Chapter 4
Gender, Work and Health Inequalities

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4.1 Introduction

The study of female labour participation has largely recognised that many gender inequalities happen in work-related settings (Acker, 1990, 2006; Calás & Smircich, 2006; Gottfried, 2006; Martin, 2003). Women have been historically more limited in their choices for employment, they are more likely to work under vulnerable conditions, and are over-represented in mid-skill occupations (International Labour Organization (ILO), 2012). When women have access to paid employment, they tend to work in more unstable and precarious conditions than men. Underemployment (working less than 35 h a week) affects women the most, leading to persistent poverty (Caceres & Caceres, 2015).

Despite the dramatic increase of women in the labour market, there has been no significant change in the distribution of domestic work. The sexual division of labour dictates that even when women enter employment, they will typically have the main domestic responsibilities. Time-use data suggests that while the number of hours that women and men spend on unpaid domestic work and paid work can vary widely across countries, women's total work time is greater than that of men, and women spend a larger share of their time on unpaid work than men in all cases (United Nations (UN), 2012).

What are the implications of these trends for women's health? We acknowledge the fact that both men and women are subject to the health effects of gender roles and expectations. For example, women face fewer physical risks at work than men, but

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more negative risks from the psychosocial work environment (Buvinic, Giuffrida, & Glassman, 2002). Some other risks may affect them equality. For instance, perceptions of multiple forms of mistreatment are associated with worse mental health for both, men and women (Harnois & Bastos, 2018). We focus on women's health as gender inequalities tend to affect them the most in all dimensions and in all regions (World Economic Forum (WEF), 2019).

Women tend to consider themselves less healthy despite the fact that their mortality average rate is lower than those given for men (Montoya, 2002). Female employees tend to show a higher prevalence of poor self-perceived health, limiting longstanding illness, multiple chronic conditions and poor mental health (Artazcoz, Borrell, & Benach, 2001). Women's perceptions of workplace gender discrimination are negatively associated with poor mental health, and perceptions of sexual harassment are associated with poor physical health (Harnois & Bastos, 2018).

Health inequalities based on gender reflect an unfair distribution of health risks and resources. When an inequality is unfair, allowing it to exist would be inappropriate (Arcaya, Arcaya, & Subramanian, 2015). The disadvantageous position in which women find themselves is not a function of their inability to gain equal remuneration or to develop their own abilities. Instead, it is a direct result of gender roles and social structures. This implies that men and women's chances of realising their own goals will be different as a direct result of preferences, desires, aspirations, and attitudes not only of their own, but also of others (Browne & Stears, 2005).

The aim of this chapter is to explore how gender, elements of the psychosocial work environment and their interaction can lead to inequalities in occupational health outcomes. We first look at whether a set of occupational health outcomes differs for male and female workers. Then, we explore how the interaction between gender and working conditions play a role in the explanation of the identified differences. We identify organisational justice, work-family conflict, and family responsibilities as key determinants in gender inequalities in health.

We aid the discussion with the relevant literature and specific evidence from Chile. Chile stands out in the Latin American region as a country that is highly participating in the global economy, experiencing rapid economic growth in the last three decades. Chile was the second country (after Mexico) to join the Organisation for Economic Cooperation and Development (OECD) in 2010. Despite this apparently favourable state of affairs reinforced by the promising and sustained indexes of economic growth, many pressing issues remain unresolved. Chile is one of the most unequal countries in the world according to the World Bank Gini Index for income inequality. This has been made explicit in the explosive social unrest the country experienced during the last quarter of 2019.

We use the initial wave of data from the first longitudinal study being carried out in Chile exploring the impact of working conditions on employee health and well-being.[1] The sample consist of 1463 workers (589 women and 874 men), from

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diverse sectors including public administration, retail, health services, and transportation. We use self-reported health status variables from the SUSESO/ISTAS21 Questionnaire (Alvarado et al., 2012), as well as scales measuring organisational justice (Colquitt, 2001), work-family/family-work conflict (Gutek, Searle, & Klepa, 1991; Netemeyer, Boles, & McMurrian, 1996), and sleep problems (Jenkins, Stanton, Niemcryk, & Rose, 1988) to identify any relevant underlying mechanism. We use simple comparative, correlational and regression statistics to draw conclusions from our data (see Regidor, 2004a, 2004b for a glossary on measures of health inequalities).

4.2 Equality, Equity and Health

There has been a considerable debate about the meaning and measurement of health inequalities, and perhaps more importantly their determinants (for a review see Arcaya et al., 2015). The discussions about equality "begin from the premise that there is some currency that should be distributed equally and then proceed to investigate what that currency might be" (Scheffler, 2003, p. 31). Therefore, a concern about health inequality is a concern for the distribution of health outcomes across individuals (Kawachi, Subramanian, & Almeida-Filho, 2002). If health outcomes are randomly distributed among all groups of population, then it may be possible to imply that there is no presence of health inequality in that population.

One way to think about health inequalities is to consider social group health differences. Social group health differences are considered to be the differences across subgroups of the population (Murray, Gakidou, & Frenk, 1999). These subgroups may be based on biological, social, economic or geographical characteristics. Frequently, these differences are based on comparisons between the mainstream population and historically discriminated groups regarding their ethnicity, gender, sexual orientation, migrant status, or disability, among others (Marmot, 2005, 2018).

Any quantifiable aspect of health that differs across individuals or social groups can be called an inequality (Bleich, Jarlenski, Bell, & LaVeist, 2012). This is a descriptive observation of differences in quantities which lacks any moral judgment regarding the fairness or unfairness of the observed quantities. Health inequality is therefore a descriptive concept.

When is a health inequality unjust? The concept of health inequity should help us determine which inequalities are unjust and which are tolerable by the application of some ethical theory (Leon, Walt, & Gilson, 2001). Health equity is therefore an ethical concept. This ethical component represents a challenge for operationalisation and measurement as the ethical interpretation of when an inequality is unfair can vary in different setting and for different people. Rawls (1971) proposes that inequalities are fair when they are attached to positions open to everyone under equal opportunities, and when they are of the greatest benefit to the least advantaged. Although any summary of Rawls's theory would be incomplete here, it is possible to

understand his theory of justice in terms of its focus on the process and distribution of valuable resources or goods.

Sen (2009), on the other hand, proposes a theory of justice where the focus is on enhancing people's freedoms to live the lives they value, instead of resources and institutional processes. In this respect, Sen's theory of justice accounts better for human diversity (Ruger, 2004). What really matters in pursuing justice is not that social arrangements are insufficient, "but that there are clearly remediable injustices around us which we want to eliminate" (Sen, 2009, p. vii). Therefore, it would be much easier to agree over what is manifestly unjust than it is to agree on a perfectly just arrangement or a perfectly just distribution of goods.

In a widely cited paper, Whitehead (1992) proposes that in analysing the possible injustice of an inequality in health, it is necessary to establish that the inequality is avoidable, unnecessary and unfair. Braveman and Gruskin (2003) further extend this definition by including social advantage. They defined health equity as the absence of systematic disparities in health and/or its social determinants between more and less advantaged social groups. Social advantage refers to the attributes defining how people are grouped into social hierarchies such as wealth, power, and prestige.

A common aspect among these propositions is the idea that people's circumstances need to be taken into consideration. The key imperative of equity is therefore to equalise the distribution of the chance people have to achieve a favourable outcome given their particular circumstances. If individual circumstances are taken into account, differential outcomes are ethically acceptable when they are the consequence of individual choice and action, but not ethically acceptable when they are the consequence of circumstances beyond the individual's control (Anderson, Leo, & Muelhaupt, 2014).

Differences based on individual choice and action are acceptable as long as they do not represent some kind of unfairness. For example, we could agree that smoking is an individual decision as long as people are aware of the consequences. However, health-damaging behaviour such as smoking or even unhealthy diets is usually overrepresented among lower socioeconomic groups (Adler, Glymour, & Fielding, 2016; Elstad, 1998). If this is the case, it is unlikely that health-related behaviours are chosen as a matter of individual freedom, but heavily influenced by social and economic status.

4.3 Gender as a Determinant of Health Inequalities

Health inequalities become unfair when poor health is the consequence of an unjust distribution of its social determinants, or the circumstances (Daniels, Kennedy, & Kawachi, 1999; Gwatkin, 2000; Woodward & Kawachi, 2000). Social determinants are functions of the social, economic and environmental conditions in which people are born, grow, live and work that impact their health during the life-course (Saunders, Barr, McHale, & Hamelmann, 2017). These are shaped by the distribution of power and resources at all levels in society and determine health outcomes.

A social determinant of health is therefore a socially controllable factor that can help to explain an individual's health status. Social determinants are closely linked to and mediate exposure to environmental risk factors such as employment and working conditions, water and sanitation or healthy lifestyles (Commission on Social Determinants of Health, 2008).

Gender is largely considered a social determinant as it is a key mechanism that explain why people are exposed differently to health risks (Phillips, 2005; Sen, Östlin, & George, 2007). To understand this, it is important to differentiate between sex and gender. Sex is determined by what biologically means to be a man or a woman. For example, being able to give birth is a biological feature. On the other hand, gender refers to the roles and expectations attributed to men and women in a given society (Torres, Jain, & Leka, 2019). For instance, expectations about parenting, or the status associated with being a mother are more closely linked to gender roles and social expectations, than to a biological condition.

Some health conditions are determined primarily by biological sex differences. Others are the result of how societies socialize women and men into gender roles and expectations. Many other health conditions reflect a combination of sex differences and gender expectations. The World Health Organization (WHO, 2010) recognizes that gender is an important determinant of health in two dimensions: (a) gender inequality leads to differential health risks exposure; and (b) gender norms and roles can explain how the social construction of identity and unbalanced power relations between men and women affect the risks, health-seeking behaviour and health outcomes of men and women.

Gender implies that men and women's chances of realising their own goals will be different as a direct result of preferences, desires, aspirations, and attitudes not only of their own, but also of others (Browne & Stears, 2005). The impact of gender as a determinant of health is likely to affect power relations, poverty, and even marginalization (Phillips, 2005). This is particularly true for women. The disadvantageous position in which women find themselves is not a function of their inability to gain equal remuneration or to develop their own abilities. Instead, it is a direct result of pervasive gender inequalities.

Both men and women are subject to the health effects of gender. For example, women tend to show a higher prevalence of poor self-perceived health status, longstanding illness, multiple chronic conditions and poor mental health (Artazcoz et al., 2001). Adult women tend to consider themselves less healthy despite the fact that their mortality average rate is lower than those given for men (Montoya, 2002). Because of the labour segregation and stratification, women and men are also likely to be exposed to different risks. Women frequently face fewer physical risks at work than men, but more negative risks from the psychosocial work environment (Buvinic et al., 2002).

In Chile, more women suffer from mental health problems, while more men suffer from musculoskeletal diseases (Superintendence of Social Security (SUSESO), 2019). Mental health and stress related illnesses seems to be affecting women the most and becoming a public health burden across the country. Data from the Superintendence of Social Security (SUSESO, 2018) indicates that only in

Table 4.1 Gender differences in health outcomes

	Women n = 589		Men n = 874				
Outcomes	M	SD	M	SD	U-test[a]	t-test[b]	d[c]
Sick leaves (number)	0.93	1.57	0.42	1.30	205651[d]	–	−0.36
Sick leaves (days)	9.00	25.95	4.08	14.89	207033[d]	–	−0.24
Mental health and vitality	2.33	0.78	2.50	0.79	–	3.78[d]	0.20
Somatic stress	1.05	0.89	0.84	0.79	225054[d]	–	−0.24
Cognitive stress	1.41	0.86	1.30	0.87	–	−2.43[d]	−0.13
General stress	1.23	0.76	1.07	0.73	227288[d]	–	−0.21
Sleep problems	2.13	1.22	1.96	1.22	–	−2.54[d]	−0.14

[a] U-test or Mann-Whitney U is reported in those cases where the assumption of equal variance is not achieved
[b]Student's t-test for mean comparison
[c]Cohen's d for effect size
[d]$p < 0.001$

2017 at least 33% of diagnosed occupational diseases were associated with mental illness. In a period of 3 years (2015/18) mental health consultations rose from 12 to 36% out of all consultations for occupational illnesses. Stress-related conditions rank first and accounted for 44% of all cases.

In our sample, men and women differences in occupational health outcomes are displayed in Table 4.1. Overall, women reported poorer self-perceived health status than men. Women took a significantly higher average number of sick leaves and were on sick leave more days in the last 12 months (not including maternity leave or leave for serious illness of a child under 1 year old). Women had significantly lower levels of mental health and vitality, higher levels of sleep problems, as well as higher levels of somatic, cognitive and general stress.

4.4 Work Environment as a Determinant of Health

Work plays an important role in the health and well-being of women and men. All over the world most adults spend much of their waking hours at work, and while work provides a number of benefits, workers are exposed to a range of working conditions. Benach et al. (2010) classify potential occupational exposures, hazards, and risk factors into five categories: physical, chemical, biological, ergonomic, and psychosocial. While each risk factor may lead to different health outcomes, the production of health inequalities is shaped by relatively general social mechanisms such as class, gender, and ethnicity/race.

Psychosocial hazards are aspects of work organisation, design and management that have the potential to cause harm to individual health and safety (Leka, Van Wassenhove, & Jain, 2015). Psychosocial hazards include, among others, unrealistic work demands and unfavourable work schedules (shift work, inflexible work schedules, unpredictable hours, long or unsociable hours), low participation in decision

making, poor physical work environment, poor relationships with superiors, lack of social support, bullying, sexual harassment, career stagnation, poor pay, job insecurity and work-life imbalance (ILO, 2016).

Several studies over the past decades have shown the impact of psychosocial hazards, including work-life balance and perceived organisational justice, on individual health and well-being (Ambrose & Schminke, 2009; Bambra et al., 2009; Elovainio et al., 2013; Ganzel, Morris, & Wethington, 2010). When a psychosocial hazard activates the physiological system, the body adjusts its parameters to adapt to the environment, a process called allostasis (McEwen, 1998). Damage is done to the body if this activation is continued, such as in conditions of repeated or chronic stress. Continuous or repeated stress factors can have long-term negative consequences, since they can accumulate, which affects the immune system, the cardiovascular system and the metabolic system (Ganster & Rosen, 2013; Juster et al., 2011).

Work-related stress is associated with heart disease, depression, and musculoskeletal disorders, and there is consistent evidence that high job demands, low control, and effort-reward imbalance are risk factors for mental and physical health (Johnson, 1996; Kivimäki et al., 2006; Melchior et al., 2007; Rosengren et al., 2004; Stansfeld & Candy, 2006; Tennant, 2001). Addressing psychosocial risks in the workplace can reduce stress-induced physical and mental illnesses such as heart disease, anxiety, depression and musculoskeletal disorders.

The unequal distribution of these occupational hazards is a key contributor to gender inequalities in health. Although perceptions of multiple forms of mistreatment are associated with worse mental health for both men and women, women tend to face higher risks from double burden, lower-paid jobs, violence from clients, and sexual harassment from fellow workers (Benach, Muntaner, & Santana, 2007; Harnois & Bastos, 2018). In the next two sections we explore how the interaction between gender and working conditions play a role in the explanation of the gender differences we observed in the health outcomes in our sample. We identify organisational justice, work-family conflict, and family responsibilities as key determinants.

4.4.1 Fair Work Is Good for Health

The existing organisational justice literature has primarily focused on three justice dimensions: procedural (the how), distributive (the outcomes), and interactional along with its interpersonal and informational sub-dimensions (the relationships) (Colquitt, 2001; Colquitt, Conlon, Wesson, Porter, & Ng, 2001). A recent trend suggests that individuals form global judgments of how they are treated (Cropanzano & Molina, 2015). As a result, a shift toward examining overall justice has also emerged. Under this perspective, when individuals form impressions of justice or injustice, they may be making a holistic judgment and, therefore, reacting to their general experience of justice or injustice (Greenberg, 2001; Shapiro, 2001).

Although individuals can distinguish between the sources of their justice experience when asked, what drives behaviour is an overall sense of fairness (Lind, 2001).

Exposure to perceived unfair working conditions can have a negative impact on workers' interpersonal relationships, stress levels, job satisfaction and, in particular, family life (Eib, von Thiele Schwarz, & Blom, 2015; Frone, Russell, & Cooper, 1992; Gutek et al., 1991; Parker & Allen, 2001). Judge and Colquitt (2004) show that workers who perceive their organisation as fair have less work-family conflict and, subsequently, report lower work-related stress levels. This is similar to what we found in our sample. The better the perception of overall organisational justice, the lower the level of work-family conflict and, as a result, the lower the work-related stress.

Now, the interaction between gender and justice is controversial. In a meta-analysis of 190 studies Cohen-Charash and Spector (2001) found that gender was not strongly related to justice perceptions. Despite this, studies tend to show gender differences regarding justice experiences. Brammer, Millington, and Rayton (2007) found that, compared to men, female workers have stronger preferences for discretionary behaviour and fair working practices while men have more interest in internal training initiatives. Similarly, Lee and Farh (1999) found that women focus more on distributive issues rather than procedural justice issues when they evaluate social arrangements. Procedural justice has been reported to be more important for male workers (Lee, Pillutla, & Law, 2000). Furthermore, men's ratings have been reported to be significantly higher than women's on distributive justice and women's ratings to be significantly higher than men's on interactional justice (Tata & Bowes-Sperry, 1996).

This is similar to what we observed in our sample. For both, men and women, organisational justice and its dimensions were correlated with our identified health outcomes (those shown in Table 4.1). Of course, one cannot infer causation from correlation, but there are reasonable assumptions about pathways perceptions of justice and health outcomes. What is more, significant differences can be observed between women and men in term of their experiences of organisational justice. Compared to men, women perceive less fairness (overall fairness experience), and in particular unfair distribution of rewards (distributive justice), and little control over how things are implemented in their organisations (procedural justice).

When women and men were compared within the subsamples corresponding to public (381 women and 388 men) and private (208 women and 488 men) organisations, additional differences can be observed. In public organisations, women report lower perceptions of procedural justice, higher levels of somatic stress and general stress, and lower mental health and vitality. In private companies, women as opposed to men reported lower levels of procedural and distributive justice as well as poorer mental health and vitality.

4.4.2 *Who Cares Matters*

Many governments have promulgated laws, regulations and policies to help employees to balance their paid and unpaid work responsibilities (Pascall & Lewis, 2004). For instance, in 1997 the Netherlands issued a white paper promoting gender equality by encouraging couples to share housework and changed tax policy and working time policy to balance paid and unpaid work in the proportion of men and women.

Latin American countries are still lagging behind at recognising paid and unpaid work. Lupica (2015) suggests that policy initiatives so far implemented have at least two weaknesses. On the one hand, patriarchal materialism is still at the core of Latin America's social policies. Current initiatives have seen women as a vulnerable group and, as such, their focus has been to reduce poverty rather than improve women's economic autonomy. Forstner (2013) adds that state interventions have been based on a male household head and breadwinner and female housewife model. On the other hand, policies are designed as if they do not reflect and reproduce social norms, biases and values. Under a gender-neutral perspective, labour institutions and social policies have not addressed the fundamental barriers for women's participation in the market.

Countries across the region still lack a clear agenda for integrating into their social protection policies care services that ensure a more equal distribution of the care burden and female labour participation (Economic Commission for Latin America and the Caribbean (ECLAC), 2012). Franceschet (2011) indicates that the biggest obstacle to women's rights in the region today is the ineffective implementation of existing laws and policies because of weak state capacity, insufficient resources and a lack of political will. Martínez-Franzoni and Voorend (2012) propose that transforming gender relations requires stronger mechanisms allowing childcare facilities and encouraging male participation in domestic labour.

Recently, Chile has also moved forward an agenda regarding the balance between family and work. In 2016, Law 20,940 was enacted, which modernised the labour relations system and contemplates the possibility of relaxing the legal minimums regarding work and working hours. However, this applies mainly to collective bargaining and significant unionization. Some companies are beginning to implement flexible working hours, maternity and paternity benefits, special permissions for personal purposes, economic support for personal development of family members, among others (Fundación Chile Unido, 2019).

In general, research regarding the existence of gender differences in family and work conflict has not been conclusive. While there is evidence supporting the existence of greater conflict in women versus men (Keene & Reynolds, 2005; Radó, Nagy, & Király, 2015), there is also literature supporting non gender-related differences (Bianchi, 2011; Higgins, Duxbury, & Julien, 2014; Shockley, Shen, DeNunzio, Arvan, & Knudsen, 2017). Our findings support the second stream of research. In our sample no significant differences were observed between women and men in relation to work-family/family-work conflict.

In cultures where gender egalitarianism is high, the roles of men and women tend to be similar, both in work and family domains (Casper, Harris, Taylor-Bianco, & Wayne, 2011; Powell, Francesco, & Ling, 2009; Shockley et al., 2017). However, Chile is not a country with these characteristics, as traditional gender roles are very much alive (United Nations Development programme (UNDP), 2018). Chilean women, whether they have a job or not, continue to spend more hours of the day performing unpaid work than men. Employed women spend 5.85 h a day in unpaid work, compared to men in the same conditions, who spend 2.85 h a day doing unpaid work (National Institute for Statistics (INE), 2015).

Therefore, our findings could be related to the fact that men and women have "made peace" with their more traditional gender roles or are less aware of them (Gutek et al., 1991). We explore further this idea by adding family responsibilities as a variable. The role of family responsibilities has been explored in previous research. For example, Sjörs, Ljung, and Jonsdottir (2014) indicate that women, having the double burden of fulfilling work tasks and doing household chores, are more likely to suffer stress related to unpaid work. Likewise, the number of women who fulfill the role of main provider has increased (OECD, 2011). For those women, the workload is greater, increasing the possibility of developing mental health problems (García, Mariscal, García, & Ritzel, 2012; Krantz, Berntsson, & Lundberg, 2005).

Family responsibilities are here defined as being the main provider and the main responsible for domestic tasks. In our sample, 34.1% of women have family responsibilities, compared to 14.8% of men. Withing this group, men presented higher levels of work to family and family to work conflict and lower job satisfaction levels, while women with family responsibilities showed higher levels of somatic stress. In other words, the greater the family responsibilities, the greater the work-related stress for women, while the lower the job satisfaction for men and difficulties to balance family and work.

4.5 Conclusions and the Way Forward

There is increasing pressure to tackle social determinants of health and health inequalities, through the implementation of appropriate interventions (Bambra et al., 2009). By looking at the fairness of the distribution of hazards and risks in the work environment from a gender perspective, companies and policymakers can address inequalities in occupational health more effectively. This chapter therefore explored how gender, elements of the psychosocial work environment and their interaction can lead to inequalities in occupational health outcomes. We looked at whether a set of occupational health outcomes differ for male and female workers. The results underline the role of gender as a social determinant of self-reported health outcomes. Women tend to consider themselves less healthy, be on sick leave more time, and suffer more from work-related stress.

The importance of the social determinants in explaining these health inequalities is well established. We explored how the interaction between gender and working

conditions play a role in the explanation of the identified health inequalities. For both, men and women, organisational justice was correlated with health outcomes. The better the perception of justice at work, the better the self-reported health indicators, and the less the number and duration of sick absences.

However, women tend to perceive their work environments as less fair than men, reducing also their health outcomes. This supports the relevance of human diversity when addressing gender inequalities in the work environment. Men and women have different conceptions of what a just working environment is, and current arrangements seem to be gender biased. Therefore, business leaders and policymakers alone will not be able to advance a precise idea of the good without this diversity (Deneulin, 2011; Sen, 2009). Our results show that those conditions also vary in public and private companies. Women and men reported different patterns in the behaviour of psychosocial risks and health outcomes.

The differential justice perceptions may be closely linked to the interaction between the work environment and gender differences in moral reasoning. Gilligan (1977, 1982) proposes that men and women speak in different moral voices. In assessing the ethical content of a decision, women tend to focus on the interpersonal aspects of the situation, as well as the acceptability of the overall decision, whereas men take more of an impersonal approach and abstract the moral content from the interpersonal situation (Stedham, Yamamura, & Beekun, 2007). In making justice evaluations, men tend to focus more on how fair the outcomes are, while women focus on the relational and procedural aspects of justice (Sweeney & McFarlin, 1997).

Our results also show that the better the perception of organisational justice, the lower the level of work-family conflict and, consequently, the lower the work-related stress for both, men and women. Now, when family responsibilities are considered (main provider and main responsible for domestic tasks), men tend to have more difficulties than women to balance work and family, leading to lower job satisfaction. Women, on the other hand, suffer more from work-related stress, but not from work-family conflict. These findings complement the growing understanding of gender and the work environment as social determinants of health, and underline that gender inequalities affect not only women, but also men.

In this respect, Torres et al. (2019) propose that companies need to assume a more transforming role towards addressing gender inequalities. A gender transforming company is a company that makes their benefits accessible to men and women beyond any bias based on traditional gender roles and expectations (such as parenting or caring responsibilities). This is key at addressing gender inequalities as long as those policies do not try to facilitate an activity which is purely based on a sex difference (e.g. giving birth, breastfeeding, etc.), or those initiatives aimed at compensating women for gender-based inequalities (e.g. affirmative/positive action, and representation quotes).

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