was conducted to address this question by comparing the stressors faced by men and women in the workplace. Some 900 employees representing 28 different companies were surveyed. Stress was measured by way of a sophisticated questionnaire that assessed various cause and effects of stress. The researchers did, in fact, find that women face more stressors than men. Women show more symptoms of physical distress if the jobs are confront to discriminatory practice. For men , however , symptoms of stress are more likely to result when they face ambiguous demands about what to do or when they work in a highly competitive atmosphere.

Impact to the Communication

When it comes to communication, the basic difference between women and men, is that, men emphasis and reinforce their status when they talk, whereas women downplay their status. Rather, women focus on creating positive social connections between themselves and others. Similarly, whereas men try to exclude confident and boast, thinking of questions as signs of weakness, women tend to downplay their confidence (even when they are sure they are correct) and are not afraid to ask questions.

The implications of this set of differences come to the surface once we point out another findings: People in powerful positions tend to reward people whose linguistic styles match their own. As a result ,in most organizations, where men tend to be in charge, the contributions of women are often downplayed because the things they say tend to be misinterpreted. The women who politely defers to a dominant male speakers at a meeting may come across (to men, at least) as being passive. As a result, her contributions may never come to the table. However d a, the women who breaks from this pattern and interjects her ideas may come across (again, to men) as being pushy and aggressive. And here, too, her contributions may be discounted. In both cases, the communication barrier has caused a situation in which organizations are not only breeding conflict, but they also are not taking advantage of the skills and abilities of their females employees.

Impact to the Leadership

A number of studies that have focused on gender and leadership style have been conducted in recent years. Their general conclusion is that males and females do use difference styles. Specifically , women tend to adopt a more democratic or participative style and a less autocratic or directive style than do men. Women are more likely to encourage participation, share power and information, and attempt to enhance followers' self-worth. They lead through inclusion and rely on their charisma, expertise, contacts, and interpersonal skills to influence others. Women tend to use transformational leadership ,motivating others by transforming their a self-interest into the goals of the organization.

Men are more likely to use a directive, command- and- control style. They rely on the formal authority of their position for their influence base. Men use transactional leadership, handing out rewards for goods work and punishment for bad.

Impact to the Glass Ceiling

As more and more women have entered the workforce, organizations have experienced changes in the relative proportions of male and female employees. In the United States , for example, the workforce in 1964 was 66 % male and 34 % female. By the year 2000 the

proportions are expected to be around 52% male and 48% female.

These trends aside, a major gender-related problem that many organizations face today is the so called glass ceiling. The glass ceiling describes a barrier that keeps women from advancing to top management positions in many organizations. This ceiling is a real barrier that is difficult to break, but it is also so subtle that it can be hard to see. Indeed, whereas 45% of all managers are women, only two females hold the title of CEO among the one thousand largest business in the United States. Similarly, the average pay of women in organizations is lower than that of men. Although the pay gap is gradually shrinking, inequalities are still present. At last, many talented women choose to leave their jobs in large organizations and start their own businesses. Still another factor is that some women choose to suspend or slow their career progression to have children. Many talented women are continuing to work their way.

Impact to Job Dissatisfaction

What are the consequences of gender bias to the job satisfaction ? The main focus are employee withdrawal (absenteeism and turnover) and job performance.

Absenteeism

By not showing up to work and/or by quitting to take new job, people may be expressing their dissatisfaction with their jobs or attempting to escape from the unpleasant aspects of them they may be experiencing. Although voluntary turnover is permanent and absenteeism is a short–term reaction , both are popular but problematic ways of withdrawing from dissatisfying jobs.

Turnover

Another costly form of withdrawal related to job satisfaction is voluntary turnover – quitting one's job. Organizations are highly concerned about withdrawal insofar as it is generally vary costly.

THE IMPACT TO THE COMMUNITY HEALTH

Despite the appearance of female visibility in the health sector, both as users of services and providers of services, the health sector and health services are strongly biased against women. Apart from maternity and reproductive services, aspects of health that are exclusive to women or occur predominantly in women are often not considered to be part of the health services and are not funded through health.

Table 1 below sets out a range of health issues that are unique to women or which are more prevalent in women. As can be seen, many of these fall outside the health sector or the health sector treats them as gender neutral so that the services are not necessarily planned and organized to meet women's needs. It is a mark of women's lack of power in shaping health services that so many of these issues are not included in the health agenda.

Table 1. Health Issues That are Unique and Prevalence in Women

Health Issues Unique to Women	Health Issues More Prevalent in Women
Mental Health: body image, sexuality, sexual expression, need for gender-sensitive training of professionals, forced sterilization	***Mental health***: depression; anxiety, eating disorders, suicide attempts, dementia
Violence against women*:* sexual abuse, rape, wife abuse, sexual harassment	***Violence***: child sexual abuse, elder abuse
Pregnancy and childbirth: teen pregnancy, medicalisation of pregnancy and childbirth, including genetic and prenatal testing, caesarean section, access to services, breastfeeding	
Reproductive & gynae health: safe contraception, infertility interventions, PID, PMS, menstrual disorders, pelvic pain, HIV and childbirth, breastfeeding, incontinence following pregnancy	***Reproductive****:* infertility
Unintended pregnancy*:* access to contraception, male involvement in contraception, safe legal abortion,	***Unintended pregnancy****:* access to sterilization, bias towards female sterilization
Elderly women*:* various forms of incontinence	***Elderly women****:* Osteoporosis, fractures, poverty, dependence, elder abuse
	Poverty*:* more women in lowest income groups, sole parents, elderly
	Care giving: status of health sector workers, unpaid caregivers, double workloads, stress
Occupational health*:* risks during pregnancy, injuries to hormonal system/health through chemicals	***Occupational health****:* RSI, stress, sedentary jobs, sex workers, unpaid work in the home
Female cancers*:* breast, ovarian, endometrial, cervical, access to screening	***Diseases more prevalent in women****:* diabetes, autoimmune diseases (arthritis, lupus, rheumatism)
	Cosmetic plastic surgery
Sexual abuse by doctors/health professionals	

THE IMPACT TO THE VIOLENCE OR INJURIES

Intentional and non-intentional injuries are among the major causes of morbidity and mortality for both women and men at all ages and across all societies. Again, precise figures are difficult to obtain but we know that in developed countries they account for more deaths in people aged 15-44 than all infectious diseases combined. Even in developing countries

they are usually among the top five causes of death at all ages[39] .

Starting with unintentional injuries, we know that men are more likely than women to die in car accidents or to suffer death or disability as a result of occupational hazards. The latter reflects their historical role as the main economic supporters of their households as well as their more frequent employment in the most dangerous industries. It also reflects the way occupational hazards have been defined. Although women have lower rates of unintentional injuries overall, their domestic responsibilities mean that they are more likely than men to suffer injuries at home. These have so far received little attention but there is growing evidence that these occupational injuries may be as important as those in more conventional health sectors.

Intentional injuries too are more common among men, with much of existing violence being directly connected to what is defined as 'masculine' behavior, risk-taking, aggression and the consumption of drugs and alcohol. In the inner cities in the United States for example, homicide is a major cause of death among young males. However, it is not just themselves that men can damage through this type of behavior. Male violence against women, particularly in the home, has many damaging consequences for women's health, including intentional injury..

All acts of violence are 'gendered' irrespective of whether the victim is female or male. In general those who commit the violence are male [40,41] . Both sexes can be the victims of violence but women and men are likely to experience the attack in distinct ways, they are likely to have a different relationship to the perpetrator and the type of harm inflicted is likely to reflect the sex of the person being attacked. When women are the victims of the attack, the perpetrator may well be motivated directly by the desire to demonstrate his own masculinity, to enforce his (male) power and to control the woman, as is usually the case in domestic violence. This has led many experts as what can be seen in table 2 to adopt the term 'gender-based violence' to describe this kind of violence [42].

Table 2. Gender-based Violence (after Heise, Pitanguy and Germain, 1994)

Health consequences of gender-based violence

Non-fatal Outcomes

a. *Physical health consequences*

STDs
Injury
Unwanted-pregnancy
Miscarriage
Headaches
Gynaecological-problems
Alcohol/drug abuse
Asthma
Irritable-bowel-syndrome
Injurious health behaviours (smoking, unprotected sex)

b. Mental health consequences

Depression
Anxiety
Sexual-dysfunction
Eating-disorders
Multiple-personality-disorder
Obsessive-compulsive -disorder

Fatal Outcomes

HIV/AIDS
Suicide
Homicide

CONCLUSION

Lack of awareness by researchers ,policy makers and planners, has frequently resulted in gender bias which often results in prioritization of men in the allocation of resources. This is often unconscious , with ‘gender blindness’ leading both individuals and organizations to ignore the realities of gender as a key determinant of social inequality. This Problem can only be resolved through the development of ‘gender sensitivity’

policies that acknowledge both the reality and also the undesirability of the inequalities between women and men, including the unequal division of labour and power.

The aim of highlighting gender in this way is to move towards a position equality between women and men. This does not, of course, mean that both sexes should be treated in exactly the same way since biological and social differences mean that each will have particular sets of needs. Instead it requires adherence to the principle of equity to ensure that women and men have their different interests recognized and their varying needs met with equality as the desired outcome. Nor does it mean that all women should receive the same treatment . A range of strategies will be needed to achieve equality for different group and this diversity needs to be build into all policies designed to promote equality both between women and men and among women themselves.

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