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The #MeToo movement: an opportunity in public health?

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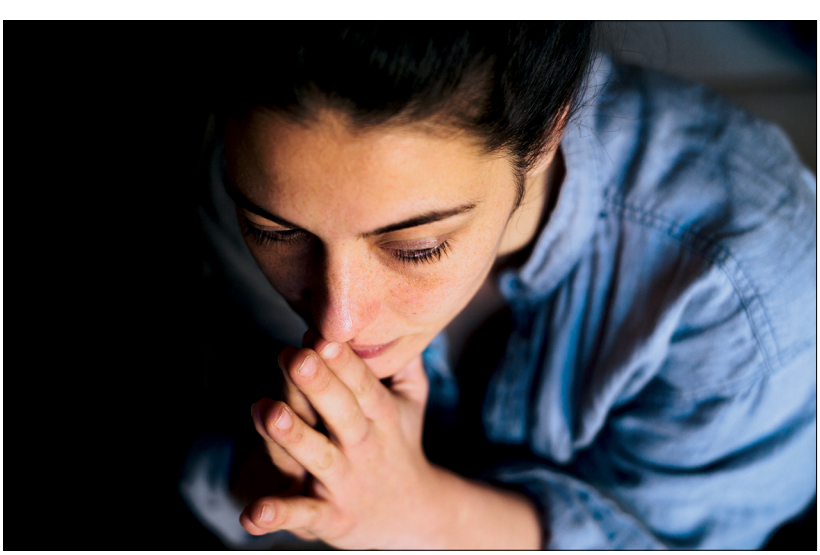
The worldwide #MeToo movement has brought renewed attention to the issue of sexual harassment in the workplace. Such sexual harassment is a form of gender-based violence at work that is an organisational, criminal, and ethical issue. Despite this renewed focus, sexual harassment is rarely considered a public health issue. The #MeToo movement presents an opportunity for the public health community to consider sexual harassment a health issue with implications for disease prevention and health promotion.

Globally, more than one in three women are victims of sexual harassment or gender-based physical or sexual violence.[1] In countries in the Organisation for Economic Co-operation and Development, such as Australia, as many as 40–60% of women have experienced gender-based violence in the context of employment.[2] In some European countries, such as Finland, almost twice as many women have experienced gender-based violence at work than men; a difference that is partly explained by exposure to sexual harassment.[3] Women are more likely to have adverse health effects owing to sexual harassment.[4-6] Victims, witnesses, or bystanders of sexual harassment can have adverse psychological consequences,[4] including depression, anxiety, and post-traumatic stress disorder (PTSD)—all risk factors for various chronic diseases.[7] A 2012 review found sexual harassment doubled the risk of persistent psychological distress after 2 years for women but not men.[4]

Sexual harassment and other forms of gender-based violence at work act as any other chronic, pervasive, environmental stressor, even after the removal of the threat. Stress is an independent risk factor for a range of chronic diseases, including cardiovascular disease and some cancers.[8] Stress incites adverse physiological effects on nocturnal blood pressure recovery[9] and daytime blood pressure,[10] cortisol concentrations,[11] and heart rate variability.[12] Furthermore, stress is associated with risk factors for chronic diseases, such as obesity,[13] hypertension,[14] smoking, and harmful use of alcohol among women.[15] Chronic stress owing to sexism or discrimination more broadly is associated with mental disorders like PTSD,[16] and more negative mental and physical health,[17] which are independent risk factors for chronic diseases.[7]

Poor organisational responses to sexual harassment in the workplace can revictimise and exacerbate the negative effects on health. Sexual harassment compromises productivity, presenteeism, turnover, absenteeism, morale, and organisational culture.[18] Additionally, sexual harassment prevents employees reaching their full professional and personal potential, accentuating gender-based inequalities that already exist in almost all employment sectors.



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From a social determinants of health perspective, addressing the social and economic inequities that drive sexual harassment is key to improving the health status of women. For example, the social gradient of heart disease first observed in the Whitehall II study[19] would potentially be alleviated by improving women's access to financial and other resources, access to power, and their socioeconomic position more broadly. From a feminist perspective, challenging complex issues such as male entitlement, rigid gender norms, and the subjugation and objectification of women that arise from patriarchal power structures is likely to benefit women's health. As generations become more accustomed to the expansion of gendered roles and egalitarianism, one would expect to see a decrease in sexual harassment, and the associated stress that drives chronic disease. While the evidence from socially progressive countries such as those in Scandinavia is mixed (eg, "the Nordic paradox"),[20] there is some evidence that women living in countries with greater gender equality have better health: population-level data from 27 countries show women who reside in countries with greater equality and positive attitudes towards women had better cognitive function in later life (>50 years), which persisted after accounting for reverse causality.[21] Other health benefits associated with key aspects of gender equality, such as greater reproductive rights, female political participation, economic autonomy and earnings, and a smaller gender pay gap, include lower levels of depression,[22,23] rates of PTSD,[24] and even mortality in both women and men.[25]

Major gaps in the evidence base exist regarding whether initiatives to prevent sexual harassment in the workplace can effectively impact health outcomes. Furthermore, key questions remain about the health effects of backlash and hostile sexism that occur in response to such initiatives. Backlash in response to progressive social change is a recognised phenomenon whereby a privileged group acts to defend its status.[26] The impact of backlash, specifically resulting from workplace gender equality initiatives, likely poses unique health risks to employees, yet the magnitude of this remains unknown. Failure to invest in this type of research or to recognise that exposure to sexual harassment is a pervasive health issue underplays the importance of efforts such as the #MeToo movement to promote women's rights and address gender-based violence. We must invest more in these areas to seize an important public health opportunity.

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Intersectionality and why it matters to global health

Leaving no one behind—a cornerstone of the Sustainable Development Goals (SDGs) agenda—represents a shift in thinking and enquiring about and tackling global challenges. However, to achieve the ambitious global health goals laid out in the SDGs, new ways to understand the complex nature of health inequities, especially among the most vulnerable populations around the world, are required.

Increasingly, intersectionality is seen as a promising approach to the analysis of multifaceted power structures and processes that produce and sustain unequal health outcomes.[1–4] Intersectionality emerged from several theories—black feminist, Indigenous feminist, third-world feminist, queer, and postcolonial—and was first coined by American sociologist Kimberlé Crenshaw in 1989.[5] Intersectionality moves beyond examining individual factors such as biology, socioeconomic status, sex, gender, and race. Instead, it focuses on the relationships and interactions between such factors, and across multiple levels of society, to determine how health is shaped across population groups and geographical contexts.

This approach achieves two crucial aims. First, it brings attention to important differences within population groups that are often portrayed as relatively homogenous such as women, men, migrants, Indigenous peoples, and visible minorities.[6] For example, it gives rise to an understanding that a white woman from a lower socioeconomic group might be penalised for her gender and class when accessing health and social care but has the relative advantage of race over a black woman. These different aspects inform each other and are not experienced separately. Second, it sheds light on the fact that individual and group inequities are shaped by interactions between multiple sites and levels of power: institutions such as families, governments, laws, and policies; structures of discrimination such as sexism, ableism, and racism; and broader processes of globalisation and neoliberalism. The goal of an intersectionality-informed analysis is to map health inequities with more precision and then to chart more effective directions in policy and programme development.

To illustrate the added value of intersectionality, we consider two global health issues prioritised on the SDGs agenda: cardiovascular disease and migration.

Cardiovascular disease is the leading cause of death globally, and differences in its distribution and risk by geography, socioeconomic status, race or ethnicity, and sex are well documented. Such factors have often been researched individually, with less attention to within-group differences in terms of aetiology, onset, trajectory, health-seeking, and outcomes across differentially situated women and men. A recent study[7] showed that although cardiovascular disease death rates have declined considerably over the past 10 years globally, there are stronger age-specific reductions in rates for men than for women.

An intersectionality lens builds on this type of analysis by advancing an approach that systematically examines various factors affecting cardiovascular disease simultaneously, bringing attention to the synergistic effects of heterogeneous risk factors and experiences.[8,9] For example, Indigenous populations in Canada experience a disproportionate and growing burden of cardiovascular disease compared with non-Indigenous Canadians due to a unique combination of factors including lower average socioeconomic status, higher levels of alcohol and drug addiction, higher prevalence of mental health issues including trauma, inadequate infrastructure for physical activity, and greater barriers to accessing or receiving health services.[10] This burden will in turn be experienced differently by Indigenous