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## Intersectionality and gender mainstreaming in international health: Using a feminist participatory action research process to analyse voices and debates from the global south and north

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### ABSTRACT

Critiques of gender mainstreaming (GM) as the officially agreed strategy to promote gender equity in health internationally have reached a critical mass. There has been a notable lack of dialogue between gender advocates in the global north and south, from policy and practice, governments and non-governmental organisations (NGOs). This paper contributes to the debate on the shape of future action for gender equity in health, by uniquely bringing together the voices of disparate actors, first heard in a series of four seminars held during 2008 and 2009, involving almost 200 participants from 15 different country contexts. The series used (Feminist) Participatory Action Research (FPAR) methodology to create a productive dialogue on the developing theory around GM and the at times disconnected empirical experience of policy and practice. We analyse the debates and experiences shared at the seminar series using concrete, context specific examples from research, advocacy, policy and programme development perspectives, as presented by participants from southern and northern settings, including Kenya, Mozambique, India, the Democratic Republic of Congo, Canada and Australia.

Focussing on key discussions around sexualities and (dis)ability and their interactions with gender, we explore issues around intersectionality across the five key themes for research and action identified by participants: 1) Addressing the disconnect between gender mainstreaming praxis and contemporary feminist theory; 2) Developing appropriate analysis methodologies; 3) Developing a coherent theory of change; 4) Seeking resolution to the dilemmas and uncertainties around the 'place' of men and boys in GM as a feminist project; and 5) Developing a politics of intersectionality. We conclude that there needs to be a coherent and inclusive strategic direction to improve policy and practice for promoting gender equity in health which requires the full and equal participation of practitioners and policy makers working alongside their academic partners.

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### Introduction

Gender mainstreaming (GM) has been the officially agreed strategy to promote gender equity in health internationally for the last fifteen years, after being adopted at the Fourth World

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Conference on Women in 1995 and ratified by the UN in 1997. Broadly speaking, GM can be understood as “a deliberate and systematic approach to integrating a gender perspective into analysis, procedures and policies” (OECD, 2000, cited in Hankivsky, 2005, p.980). It has always been an “essentially contested form of feminist politics and policy” (Walby, 2005a, p.463), but critiques have gathered pace as learning from implementation has emerged. To date a critical mass of evaluation and comment has reached the verdict that GM has had a limited impact, at least in part because of critical flaws in its conception (Hankivsky, 2005; Daly, 2005; Aasen, 2006; Sundari Ravindran & Kelkar-Khambete, 2007; Walby, 2005b; Zalewski, 2010). This paper aims to contribute to the debate on the implications of this failure for future action for gender equity in health, drawing on experiences shared at a seminar series that aimed to review GM in international health.

### *Critiques of gender mainstreaming*

GM has been interpreted in a range of ways in its implementation in both the north and south, reflecting different interpretations of gender equality as well as the different ‘mainstreams’ – varying social, political and economic contexts (Walby, 2005a). For example, the requirement within EU member states to implement gender mainstreaming within economic and social policies is interpreted rather differently by its member states, resulting in variations in implementation and outcomes (Lewis, 2006; Walby, 2004). Critics of GM have argued that the radical and ‘transformational’ intent of GM has been watered down by the ‘integrationist’ and ‘technocratic’ approach adopted by neo-liberal state bureaucracies and international policy making organisations in the north and south (Baden & Goetz, 1998; Jahan, 1995). Others have gone further, seeing GM as the reinventing or ‘re-branding’ of feminism, which effectively neutralises the power of feminist discourses by creating an ‘acceptable’ and depoliticised alternative to discussing female subordination (Mc Robbie, 2008); in some situations the vocabulary of gender has been used “to deny the very existence of women specific disadvantage and hence the need for specific measures which might address this disadvantage” (Kabeer, 1994, p.12). The problem of lack of implementation of gender mainstreaming policy, or ‘policy evaporation’ has also been highlighted (Sundari Ravindran & Kelkar-Khambete, 2007), with some critics drawing attention to the lack of a clear methodology for change (Gujit & Shah, 1998), particularly with regard to the strategic issue of engagement with the state (Hankivsky, 2005).

### *Barriers to dialogue on ways forward*

We have reached a decisive point at which the apparent failures of GM demand a new strategic approach (Hankivsky, 2005). However, there has been a notable lack of dialogue between gender advocates in the UK and European Union and their Southern counterparts, resulting in disparate voices from north and south, policy and practice, governments and non-governmental organisations (NGOs). The opportunities for meaningful debate around gender mainstreaming issues are further hindered by geographical, structural, organisational and financial issues, resulting in a lack of interdisciplinary and inclusive fora where actors with disparate positionalities can be brought together to discuss key issues and create the necessary networks to promote an open dialogue on key issues in GM.

## **Methods**

### *Creating a forum for debate*

To create such a space in which other voices could be heard, colleagues at the Liverpool School of Tropical Medicine and the

University of Liverpool in the UK hosted an international seminar series entitled: ‘Gender Health Equity: Embracing local and global challenges to mainstreaming’ ([https://vocal-external.liv.ac.uk/sites/genderandhealth\\_escrseminars/\\_layouts/viewlists.aspx](https://vocal-external.liv.ac.uk/sites/genderandhealth_escrseminars/_layouts/viewlists.aspx)). The series of four seminars held during 2008 and 2009 was funded by the UK Economic and Social Research Council (ESRC), which enabled wider calls for participants and the attendance of international contributors. Despite encountering structural barriers to participation, including difficulties in getting visas, and family commitments, there were almost 200 participants, including advocates, researchers and practitioners working on gender and health in diverse roles and contexts across 15 different countries in the global south and north. All seminar participants (see [https://vocal-external.liv.ac.uk/sites/genderandhealth\\_escrseminars/Shared%20Documents/Forms/AllItems.aspx](https://vocal-external.liv.ac.uk/sites/genderandhealth_escrseminars/Shared%20Documents/Forms/AllItems.aspx)) were sent a full draft of the paper and asked to respond within 2 weeks if they had any concerns about the paper or wanted to suggest any changes.

The purpose of the seminars was to engender critical reflections on theoretical approaches and pragmatic experiences in GM internationally in order to contextualise the concept of GM in international health within several ongoing feminist debates and to further define and refine the strategic options available to gender advocates in the South and North.

### *Methodology of the seminars*

The planning of the programme was informed by the democratic principles of (feminist) participatory action research (FPAR), to promote the engagement of participants in an inclusive debate on issues relevant to them. FPAR explicitly develops the links between feminist theory, PAR’s use of participatory methods to achieve social change, and critical engagement with issues of power and structural inequalities (Fine, 2007; Krumer-Nevo, 2009). While the seminar organisers introduced events and chaired sessions, overall there was a ‘flat’ and democratic structure, privileging no particular voices. In Seminars 3 and 4, we eschewed the traditional format of presenting papers and instead created panels and small groups for discussion and included dialogues and ‘conversation’ (for example between activists and researchers) as a form of presentation of issues and dilemmas. Although there are limitations to applying the principles of FPAR to the seminar series, there are a number of ways in which FPAR informed our involvement in, and analysis of, the material produced by the seminars. By seeing the seminars as forums where practice (and ideology) can be unpicked and remade, we aimed to create the opportunity to contribute more meaningfully to the GM debates:

‘... participatory action research offers an opportunity to create forums in which people can join one another as co-participants in the struggle to remake the practices in which they interact’ (Kemmis & McTaggart: 227).

Despite the variation in the ways in which FPAR is practised, there are recurring elements to PAR inquiry: (i) questioning an issue; (ii) critical reflection; (iii) the development of an action plan; and (iv) implementation (McIntyre, 2008). While we can be rightly criticised as having stopped short of the implementation stage, we ascribed a different theme and purpose relating to the FPAR model to each seminar. In Seminar 1 we elicited the challenges for GM in the changing context of international health; in Seminars 2 and 3 we encouraged critical reflection on debates, dilemmas and good practice in GM and addressed the intersections between gender, sexuality, disability, and ethnicity in relation to health. Based on these, in Seminar 4, we developed a research and action agenda to take forward strategic directions for gender mainstreaming in health internationally. The analysis of the key themes emerging

from discussions was therefore a joint process conducted throughout the seminars but consolidated in Seminar 4. This analysis was further developed through e-mail, skype and face-to-face discussions between all authors following the Seminars.

Underpinning our approach to the meetings was Beresford et al's (2007) concept of 'inclusive debate', that is, our belief that all participants had valuable knowledge to impart based on their personal perspectives, experiences, education and training. The range of positionalities within the groups ranged from some participants' involvement with GM practice and research, to others' more critical 'outsider' perspective on epistemological problems and issues. All forms of knowledge were valued as sources of data and information, enabling the discussion to ground itself in 'real life' as ideas were discussed and tested against what was known, experienced and understood (Fine, 2007; Kemmis & McTaggart, 2008). While we were able to agree on some core principles, including a critical feminist standpoint, a conceptualisation of gender as relational, and the need for an intersectional approach to understanding gender, we have made any different perspectives visible in this article as part of our commitment to 'transparent reflexivity' (Rose, 1997) to maintain the feminist epistemological position of 'situated knowledges'. We therefore do not seek to artificially resolve any tensions in the findings, but aim to suggest both epistemological and practical directions for their resolution.

### Key themes and debates emerging from the seminar series

As a result of the presentations, discussion and debate, the participants in Seminar 4 identified core issues and proposed the following agenda for research and action to improve the reach and impact of GM:

1. Address the disconnect between gender mainstreaming praxis and contemporary feminist theory;
2. Develop appropriate methodologies to enable an accurate understanding of gender issues and the impact of GM policies and practice;
3. Develop a coherent theory of change in GM;
4. Seek resolution to the dilemmas and uncertainties around the 'place' of men and boys in GM as a feminist project; and
5. Develop a politics of intersectionality.

This section explores the conceptual and practical implications of these issues, using context specific examples presented and discussed at the seminar series to illustrate the challenges and highlight the key issues and debates before suggesting potential strategic directions.

#### *Addressing the disconnect between GM praxis and contemporary feminist theory*

GM assumes that gender identities are based on sex and are easily identifiable (Zalewski, 2010), yet contemporary feminist theory states that more than two genders exist; for example anthropological texts have pointed to culturally specific alternatives to the traditional male/female binary, such as *hijra* in India and *bantut* in the Philippines (Towle & Morgan, 2006). However, categories such as third gender or 'transgender' do not translate easily between cultural contexts as gender identities are not necessarily based on biological sex, creating a multiplicity of genders. For example, disabled people (whether male or female) are often de-sexualised, feminised and seen as powerless, which oversimplifies disabled people's lived experience, and potentially obscures specific inequalities.

Participants discussed how there has been a failure in some countries to transmit wider debates in contemporary feminist theory to policy makers and practitioners resulting in the use of biologically static and absolute male/female binary (sex) measures as proxies for 'gender'. In addition, there was awareness that GM has tended to characterise gender in terms of apparently fixed 'norms' and 'roles' with insufficient attention to the dynamic, complex, and diverse nature of gender and its intersection with other societal axes of power to create specific positionalities for individuals. It was agreed that this was arguably one of the reasons for the multiple silences and exclusions that have occurred within social justice advocacy movements, including women's movements.

Anuj Kapilashrami and Janet Price gave an example in their 'conversation' in Seminar 3 of how women's groups have come under much criticism from those working with alternative gender and sexual identities for their historical silence on sexual rights outside heterosexual rape, and treatment of 'lesbian issues' as distinct from 'women's issues'. The consultations on the draft of the domestic violence (DV) bill in India (in which they were both involved through different groups) highlighted the discomfort and tensions within activism on gender-based violence and its attempts to grapple with the issue of same-sex violence. Defining domestic violence was a subject of much debate, in particular with respect to the scope of persons protected and the nature of relationships under the purview of the law. For instance, the general silence around bringing violence in same-sex relationships under the purview of the DV bill was questioned, raising concerns over the tacit acceptance of hetero-normativity and taboo on discussions on same-sex relationships. The applicability of a DV bill to the already stigmatised LGBT community was questioned in the light of the political resistance and the criminalising environment within which they operated. The final bill therefore created the need for further engagement of these tensions by both the women's and the queer movement.

Participants went on to discuss how globally, violence against disabled people has also mostly been ignored within gender-based approaches, despite evidence that physical and sexual abuse is up to three times more likely than in 'non-disabled' people (WHO/UNFPA, 2009).

Post-modern and post-colonial feminisms have challenged assumptions about the very category of 'woman', and pointed to the multiple divisions and hierarchies between women on the basis of social axes such as race/ethnicity, class, nationality, age, sexuality, dis/ability and religion (Mohanty, 1988; Papart, 1995). They have argued that it is not sufficient to view these differences as 'additive' to gender binaries; that is, a woman is not simply 'even more disadvantaged' because she is also disabled. Rather gender intersects with these multiple social divisions and inequalities to create specific positionalities in relation to power. These interactions have been the basis for theories of 'intersectionality'. Understanding how different axes of power intersect requires new methodological approaches to the study of health status and health systems, which currently tend to assume a primary binary (e.g. social class) and then investigate any differences within that binary (e.g. differences between poor women and men) (Sen, Aditi, & Chandan, 2009). This resonates with the view that the gender analysis tools used as the basis for GM have tended to treat women and men as unitary, one dimensional categories of analysis, or given weak directives to consider how experiences of women and men

will differ according to geography, poverty etc. which are insufficient to enable a robust analysis of these intersections (Hankivsky, 2005).

Seminar participants discussed how applying these theoretical principles to gender analysis requires us to be creative about the type of data we need to collect to inform policy and action, and which indicators and approaches to analysis are the most strategic at specific times and in specific contexts. In the assessment of health and health systems we need to open categories up. In quantitative assessments this may mean allowing for more than two gender categories in surveys and routine information, and giving 'permission' to respondents to identify beyond the male/female binary. It also means developing ways of measuring disability that are appropriate to specific contexts. Since disability is a political organising category and lived experience and identification along the spectrum of ability to disability is extremely fluid, it is difficult to categorise and measure. However, the near invisibility of disabled people's experience in mainstream health statistics requires that we find proxies for disability that can be used to begin to identify its intersection with structural axes such as gender, whilst always understanding that these are provisional constructs that are open to change and interrogation.

#### *Developing appropriate gender analysis methodologies*

In the field of health, we are far from this ideal in terms of the data and tools we have available to collect and analyse information on health and health systems. Advocating for multiple disaggregation (even by simple gender binary and socio-economic status) within national data collection processes can highlight a host of practical, human resource, time and financial implications. Participants in Seminar 4, including researchers and programmers from several sub-Saharan African contexts, discussed the difficult choices about what types of disaggregation it is most strategic to advocate for, balancing the need for useful data with acceptability to programme managers and data collectors. In some contexts where time and resources are scarce advocates argue that it made sense to prioritise sex disaggregation in the first instance, as this is arguably easier and requires less context specific knowledge and training of data collectors than also collecting data for example, by socio-economic status and disability. This is an example of Annandale and Kuhlmann's (2010) point that efforts to increase sex disaggregation can actually ironically reinforce the male/female binary. It raises questions around how to strategically identify the 'best' categories in such contexts to challenge the gender binary without over-essentialising the fluidity of identities. However, creating the policy and political spaces for such a move may be a slow process. The methodological tools for adequately investigating intersectionality in data analysis are also under-developed (McCall, 2005), though there are some suggested ways forward (e.g. Sen et al., 2009). We then need to seek opportunities to make sense of data in particular contexts. Participants generally agreed that qualitative data and analyses are important to enable the ongoing interrogation of categories through deep understandings of lived experiences and the creation of spaces for the voices and agency of women and men with different positionalities. Qualitative and particularly participatory approaches offer more potential with regard to facilitating 'conscientisation' or awareness and analyses of how multiple structural power inequalities shape embodied experience for those oppressed by them, which offers potential for creating change (Freire, 1970; Cornish, 2004). Feminist researchers have further developed participatory approaches that are sensitive to gendered power in their processes (whose voices are privileged and whose are silenced) and analyses (Cornwall, 2000; Guijt & Shah, 1998). Analyses need to be informed by

In Seminar 1, Francelina Romao outlined a practical process for making sense of available data drawn from her experience as the Senior Gender Focal Point (GFP) in the Mozambique, Ministry of Health. Mozambique has a well resourced GFP structure, with 18 GFPs working at national level. There are 11 provinces with 6 departments and each department has at least 1 GFP. GFPs meet with national and provincial health officers, health workers and community representatives on a monthly (at national level) or trimestral (at provincial level) basis to discuss the implications of their disaggregated data sets. This enables the team to embed the findings within the local context, to discuss important intersections such as how gender and cultural norms, literacy and age may be interacting to shape women's and men's health and service access for malaria, HIV, other diseases, and following violence. These discussions develop ownership over the data and enable the team to critically develop context embedded approaches to address the challenges and inequities uncovered. The role of health providers to improve health status based on these findings and approaches to involve men in gender equitable change are among the broader strategic issues discussed.

nuanced theoretical understandings of the operation of power and sensitive to the flow of power through networks of multiple categories and these understandings need to be translated from the theoretical realm into participatory approaches.

There was heated discussion amongst seminar participants about whether the above analysis implies the need to move away from automatically privileging the gender binary as the most important form of oppression (Hankivsky, 2005). Whilst some participants agreed with this implication, others emphasised the legitimacy of a feminist concern with women's position. However, there was agreement that a more nuanced concept of gender is a legitimate starting point for analysis, particularly in relation to certain strategic issues in health, including sexual and reproductive health and rights and GBV. Furthermore we agreed that it remains vital that critical feminist principles are central to analyses; that we need to continue to make gender visible as an axis of power and privilege and to insist on action to counter this. There was further agreement that insights and learning from feminist theory outlined above are also helpful in wider analyses of power and structural inequalities.

#### *Developing a coherent theory of change in GM*

A common critique of GM is that it has diluted or even undermined a feminist agenda and has insufficiently engaged with power relations (Baden & Goetz, 1998). GM has been described as "a concept in search of a methodology" (Guijt & Shah, 1998, p.6) because it has paid relatively little attention to methodologies for promoting change, showing naivety in unrealistic expectations of the state as an agent of social transformation, and conflating state policy development and implementation with processes of social change (Daly, 2005; Standing, 2004).

The tensions in the translation of feminist goals into policy and practice within state bureaucracies were vigorously debated by participants from different perspectives. Some seminar participants, particularly researchers and activists from the north, were concerned about the bureaucratic capture of feminist aims and saw this as 'neutralising' feminist action and thus as a central flaw in GM as a strategy. Others, particularly those who were health service providers and gender and health advocates from the south,

discussed in depth the pragmatic need for gender advocates working in the bureaucratic environment to deploy ‘strategic frames’ that will be understood in the contexts of mainstream institutional discourses (Hafner-Burton & Pollack, 2002). However, they also emphasised the potential for expanding spaces in policy and public discourse through this strategy.

For example, in Seminar 2, Nduku Kilonzo discussed her experiences as the Director of ‘Liverpool VCT and Care (LVCT)’, a Kenyan NGO which is the largest provider of HIV Voluntary Counselling and Testing services in Kenya. LVCT is concerned with both gender equity, and broader issues of social inequity, marginalisation, and discrimination, including meeting the needs of disabled people and ‘men who have sex with men’ in a legally and socially prohibitive environment. Advocacy to the state around policy and service provision for survivors of sexual violence, people living with disability and ‘men who have sex with men’ have been ‘strategically framed’ within the dominant hegemonic public health paradigm in terms of ‘universal access’ rather than a rights-based or explicitly feminist paradigm. As a service provision organisation LVCT has a ‘seat at the policy table’, a voice in and access to policy space that it would not have as an organisation representing the rights of any ‘interest group’. The public health strategic frame also offers entry points for discussions with not only government but also other key societal stakeholders such as religious leaders, where both policy space and public discourses are open to expansion and shifts. The current focus within HIV prevention programming on ‘Most at Risk Groups’ (MARPS), including ‘men who have sex with men’ is narrowly bio-medical, contributes to ‘fixing’ unitary and marginalising social categories, and does not generally consider ‘groups’ not judged to be epidemiologically important, such as lesbians (who nonetheless face HIV risk and sexual violence). However, it offers strategic opportunities to promote public discussion of issues for which there is no alternative policy space. Ultimately LVCT judges that their gradual pushing of boundaries and opening up spaces for debate around sexuality more widely through the entry point of ‘MSM’ is the best strategic option.

Participants discussed the need to be clear about who to target for influence. This includes clearly identifying which goals are to be achieved within and by state bureaucracies and services (e.g. provision of accessible comprehensive post-rape care that meets the needs of women and men with different positionalities) and which goals need to be pursued in other sectors or organisations (e.g. social and legislative change related to GBV and how this interacts with violent manifestations of other power relations such as violence against disabled people). Greater clarity about both specific goals and target groups may enable strategic decisions on influencing approach such as being clear on when it is strategic to frame action as a feminist project in terms of achieving goals and when it is not. Some participants argued, in line with Standing (2004) that there is a strategic need to support the health sector to deliver its core business of health care accessibly to all and make intersectoral links with other actors to address the multiple factors that shape health and wellbeing for women and men in different positions. However, there was also an acknowledgement that more ‘bottom up’ planning processes are needed to understand the interests and priorities of different groups of women and men and to build their capacity to engage in development and policy processes, in line with the argument of Sundari Ravindran and Kelkar-Khambete (2007).

For example, in Seminar 1, Francelina Romao outlined a strategic approach to developing intersectoral state action in Mozambique, where the social determinants of health for poor people living in rural areas include limited livelihood opportunities, low literacy, poor access to safe water, and violence, and these are gendered in multiple ways across other axes of social disadvantage. Gender Focal Points are well connected with initiatives in other sectors, including other Ministries and International Agencies and NGOs. One of three groups working on gender mainstreaming at national level is led by the Ministry of Women and Social Action and deals with intersectoral policies. There are successful examples of intersectional policy initiatives, such as (1) integrating health and gender curricula into adult literacy programmes to meet the needs of illiterate rural women and men and (2) sexuality and young girls and boys’ programmes in rural areas. The team decide on a bi-monthly basis which meetings to prioritise in order to explore and make concrete intersectoral policies and programmes, for example ranging across government departments such as Transport, Education, Agriculture, Public Works (with a focus on access to safe water), Justice and Police (with a focus on addressing violence) and across issues such as income generation, disability and rights. This is a challenging endeavour. Even with the well established and wide reaching Gender Focal Point structure in the Ministry of Health Mozambique there are always more meetings than staff. Hence often difficult decisions need to be taken about which to prioritise and what sort of intersectoral action would be the most strategic to pursue.

Some participants further argued that social and political action to advance gender equity in health also needs to draw on the insights from contemporary feminist theories. Post-modern feminist theory has posited that gender is ‘performative’ (Butler, 1990) in that it is constantly ‘re-made’ or ‘rewritten’ through daily actions and interactions. Institutions and organisations work to ‘fix’ and solidify these performances, for example through policies, laws and institutional cultures. Gender roles, relations and identities are therefore inherently unstable and dynamic and interact with social change processes. The implications of these are that we need to look for strategic opportunities to resist, disrupt, and re-frame the constant (re)writing of gender as a narrative script in positive ways, intervening as actors in constant social change. This may include looking for ‘mediating moments’ for change through participatory processes, drawing on community psychology theory (Cornish, 2004). Cornish (2004) provides an example of mediating moments through exploring how gender and poverty relations mediate to shape condom negotiations in sex-worker–client interactions in Calcutta.

#### *Addressing dilemmas and uncertainties around the ‘place’ of men and boys in GM*

The extent of, and rationale behind, including men and boys in GM emerged as an ongoing tension in the seminar discussions. Some contributors argued that men and boys need to be included because they are instrumental to women’s health, for example women’s gendered vulnerability to HIV means working strategically with men. Others argued that men and boys have gendered needs and interests which should be addressed in their own right. If men and boys are to be addressed only instrumentally, this raises questions about the real meaning of ‘gender’ (which may be read as ‘women’s interests’), but if they are to be viewed as interest groups

there is a concern amongst some that this may undermine the feminist goals of the GM project, which are framed as primarily about empowering women.

However, some argued that a nuanced understanding of the operation of power suggests that it should not be viewed as a zero sum game and that addressing hegemonic masculinities should operate in the interests of many women and men. Two reviews of interventions to engage with boys and men in health programmes internationally found that (1) interventions that are 'gender transformative' are more effective in changing men's behaviour and attitudes, and (2) ensuring that women are also supported and given voice is necessary to prevent unexpected consequences such as men using initiatives to consolidate their power (WHO, 2007; Barker et al., 2010). However, recent work on masculinities has highlighted the need to go beyond micro-level work with men as individuals to challenge normative, heterosexist male power as it is structurally invested in institutions, such as the legal system and police, for example, by challenging violence by agents of the state against men who have sex with men (Esplen & Greig, 2007). Such work has highlighted the need to avoid the danger of drawing a 'false equivalence' between vulnerabilities of women and men which glosses over real differences in power and privilege based on gender and does not hold men to account over the ways in which they choose to act out their privilege (Esplen & Greig, 2007).

A particularly complex presentation of this debate is the way in which violence, including sexual violence, against boys and men is often not constructed as gender-based violence (GBV) although some of it may have strong gender dimensions, including violence against men and boys who are effectively gendered female (e.g. disabled or gay men), and violence that results from the mobilisation of hegemonic masculinity in the interests of certain elite groups of men (and women), such as in some conflicts (Linos, 2009).

In a panel discussion in Seminar 3, Paluku Sabuni, drew on his experiences working with the Institut Panafricain de Santé Communautaire (IPASC), which provides services and advocates for survivors of sexual violence in the eastern Democratic Republic of Congo. He explained that anecdotal accounts of sexual violence against men exist, but are rarely acknowledged. For a man to acknowledge experiencing sexual violence involves feminising himself, by casting himself as a 'victim' rather than an agent; the silence around such violence thus contributes to the gendered stereotype of women as passive and men as active in relation to sexuality. Other participants commented that acknowledging sexual violence against men would challenge the fiction that it is only homosexual men who would sexually abuse another man; homosexuality is thus constituted as ever more unacceptable, as a site of violence as well as of non-normative sexual acts.

Participants discussed how asking critical questions about the construction of GBV, and including a real focus on the violence experienced by boys and men, raises fears about detracting from much needed advocacy for policies and resources to address the needs and interests of women and girls experiencing SGBV. However, silence around violence against men and boys *in itself* contributes to fixing the gendered conceptualisations that drive the violence. A feminist approach to sexual violence against men is needed to simultaneously interrogate these norms in challenging violence mainly perpetrated *by men*, *in addition to* ensuring that legal frameworks, health and rehabilitative services recognise and cater for men as survivors of sexual violence. Recent work on

masculinities has highlighted the need to avoid the danger of 'counterposing' women's and men's experiences and perpetration of violence, but has emphasised instead the need "to help illuminate the workings and functions of violence within the systems of oppression that organise our different societies, while holding accountable the individuals and institutions (mostly men and male dominated) that are responsible for enacting this violence" (Esplen & Greig, 2007, p.33).

The rising concern about "men's health" (particularly around life expectancy) and concomitant policy interest has thrown into sharp relief questions about the relationship of GM to policies aimed at health inequalities in many countries of "The North".

Steve Robertson presented a paper in Seminar 2 that reviewed and interrogated different approaches to "men's health" in "The North". For example, he argued that Canada has a well established and integrated strategy for mainstreaming gender equality at all levels, including integrating gender equalities considerations into the (health) policy making process. As early as 1976, all federal initiatives and decisions had to be assessed for their impact *on women*. Despite this long-standing commitment to gender mainstreaming within the Canadian context "there are few examples of how gender mainstreaming and GBA have been utilized or actively implemented to revise and refine health services that are sensitive or responsive to the health promotion needs of men" (Robertson, Galdas, McCreary, Oliffe, & Tremblay, 2009, p.268). If GM is implemented as a purely instrumental approach men's gendered concerns can become negated. In contrast, Australia, also a pioneer in recognising the importance of gender mainstreaming in promoting equity for both women and men, have taken a different approach. Following a lengthy consultation process, they have recently launched a National Men's Health Policy (Australian Government: Department of Health and Aging, 2010) that explicitly draws on principles of gender equity and gender mainstreaming. The premise here is that GM works most effectively when supported by policies that also recognise the importance of addressing the specific interests of each biological sex in their own right (i.e. it is supported by women's health and men's health specific policies). This has been critiqued however, with some arguing that catering for men in their own right and pursuing sex-specific policies will lead to an unjust re-allocation of health resources away from the health needs of women.

#### *Developing a politics of intersectionality*

Seminar participants discussed the need to develop a politics of intersectionality, which overcomes the gender binaries inherent in GM, and simultaneously addresses dilemmas around the place of men and boys. Transversal politics may offer ways forward in addressing these concerns and contribute towards the development of theories of change. Transversal politics is based on first, standpoint epistemology, which holds that "the only way to approach 'the truth' is by a dialogue between people of differential positionings" (Yuval-Davis, 1999, p.95). Second, on the recognition that differences are important, but that notions of difference should encompass, rather than replace notions of equality (Yuval-Davis, 1999). Third, on a differentiation between positioning, identity and values. Similar, compatible values can cut across differences in positionings and identity to form 'epistemological communities', which share common value systems, and can exist across difference (ibid). Struggles against oppression and discrimination might, and

mostly do, have a specific categorical focus but are never confined just to that category.

Thus whilst participants agreed that feminist goals need to remain central, they discussed the need to look at the points of convergence with political struggles with other categorical foci. This includes identifying aspects of the identities of men and boys where intersections of interests in terms of shared values of social justice may be identified and coalitions consequently formed at strategic points in time.

For example, the campaign to repeal section 377 of the Indian Penal Code crystallised in 2001 when a court petition from Naz Foundation of Delhi sought legalisation of homosexual intercourse between consenting adults. In Seminar 3, Anuj Kapilashrami, Geeta Misra and Janet Price, who were linked to groups in the campaigning coalition 'Voices against 377', discussed the role of transversal politics in the coalition and the ways in which feminist voices found space. The petition emphasised the importance of HIV/AIDS outreach work with 'Men who have Sex with Men', and that the prohibition of private, consensual adult sex violated the right to privacy (and liberty) guaranteed by the Indian constitution. In doing so it drew synergies with the ongoing mobilisation of women's organisations around the demand to make sexual assault gender neutral, encompassing all forms of penetrative intercourse.

By 2003, the growing campaign had garnered support and momentum from women's, children's and human rights groups and nascent LGBT organisations. These groups challenged the inadequate representation and consultation beyond MSM and the AIDS context. Lesbian groups, for example, objected to the absence of the analysis of patriarchy from discussions on sexual rights. Class also emerged as a crucial dividing line as members of the autonomous women's movement, itself largely urban, middle class and newly emerging from a predominantly hetero-normative history, argued for a sanctioning of alternative sexuality as a 'private' and fundamental right whilst simultaneously demanding state interventions on issues deemed private, such as rape, domestic violence and incest. In contrast, many sexual subalterns, socially and economically amongst the most disadvantaged groups, who have no choice but to create sexual space within the public arena, challenged the privileging of private consensual sex.

By mid 2009, Voices against 377 had mobilised widespread support. On 2 Jul 2009, Delhi High Court overturned the 150 year old section, thus legalising consensual homosexual activities between adults and in doing so, it instituted the notion of sexual citizenship for the first time within South Asia (Misra, 2009). From a feminist perspective, the struggle to repeal 377 has enabled the development of an inclusive theoretical and political agenda for sexual rights which rests on a strong critique of patriarchy and hegemonic masculinities as underpinning both the subordination of women as well as repression of alternative sexual and gender identities. But the extent of the gains remains under dispute.

However, participants agreed that shared values, such as gender equality, need to drive such coalitions; where the development of policies to 'include' men in health and development initiatives takes the shape of 'family rights' that in effect cancel out women's rights, feminist involvement in such a coalition would break down. Equally the feminist theories underpinning this paper would preclude coalitions based on "essentialised notions of identity and

difference which may be used to naturalise forms of social, political and economic exclusion" (Yuval-Davis, 1999, p.97). Spivak (1987) has used the concept of 'strategic essentialism', to refer to the ways in which subordinate or marginalised social groups may temporarily put aside local differences in order to forge a sense of collective identity as the basis for a political movement. Whilst this may result in problematic and unstable groupings, nonetheless these acts of temporary identity formation support important political ends.

Some commentators have discussed 'diversity mainstreaming' as an alternative framing to GM (e.g. Hankivsky, 2005). The potential 're-framing' of GM was the subject of intense debate between seminar participants. Whilst most agreed on the need for change, views on appropriate directions ranged from rejecting GM as a failed strategy and focussing on revitalising grass-roots feminist politics, to re-envisioning GM to provide an appropriate context for feminist transversal politics. Many participants were concerned about the loss of a clearly articulated feminist politics as an organising principle, whilst others pointed to critiques of diversity politics, including the tendencies of 'multi-cultural' discourses to reinforce differences, whilst depoliticising power inequalities (Bhabha, 1994). This diversity and strength of views suggests that both strategic approaches and appropriate terminology need to be identified through further consensus-building processes, which need to include voices from multiple positionalities that share values of social justice and gender equity.

## Conclusions and strategic directions

While we acknowledge the contribution of GM in placing the need to address inequality and power relations in the policy sphere, and establishing the importance of gender as a critical axis of power, we argue that we have reached a critical point where the failures of GM demand a new strategic approach.

This revised approach needs to address the disconnect with contemporary feminist theory by opening up categories beyond the static male/female binary, acknowledging the diversity of gender and its intersection with other societal axes of power. Applying these principles in routine monitoring and evaluation presents many political and practical challenges, requiring a process of strategic engagement with decision makers. Beyond routine data, intersectional gender analysis requires the further development of epistemologies and methodologies that both take a nuanced approach to power and the fluidity of categories, and ground meaning and action in the lived experiences of women and men, including through participatory approaches. Seeking resolution to the dilemmas and debates around the place of men and boys in gender mainstreaming requires a nuanced understanding of the operation of power that recognises the potential value of addressing hegemonic masculinities for many women and men. The challenge is to balance addressing the vulnerabilities created by intersections between masculinities and other structural positionalities with simultaneously confronting male hegemonic power and its consequences for equity in health.

We argue that GM now needs re-framing to enable effective strategies to address gender as an intersecting component of wider structural inequalities. Feminisms provide both principles and theoretical insights to inform the development of an intersectional approach to pursuing gender equity as part of an agenda of social justice, and transversal politics offers a potential way forward. However, we need to develop theories of change that link multiple levels from the (social) individual, through institutional practices, legal frameworks and societal discourses, including, but not limited to, state bureaucracies. Further participatory documentation and



analysis of the political and social change processes will be needed to develop a coherent theory for the new transversal politics.

The lack of fora for the full range stakeholders to engage in serious critical debate around the praxis of GM needs to be addressed. Our work has contributed to this process and current debates through bringing together the voices of different actors and analysing the points of divergence and coalescence to identify a potential agenda for the future of GM that engages with existing tensions and challenges.

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