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# GENDER AND HEALTH PROMOTION: A MULTISECTORAL POLICY APPROACH

*Piroska Östlin*(1), Elizabeth Eckermann (2), Udaya Shankar Mishra (3), Mwansa Nkowane (4), Eva Wallstam (4)*

1. Department of Public Health Sciences, Division of International Health, Karolinska Institutet, Stockholm, Sweden
2. Research, Arts Faculty, Deakin University, Geelong, Australia
3. Centre for Development Studies, Kerala, India.
4. World Health Organisation, Department of Gender, Women and Health, Geneva, Switzerland

**Corresponding author*. Karolinska Institutet, Department of Public Health Sciences, Division of International Health, SE-171 77 Stockholm, Sweden. E-mail: piroska.ostlin@ki.se

**Abstract**

Women and men are different as regards their biology, the roles and responsibilities that society assigns to them, and their position in the family and community. These factors have a great influence on causes, consequences and management of diseases and ill-health and on the efficacy of health promotion policies and programmes. This is confirmed by evidence on male-female differences in cause-specific mortality and morbidity and exposure to risk factors. Health promoting interventions aimed at ensuring safe and supportive environments, healthy living conditions and lifestyles, community involvement and participation, access to essential facilities and to social and health services, need to address these differences between women and men, boys and girls in an equitable manner in order to be effective. The aim of this paper is to (a) demonstrate that health promotion policies that take women's and men's differential biological and social vulnerability to health risks, and the unequal power relationships between the sexes, into account are more likely to be successful and effective compared to policies that are not concerned with such differences, and (b) discuss what is required to build a multisectoral policy response to gender inequities in health through health promotion and disease prevention. The requirements discussed in the paper include 1) the establishment of joint commitment for policy within society through setting objectives related to gender equality and equity in health as well as health promotion, 2) an assessment and analysis of gender inequalities affecting health and determinants of health, 3) the actions needed to tackle the main determinants of those inequalities, and 4) documentation and dissemination of effective and gender sensitive policy interventions to promote health. In

the discussion of these key policy elements we use illustrative examples of good practices from different countries around the world.

## Introduction

In most countries, resources allocated by government to health promoting activities are very limited compared to investments in medical care (McGinnis *et al.*, 2002). This imbalance is evident also in the richest countries of the world. For example, in the US approximately 95 percent of the health expenditure goes to direct medical care services, while only 5 percent is allocated to prevention activities (Centers for Medicare and Medicaid Services, 2000). In Canada, the medical care systems absorbs the majority of health sector resources, with less than 3 percent of health spending allocated towards health promotion (Hylton, 2003). Therefore, it is of utmost importance to invest these limited resources in preventive activities with high potential for success and cost-effectiveness.

In the first section of this paper we argue that health promotion policies that take women's and men's differential biological and social vulnerability to health risks (as well as their unequal access to power), into account are more likely to be successful and cost-effective compared to policies that are not concerned with such differences. Examples of the lack of gender perspectives in health promotion programmes are provided and discussed in this section.

Illustrated by examples of good practices from different regions of the world, we discuss in the second section what is needed to counteract gender insensitivity in health promotion interventions and what is required to build a strong multisectoral policy response to gender inequities in health through health promotion and disease prevention. We emphasize the need for upstream health promotion actions within the broader social and economic arena (e.g. finance, labour market, education) where the unequal distributions of power, wealth and risks to health between men and women are generated, beyond the reach of the health care sector.

## 1. Why should health promotion and disease prevention policies and interventions pay attention to gender?

There is overwhelming evidence from all fields of health research that women and men are different as regards their biology (sex differences), their access to and control over resources and their decision-making power in the family and community, as well as the roles and responsibilities that society assigns to them (gender differences). Together gender and sex, often in interaction with socioeconomic circumstances, influence exposure to health risks, access to health information and services, health outcomes, and the social and economic consequences of ill-health. Recognizing the root causes of gender inequities in health is crucial therefore when designing health system responses. Health promotion as well as disease prevention needs to address these differences between women and men, boys and girls in an equitable manner in order to be effective (for a more detailed discussion and examples see Keleher 2004).

Today, there is a growing recognition, among health professionals, researchers and policymakers, of the widespread and profound implications of gender-based inequities in health. There is also emerging evidence that integrating gender considerations into interventions has a positive effect on health outcomes across various domains (Boerder *et al.*, 2004). Even though knowledge of gender differences in health is increasingly available, it does not always translate easily into realities of health planning and programme implementation. The field of health promotion is no exception: the lack of translation of knowledge about gender inequities in health into health promotion interventions leads to misallocated resources and weakened potential for success. For example, violence against women - arguably the most extreme phenomenon of gender inequality - affects millions of women. Until recently, the magnitude and health consequences of domestic violence against women have been neglected in both research and policy (Garcia-Moreno, 2002). We have now clear evidence (Astbury and Cabral, 2000; WHO/WPRO, 1998; WHO, 2002; WHO, 2005; ARROW, 2005) that gender-based violence causes physical and psychological harm. In addition, it undermines the social, economic, spiritual and emotional well being of the survivor, the perpetrator and society as a whole, but it also compromises the trust relationship between men and women. The social, economic, psychological, physical, emotional and relationship harm to individuals from gender-based violence constitutes a major health concern which requires creative and imaginative responses from the plethora of policy-makers and intervention agencies dealing with health promotion and prevention of violence. In particular, lack of attention to the hidden emotional outcome of gender-based violence, loss of trust, loss of dignity and a deeply compromised self esteem need to be addressed alongside housing, economic

support, social welfare and legal issues as part of an integrated health promotion strategy (Eckermann, 2006).

### *1.1 Gender blindness*

When planning and implementing health promotion and disease prevention strategies, gender is an issue that is often neglected (Cristofides, 2001; Roses Periago, 2004; Östlin, 2002). Generally, there seems to be an assumption that interventions will be just as effective for men as for women. Many health promotion programmes are gender blind and based on research where the sex of the study participants is not made explicit. Gender-neutral expressions, such as 'health care providers', 'children', 'adolescents' or 'employees' are often used in programme descriptions and reports (Ekenvall *et al.,* 1993). As a result, collection, analysis and presentation of data are often not sex-disaggregated and no gender analysis is undertaken.

Terminology is crucial in framing gendered responses to health promotion challenges. For example, the WHO, 2005 Multi-country Study authors recommend using the term 'gender-based violence' to replace the commonly used descriptive terms: intimate partner violence (denotes relationship to perpetrator), domestic violence (denotes location of the abuse) and violence against women (denotes the sex of the survivor). This ensures that the cause of the violence is not forgotten. Violence is regularly the product of socialized but mutable gender relationships, and this is written into the term 'gender-based violence'. Relationship problems take centre stage with risky behaviour, social disadvantage, environmental degradation and germs in the aetiological chain of events that lead to ill-

health and compromised wellbeing (Eckermann, 2006). Health promotion initiatives need to recognize the importance of good gender relationships in promoting health and wellbeing.

### *1.2 Gender' as a proxy for 'women'*

Health promotion involves the agent of promotion and the beneficiary of it. In this context the social construction of gender roles come into play as many of the promotional measures are put into action by women being the care guarantor of every individual in the household. Consequently, health promotion messages often target women in their assigned role as caregivers in the family (Doyal, 2001). Since women's ability to make decisions about implementing health promotional measures is often limited in many countries due to their lower status in the household, the positive health effects of the promotional measures may be less than expected. When health promotion campaigns are addressed to the family as a whole, and to the relationships between males and females of all ages, health programmes can be considerably improved. In Ghana, for example, information about the importance of child immunization was directed to both fathers and mothers. As a result, men have taken greater responsibility for their children's health, leading to increased vaccination rates and earlier immunization (Brugha *et al.,* 1996). In Lao PDR, an outreach health promotion programme attached to the Bolikhan District Maternity Waiting Home targeted men in 11 remote Hmong and Lao villages to encourage them to take an active role in reproductive health. Interactive sessions addressed, male and female anatomy and function, fertilization, physiology of pregnancy,

birth spacing including responsibility of men, STI and HIV prevention, the importance of antenatal and postnatal care, nutrition and relaxation during pregnancy. Attendance rates were over 80% of the men in each village. Before the programme, only 18 % of participants said they had a very good knowledge of reproductive health issues. At the end of the programme, 72 % of participants reported very good knowledge. Thus gendered knowledge barriers to health improvement were greatly reduced in all 11 villages (Eckermann, 2005).

### *1.3 Focus on behavioural change*

Many health promotion strategies aim at reducing risk behaviours, such as smoking, while ignoring the material, social and psychological conditions within which the targeted behaviours are embedded. For example, in many countries there is a strong association between material hardship, low social status, stressful work or life events and smoking prevalence (Bobak *et al., 2000;* Osler *et al*., 2001). Critics have argued that gender roles and health-related behaviours linked to those roles in many health promotion programmes have led to a focus on behavioural change at the individual level, rather than on policy change at the societal level (Kabeer, 1994; Stronks *et al.,* 1996). For example, prevention strategies to reduce harmful stress among working women often include measures where the onus is put on women to develop their own personal stress coping strategies to balance competing gender roles. Targeted women often feel accused of not being able to cope with multiple pressures arising from their responsibilities as mothers, wives, housekeepers and workers. To avoid this, complementary measures to ease

women's burden, such as the universal provision of accessible and affordable day-care centres for children and the introduction of more flexible working hours, should also be introduced.

Similarly, many men may experience extraordinary pressures from unemployment and material hardship, which constrain them to fulfil their assigned gender role as "breadwinners" (Möller-Leimkühler, 2004). Those who try to cope with stresses through behaviours, such as smoking, drinking or drug abuse, are accused of risking their health by their own personal choice. Strategies that aim at changing the life-styles of these men would probably be more effective if combined with measures to change the social environment in which the health damaging life-styles are embedded.

According to a study from Thailand, while the nationwide "100% condom programme" to prevent HIV infection has led to a decrease of the infection among men, young women who were engaged in commercial sex have not been protected from the infection to the same degree as men (Kilmarx *et al.*,1999). Obviously, there is a need for policies that recognise and address the gender differences of status and power that structure sexual relationships and counteract women's lack of assertiveness to insist on condom use. Again the issue of trust in the relationships between men and women is a key factor for health promotion programmes to take into account.

### *1.4 Lack of multisectoral approach*

Traditionally, the health field has been predominantly the domain of medical professionals and the health care sector, where the main focus is on individual health and individual risk factors. Therefore, health promotion and disease prevention strategies within the health care sector are often limited to individual health advice, e.g. on smoking cessation. One limitation of this is that certain groups of people, such as the poor who cannot afford user fees, or women who cannot without permission from their husbands visit health clinics, will be excluded from health advice and information. Another limitation is that the promotional measures within the health care sector are unable to tackle the root causes of health disparities. Many of the health determinants need to be tackled by policies in sectors where health is created, such as the labour market, social services, education system, housing, environmental protection, water and sanitation, transport, road safety and security. These policies have direct and indirect health impacts, which may differ between men and women (Benzeval *et al., 1996)*. The understanding that both women's and men's health is dependent on several societal sectors is critical to upstream, multisectoral health promoting policies and interventions. Any such initiative should take into account the involvement of key stakeholders in communities and needs to be acceptable at individual, household as well as societal levels. In many traditional communities traditional chiefs, or village leaders, act as gatekeepers in all educational and community-based activities so it is essential to incorporate these key stakeholders in any health promotion policies and interventions designed to reduce gender inequities.

### *1.5 Top-down approach*

The traditional public health approach is top-down rather than bottom-up, with experts identifying problems and formulating interventions while the problems and solutions as perceived by those at particular risk rarely constitute the base for action (Dahlgren, 1996). The power of change is then defined primarily in political and professional terms without the possibility of the targeted people to influence and control various determinants of health. Because of power imbalances, and because of the low representation of women in decision-making bodies, women can seldom make their voices heard. As a result, health promotion programmes designed in top-down manner will not necessarily correspond to women's health needs. Health promotion policies and activities are most meaningful when target communities and groups are involved in all aspects of policy and programme development, implementation and evaluation. For example, "The Blue Nile Health Project" in Sudan with the objective to control water associated diseases was perceived as very successful, thanks to the particular emphasis in the programme on gender-related aspects that defined women's role and participation (A/Rahman et al., 1996). The study urges health planners to persuade the subordinated communities of women in many African countries, like Sudan, to play a more active role in the health programmes.

## 2. The way forward: multisectoral policy response to gender inequities in health through health promotion and disease prevention

Building on past experience from successful and less successful health promotion strategies from a gender equity perspective, we discuss in the following some minimum requirements for gender-sensitive health promotion and disease prevention policies and programmes.

### *2.1 Joint commitment*

Through international agreements, such as the Ottawa Charter for Health Promotion and the WHO Health For All Strategy (World Health Organization, 1981), many countries have already committed themselves to health promotion. Likewise, most countries in the world have committed themselves to promote gender equity. These agreements state that all women and men have the right to live without discrimination in all spheres of life, including access to health care, education, and equal remuneration for equal work[1]. The recently adopted Bangkok Charter for Health Promotion states that health promotion contributes, among other things, to reducing both health and gender inequities.

Some major achievements in working towards gender equity are evident. For example, the Multi-country Study on Health and Domestic Violence against Women acknowledges

[1] The United Nations International Covenant on Economic, Social and Cultural Rights, Article 12 and the United Nations International Covenant on Civil and Political Rights, Article 2.1 and Article 3. The United Nations Economic, Social and Cultural Rights, Article 2.2, Article 3, Article 7(a)(i), Article 12.2(d), and Article 13.

the ‘combined efforts of grass-roots and international women’s organizations, international experts and committed governments’ in producing ‘a profound transformation of public awareness’ (WHO, 2005:1) about gender-based violence. Since the World Conference on Human Rights (1993), the International Conference on Population and Development (1994) and the Fourth World Conference on Women (1995), the perception of gender-based violence as purely a welfare and justice issue has changed significantly to the point where violence against women is ‘now widely recognized as a serious human rights abuse’ as well as ‘an important public health problem that concerns all sectors’ (WHO, 2005:1). However, as the 10 year reviews of the ICPD Plan of Action and the Beijing Platform for Action have highlighted (ARROW, 2005; WHO, 2005), all countries still have a long way to go to achieve gender equity in all areas of health and wellbeing.

The internationally agreed Millennium Development Goals (MDGs) identified “Gender equality and empowerment of women” as the third of eight goals and a condition for achieving the other seven. Although, these and similar commitments[2] have been ratified by most United Nations Member States, action by governments to bring national laws, policies and practices in line with the provisions of the ratified conventions has lagged

[2] E.g. Article 25 of the Universal Declaration of Human Rights in 1948; The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) in 1973, the Declaration on the Elimination of Violence against Women of 1993, the Programme of Action of the International Conference on Population and Development (ICPD) in Cairo in 1994, the World Summit for Social Development in Copenhagen and The Beijing Declaration and Platform for Action in 1995, The Declaration of Commitment on HIV/AIDS adopted at the UN General Assembly Special Session on HIV/AIDS (UNGASS) in 2001.

behind (United Nations, 2005). Moreover, these commitments have not been pursued in the health sector.

The Beijing Declaration and Platform for Action in 1995 as well as the UN Economic and Social Council (ECOSOC) in 1997 have clearly established "gender mainstreaming" as the global strategy for promoting, among other things, women's health. In the field of public health, this strategy means the integration of both women's and men's concerns into the formulation, monitoring and analysis of policies, programmes and projects. In relation to health promotion, it entails taking into account gender issues that have implications for individual and community health.

Setting international, national and local objectives for gender equity in health is the first step in establishing a joint commitment. These objectives need to be measurable and translated into policies and actions.

A good example of translating international objectives to promote gender equity and health into national objectives comes from Lao PDR. The Lao Ministries of Health and Education have signed, in response to the need to meet the targets of the MDGs, a memorandum of understanding to collaborate in developing health promotion programmes in Lao primary schools which address all 8 targets including MDG 3 to promote gender equity. In combination with the Lao Women's Union, village health committees, NGOs and international organizations, the Lao government ministries have

also developed a multi-sectoral national development plan to mainstream gender into all areas of health and wellbeing.

### *2.2 Assessment and analysis of gender inequities in health*

In order to maximize efficient use of resources, health promoting strategies and actions, in general, need to be based on an assessment of the size, nature and root causes of gender inequalities in health. More specifically, health promotion relating to certain issues, for example gender-based violence, HIV/AIDS, malaria, nutrition or smoking, needs to be designed with an understanding of how women and men differ in relation to the issue's causes, manifestations and consequences. Collection, analysis and reporting of data disaggregated by sex, age, socioeconomic status, education, ethnicity, and geographic location should be performed systematically by individual research projects or through larger data systems. Attention needs to be paid to the possibility that data may reflect systematic gender biases due to inadequate methodologies that fail to capture women's and men's different realities (Östlin *et al.*, 2004). The promotion of gender sensitive-research to inform the development, implementation, monitoring and evaluation of health promotion policies and programs is also desirable.

One good example of recording sex disaggregated, gender sensitive and gender specific health data comes from Malaysia. In 2000, the Asian-Pacific Resource & Research Centre for Women (ARROW) published 'A Framework of Indicators for Action on Women's Health Needs & Rights after Beijing' (ARROW, 2000). This publication was

developed as a tool for all government, non-government and international organisations to use in monitoring implementation of the Beijing Platform for Action. The framework presents selected Beijing recommendations on women's health and rights, sexual and reproductive health, violence against women and gender-sensitive health programmes, which are then operationalised into quantitative and qualitative indicators. These can be measured to assess progress particularly in women's health status; health service provision, use and quality; and national laws, policies and plans. This will be reviewed in a publication to be released in late 2006. Meanwhile, ARROW (2005) has applied a similar framework in its 'Monitoring Ten Years of ICPD Implementation'. Eight countries in the Asia Pacific region were examined in detail, using indicators derived from the ICPD recommendations, to 'assess progress in policies, laws and services and changes in women's health, status and lives', over the past ten years and to 'identify the main barriers and facilitating factors in implementing commitments made in the Programme of Action, ICPD' (ARROW, 2005:17). The Report reveals that ten years after ICPD, 'women's lives have seen only minimal improvement' and 'violence against women is on the rise, as is HIV/AIDS transmission for women and men' (ARROW, 2005: 17). The Report argues that 'one of the best indicators of real change in power relations between men and women is a decrease in domestic violence and rape' yet 'only two of the eight countries (Cambodia and Malaysia) had ever had a national prevalence survey on domestic violence' (ARROW, 2005:43) let alone put prevention strategies in place.

The health promotion recommendations that emerge form the 2005 ARROW Report suggest a major rethinking of intervention to deal with key challenges. These challenges

include:  deeply embedded patriarchy, early marriage and early first parity, declining commitment of service providers, lack of political will and stability, social inequities, religious fundamentalism in some areas, trends to privatisation, liberalisation and globalisation, and persistent low levels of literacy among women and girls. Key recommendations for health promotion include niche planning by governments, rather than the use of uniform 'one size fits all' health promotion programmes, using NGOs as clearing houses for up-to-date dissemination of data and community-based workshops on a variety of health issues and using traditional authority processes (such as village chief authorization) to run campaigns to promote female literacy and education.

Another good practice in analysing data by gender to inform implementation of a health promotional intervention has taken place in São Paulo in Brazil. The Agita São Paulo Programme to promote physical activity is a multi-level, community-wide intervention. Gender analysis of sex-disaggregated data revealed important differences between adolescent boys and girls concerning patterns of physical activity (Matsudo *et al.,* 2002). Firstly, girls were more involved in vigorous physical activity than boys, which was a surprise because literature from several developed countries suggested the opposite. Further analysis showed that the main reason behind this was girls' involvement in strenuous housekeeping (42% of girls versus 6% of boys). On the other hand, boys utilised more active transportation to and from school (100% of boys versus 57% of girls). This was a very important source of information for the programme managers for the design and kind of intervention to increase physical activity among girls and boys.

### *2.3 Actions needed to tackle the main social and environmental determinants of gender inequities in health*

The prime determinants of gender inequities in health are social and economic disadvantages related to factors such as decision-making power, income, employment, working environment, education, housing, nutrition and individual behaviours. As mentioned previously, women and men are exposed to various risk factors to different degrees due to differences in gender roles and living and working conditions. These differences are crucial to recognize, estimate and monitor when designing interventions, programmes and population-wide risk reduction strategies. Many determinants of gender inequities in health can be influenced by health promoting measures and risk reduction strategies ranging from micro to macro public policy levels (Dahlgren and Whitehead, 1991). Keleher (2004) emphasises the need for sustainable upstream strategies that address the economic, social and cultural obstacles that prevent women from fulfilling their potential. She argues that such strategies are much more likely to bring about sustainable change than a continual reliance on midstream and downstream strategies.

*(a) Actions to strengthen individuals*

Many health promoting interventions with a gender perspective have focused mainly on strengthening women's and girl' capacity to better respond to, and control determinants of, health in the physical and social environment. They include gaining access to

economic capital, as well as social and cultural capital. The most effective interventions are those with an empowerment focus (Sen and Batliwala, 2000). They aim to help women to: gain knowledge about, and access to, their rights, access micro-credit to start their own businesses, improve their access to essential services, address perceived deficiencies in their knowledge (including literacy and secondary education), acquire personal skills, and thereby improve their health. Empowerment initiatives aim to encourage both sexes to challenge gender stereotypes. Such actions can include, for example, training boys and men to reduce gender biases by promoting gender-sensitive behaviour and reducing violence. Another example of such initiatives is raising awareness among young girls and their families about unfair discrimination against girls and thereby promoting the status and a value of the girl child. The Girl Child Project in Pakistan has for example made girls aware that unequal food allocation in the family is wrong (Craft, 1997).

*(b) Actions to strengthen communities*

Strengthening communities can cover a wide spectrum of strategies aimed at strengthening the way deprived communities function collectively for mutual support and benefit. These range from helping to create meeting places and facilities for social interaction to supporting communities' defence against health hazards, such as substance abuse, crime and violence or environmental pollution. For example, several innovative and gender-sensitive community level initiatives have emerged in Africa over the past decade in response to the devastating effects of the AIDS epidemic in the region (Iwere,

2000). One of these initiatives is the Community Life Project in Lagos, Nigeria which is a unique example of how synergistic partnerships between activists, community and religious organizations, local institutions, involving men, women, and children simultaneously, can help to effectively break the silence on sexuality issues (Ojidoh and Okide, 2002). The project is working with 23 community groups to increase and sustain HIV/AIDS awareness in the community; addressing HIV/AIDS within the broader framework of sexual and reproductive health through sexuality education sessions; and increasing community ownership and participation by training representatives of the groups as volunteers and family life educators. Thus, the initiative places sexuality education on the community's agenda, thereby creating a supportive environment for advancing women's reproductive and sexual health.

In the Woorabinda Aboriginal community in rural Queensland, Australia, the community has organized sanctions around the weekend Australian Rules Football match related to gender-based violence. Any player who has been identified as having abused his partner during any week is banned by the team committee from playing in the football match at the weekend. This reinforces community and shared abhorrence of gender-based violence and acts as a public endorsement of good relations between men and women in the community (ABC, 2000; Queensland Government, 2000).

*(c) Actions to promote gender equity in access to essential facilities and services*

In both industrialized and developing countries improvements in living and working conditions and access to services have been shown to bring substantial health

improvements to populations. Public health initiatives influencing living and working conditions include measures to improve access to clean water, adequate nutrition and housing, sanitation, safer workplaces and health and other welfare services. Policies within these areas are normally the responsibility of separate sectors and there is a need for them to co-operate in order to improve the health of the population. Health promotion policies and interventions aiming at improving living and working conditions and access to services need to be particularly gender sensitive due to the fact that women and men face distinct health risks in their living and working environment and have different health needs. For example, many developing countries suffer from weak health services, infrastructures and unaffordable services, a situation that disproportionately affects women as they require more preventive reproductive health services. The inadequacy and lack of affordability of health services is compounded by physical and cultural barriers to care. At the national level some attempts have been made to tackle cost and affordability barriers in health services to women. For example, South Africa and Sri Lanka provide free maternal and infant health services. In some cultures, women are reluctant to consult male doctors. The lack of female medical personnel is an important barrier to utilization of health services for many women (Zaidi, 1996). To overcome this barrier, the Women's Health Project in Pakistan works with the Ministry of Health to improve the health of women, girls and infants in 20 predominantly rural districts in four provinces through measures, such as the expansion of community-based health care and family planning services through the recruitment and training of thousands of village women as Lady Health Workers, a 'safe delivery' campaign, and the promotion of women's health and nutritional needs and family planning (Asian Development Bank, 2004). The project

assumes that a female health care provider could better understand the problem of another woman.

*(d) Actions to encourage social and economic policy change*

Policies at the structural level include economic and social policies spanning sectors such as labour market, trade environment, and more general efforts to improve women's status. These policies have a great potential to reduce or exacerbate gender inequality, including inequities in health. Influencing factors affecting social stratification is therefore a key for the improvement of women's social position relative to men. Policies aimed at improving women's education, increasing their possibilities to earn an income within the labour market, giving women access to micro-credit to start small businesses, and family welfare policies are all measures for improving women's social status in the family and in the society. Improved social status for women relative to men may improve women's control over household resources and their own lives. For example, development policies in Matlab (Bangladesh) included strategies, such as micro-credit schemes linked to employment and provision of more places in school for daughters of poor families, which successfully increased the status of the poorest women. Equity-oriented policies in a social context in which women had traditional matrilineal rights to property and girls were valued as much as boys have resulted in considerable health gains in Kerala, India. Women could benefit from improvements in health care provision and to achieve high levels of literacy. Kerala is the only state in India where the population sex ratio has been favourable to women throughout the twentieth century and it is not plagued by the problem of "missing women" (Östlin *et al.,* 2001). Increasing the participation of women

in political and other decision-making processes - at household, community and national levels and ensuring that laws and their implementation do not discriminate against women are measures that have a great potential to improve gender equality and health equity.

The examples presented above suggest that most successful interventions are those that combine a wide range of intersectoral and upstream approaches as well as downstream interventions to tackle a problem. For example, interventions at the individual level to empower women to deal with the threats to their mental and physical health from violence are important. However, interventions are also needed at the structural level, where governments have a central role in policy and legislation and in mandating organisational change to ensure that women are in the position to be empowered. The establishment of societal freedoms from discrimination and violence must sit alongside other efforts to increase women's access to economic resources and social inclusion. These economic, legal, social and cultural assets are fundamental to generating and maintaining women's health and wellbeing but they also benefit men.

### 2.4 Documenting and disseminating effective and gender sensitive policy interventions to promote health

There is a paucity of information on cost-effective and gender sensitive health promoting strategies and interventions that have successfully addressed social determinants of health,

and little concrete guidance is available to policymakers. Developing an international reporting system to collect such information in order to increase the accessibility for policy-makers to relevant information needs to be encouraged. Monitoring and evaluation of strategies and interventions are also important for informing future processes and track progress towards gender equality.

Indicators and methods should be developed urgently for systematic integration of gender dimensions in health impact assessments that assess not only a policy's impact at an aggregate level, but on different population groups, including the marginalized and vulnerable; such an assessment should be applicable not only to health systems policy, but also to policy in other sectors (Lehto and Ritsatakis, 1999; Whitehead *et. al*, 2000).

**Conclusion**

Recognizing gender inequalities is crucial when designing health promotion strategies. Without such a perspective their effectiveness may be jeopardized and inequities in health between men and women are likely to increase. Although, the dynamics of gender inequalities are of profound importance, gender biases in health research, policy and programming, and institutions continue to create a vicious circle that downgrades and neglects gender perspectives in health.

In some countries, such as Canada (Status of Women Canada, 2001) and a number of European countries (Pollack and Hafner-Burton, 2000), considerable work is underway to

integrate gender perspectives in policy and practice. The country case study examples presented in this paper suggest that it is feasible and beneficial to integrate gender in health promotion policies. However, greater efforts are needed to sensitize stakeholders including health professionals - policymakers and researchers alike - to its importance. Many lessons have been learnt which can be used as building blocks for adaptation to ensure that health promotion policies are contextual in nature taking into account gender specific factors that can impinge on the promotion of health among a given community. Effective health promotion policies and programmes are those centred on joint commitment and a multisectoral approach and which are based on evidence gathered with gender dimensions in mind.

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