

Gender and health in the Eastern Mediterranean Region

Conceptual and operational advocacy



**World Health
Organization**

Regional Office for the Eastern Mediterranean

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1. Introduction

A gender perspective in health leads to a better understanding of the factors that influence the health of women and of men and is vital if equitable and effective health policies and strategies are to be developed and implemented. It is not only concerned with biological differences between women and men, or with women's reproductive role, but acknowledges the effects of the social, familial, cultural, political, economic, behavioural and spiritual determinants on relationships, roles and responsibilities of men and women, especially on individual, family and community health. The concept of gender can be used as a tool for exploring the reasons for these differences, and for identifying ways in which health outcomes for both males and females can be improved.

The basic principles of most cultures of the countries of the WHO Eastern Mediterranean Region support, protect and promote women's rights, including their right to a high standard of health and quality of life. This principle of gender equity is enshrined in the religions of the Region, which all emphasize that men and women have equal responsibility for building and maintaining human life on earth, the same rights to undertake any profession, the same rights to education and equal responsibilities in the home. Thus, religious concepts and principles should be emphasized in efforts to provide a sound foundation for social behaviour, and for optimal health outcomes for all members of society, males and females. It is important to distinguish between religious influences on behaviour and traditional influences that have developed over time, which may not be optimal for ensuring health equity.

While the conceptual and methodological framework of gender mainstreaming concerns both males and females, widespread gender disparities existing between women and men entail that particular attention is given to women's inequality. Historical evidence suggests that government policies and societal practices, coupled with low investment of resources in women's potential, have created a serious imbalance between the opportunities afforded to women to develop themselves, and thereby contribute to the socioeconomic development of the country, and those afforded to men. Globally, low levels of literacy among women, their lack of economic power and their low rates of participation in development and in political decision-making processes are among the key factors that have led to continued poor health status for women, including high levels of maternal mortality, especially in poor and developing countries.

This booklet is aimed at stakeholders in health and other sectors that determine health, both public and private. It seeks to clarify the conceptualization of gender in health in the Eastern Mediterranean Region, as well as promote the operationalization of gender in health.





2. Background

2.1 Gender and development

The past two decades have witnessed an active interest in the gender dimensions of the human, economic, social and environmental development processes. One of the major approaches to development identified by the major global conferences on women and gender convened during the 1990s, in which WHO participated, was to place improvement in the status of women, including their empowerment, at the centre of efforts to reach sustainable development in all of its economic, social and environmental dimensions.

Gender mainstreaming is a process of assessing the implications for females and males of any planned action, including legislation, policies or programmes, in any area and at all levels. It integrates females' as well as males' concerns and experiences in the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and social spheres, so that inequality between females and males is not perpetuated and that equal opportunities is promoted at all levels. It evolved from the women in development (WID) approach promoted by development theory in the 1970s and 1980s.

The WID approach arose out of the concern that women were being excluded from the development process and its benefits and, therefore, focused on women-specific programmes and projects as a way of "integrating women into development". The approach, while important, tended to isolate women as a separate and homogeneous category and did not bring about sufficient long-term changes in the social and economic conditions experienced by women. The gender and development (GAD) approach aims at redressing the inequalities between women and men, and emphasizes that women's disadvantaged position needs to be analysed and addressed, not in isolation but in relation to that of men.

2.2 Milestones

The Fourth World Conference on Women, held in Beijing in 1995, noted that 'it is essential to design, implement and monitor, with the full participation of women, effective, efficient and mutually reinforcing gender-sensitive policies and programmes' [1]. Following the Beijing Conference, most countries of the WHO Eastern Mediterranean Region established national committees for women, developed national plans of action to implement their commitments and set up monitoring systems to regularly map the progress made towards mainstreaming gender in the national development process, thereby contributing to the achievement of the Millennium Development Goals.

Following the Beijing Conference and its resolutions and commitments, the United Nations system, including WHO, formally endorsed the conclusion of the United Nations Economic and Social Council (ECOSOC), stated in July 1997, that 'gender mainstreaming in all activities of the United Nations system is a high priority' [2]. Subsequently, at the Fifty-first World Health Assembly, WHO adopted the World Health Declaration, endorsing the health-for-all policy for the 21st century which underscores gender mainstreaming as a key value, along with equity, ethics and the right to health, for achieving Health for All.

In 1999, at the Forty-sixth Session of the WHO Regional Committee for the Eastern Mediterranean, a strategy for gender mainstreaming in development (Document EM/RC46/9) was endorsed and the need to give equal opportunities to women and men to participate in public health and environmental health programmes was acknowledged. In Resolution EM/RC46/R.8, Member States of the Eastern Mediterranean were specifically called upon by the Regional Committee to establish, support and strengthen gender focal point(s) and/or gender units for health, to enhance the role of women in community-based development initiatives and to build and strengthen capacity and partnerships with national and international nongovernmental organizations and civil society institutions, in order to mainstream gender in national health and development planning processes.

A global WHO Gender Policy on Integrating Gender Perspectives in the work of WHO was endorsed by the Director-General in 2002 and accepted by the Cabinet on March 6, 2002 [2].

In September 2000, 189 nations ratified the United Nations Millennium Declaration, affirming the right of every woman, man and child to development. To allow for monitoring of progress towards development and freedom, representatives of UN agencies and other international organizations have promulgated a set of 8 Millennium Development Goals (MDGs). The MDGs acknowledge gender equity as an important prerequisite for development. MDG number 3 is expressly about gender, calling for equity between boys and girls at all levels of education. It is important to emphasize, however, that the relevance of gender is not only confined to education, but needs to be taken into serious consideration in order to achieve success in each of the MDGs [3].

2.3 Regional concept definitions of gender and related terms

Gender is a social construct which defines and describes the socially perceived roles, responsibilities, rights, opportunities and interactions for females and males for the betterment and maintenance of society, which are influenced by familial, cultural, political, economic and spiritual determinants. **Gender analysis** is a systematic gathering and examination of sex-disaggregated health indicators and data in order to identify, understand and redress health gaps based on gender.





Gender analysis identifies, analyses and defines actions to address inequalities that arise from different roles of females and males, or the disproportionate power relationships between them and the consequences of these inequalities on their lives, their health and well-being. Gender analysis reflects the positive and negative social factors and status as well as health risks and problems which both sexes may face as a result of their existing roles.

Gender equality is the absence of discrimination based on gender determinants for both sexes in access to opportunities and services, and allocation of resources and benefits.

Gender equity refers to the fairness, justice and balance in the distribution of benefits, responsibilities and roles according to gender determinants. The concept takes into consideration both sexes' needs and abilities. These differences should be identified and addressed in a manner that rectifies the imbalance between the sexes at different phases of the life cycle.

Gender mainstreaming is a process of assessing the implications for females and males of any planned action, including legislation, policies or programmes, in any area and at all levels. It integrates females' as well as males' concerns and experiences in the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and social spheres, such that inequality between males and females is not perpetuated and that equal opportunities exist at all levels. Gender mainstreaming should be responsive to the importance and requirements of cultural and spiritual norms and value systems, and contain mechanisms for affecting the way these value systems are interpreted in order to make them more cognizant of, and responsive to, the need for equity and equality.

2.4 Religion and health

A regional consultation on gender issues in health in the sociocultural context of the Eastern Mediterranean Region held in Cairo, Egypt, in December 2004 (5) identified several precepts that guarantee and promote health within religion for both males and females, including:

- the responsibility of human beings to protect the body and maintain its health
- the responsibility for personal cleanliness and domestic hygiene
- the right for every human being to be respected, to live in dignity and security
- the promotion of breastfeeding
- the promotion of sexual abstinence
- the prohibition of alcohol and drugs
- the prohibition against suicide.

The consultation sought to identify ways in which religious institutions could contribute to closing health gaps faced in the Region and work with other institutions to promote health as a human right for all males and females. It was felt that religious leaders need more specific knowledge to encourage healthy practices and dissuade people from following unhealthy ones, and that prayer time and sermons could be used for health promotion. Curricula for religious leaders should provide more information about current health issues and their relationship to religious precepts, while curricula for health workers should include religious precepts relevant to the preservation of health. Religious institutions and leaders could also play a critical role in separating religious justification from harmful cultural traditions such as female genital mutilation.

3. Gender and health in the Eastern Mediterranean Region

3.1 Mental health

The Region is undergoing a rapid transition in all aspects of life, which adversely affects mental health. The extended family, which used to provide economic security and a social support system, is being replaced by the nuclear family, and roles within the family are changing. Conflicts result when women are working but men's attitudes are not changing at the same pace. For example, in the Islamic Republic of Iran, a sudden increase in the suicide rate among young women in rural underdeveloped areas was noted; this was generally related to rapid transition, with an increase in women's literacy rates and employment, but no corresponding change in the attitude of men. There is a conflict between the pace of women's development and men's adaptation to this change.

Mental disorders are exacerbated by unplanned urbanization, the lack of basic needs such as running water and electricity, and problems of unemployment and the growing youth population. Overall, rates of mental disorders for males and females are similar, but the types of disorders, time of onset and patterns of treatment may be different. While minor early childhood disorders are more common in boys, by adolescence, girls experience more serious problems, such as eating disorders and lack of self esteem. For women, hormonal surges result in pregnancy-related problems, post-partum depression and menopausal problems. Anxiety and depression are more common among women, who are also more likely to seek help for mental disorders, and therefore have a higher use of psychotropic drugs. This may also be a result of physicians' practices, for prescribing drugs saves time and the need to consider alternative approaches. Co-morbidity is usually more common among women, often in the form of somatoform disorders—physical symptoms that are expressions of mental illness. Substance abuse is more common among men, but may be increasing among women throughout the world, including in the Eastern Mediterranean Region.





Patterns of substance abuse are also changing, with an increase in intravenous injections. Schizophrenia is more severe in men and may have an earlier onset than for women. Men can be inhibited from seeking treatment for mental disorders. The social construction of masculinity in most cultures requires them to mask their emotions and to act as if they are invulnerable. Women may also show a reduced tendency to seek care as they become more involved in paid employment, in part a response to the increasing accountability of such work, in terms of professional status and hours worked.

Within the family, a woman's mental illness affects her ability to care for her children. Emotional distress in women is often linked to domestic abuse. The burden of women's double role increases if they have to take care of family members with mental illness. The decline of the extended family increases the demands on women in such situations, as well as having a negative impact on the support system for the elderly. In addition, the whole family unit can experience stigma if one of the members is mentally ill.

Some solutions to the growing problem of mental disorders are preventive, such as life skills education, especially parenting skills. The integration of mental health services into the public health system, and the coverage of mental disorders in health insurance, would also help to protect affected families.

3.2 Women's health

Women's access to cash income in many countries of the Region is limited, and women's economic activity rate in these countries is extremely low compared to that of men. Poverty places a double burden on women, as it makes women more vulnerable to disease while being less capable of obtaining health care when it is needed. Throughout the Region, the adult literacy rate and gross primary school enrolment ratios for males are higher than for females. Women's lack of education leads to a dramatic decrease in social and economic opportunities, compared to men, with a consequent deterioration in health.

The above social factors come into play and determine much about the health risks a woman faces in her life, including her knowledge, vulnerability, personal resilience, capacity, self-confidence and access to social support systems which help her to deal with health problems as they arise. Existing gender norms hinder adolescent girls' access to formal education and, consequently, employment opportunities. This in turn places restrictions on future income and reinforces the social factors that negatively influence health. Examples include: health-related behaviour, such as seeking and receiving health care; harmful practices, such as female genital mutilation; and health policy with regard to women's health.

Health policy can influence health care provisions for women, by emphasizing the importance of equity, and the nature and quality of services available for women. Several areas have been given specific priority in WHO's policies on women's health, including the need for sex-disaggregated health data and the use of this data to inform and enhance health care delivery to meet the specific needs of males and females. In addition, the training of health staff on the management of women's health problems throughout the life cycle is critical to address the gaps being faced in women's health.

3.3 Youth

Research suggests that men and boys perceive greater pressure than women and girls to accept the gendered stereotype that men should be rugged, robust and strong. Such concepts lead to a dangerous combination of risk-taking and lack of preventive health activities. Youth are especially prone to accidents and injuries as adolescents often ignore the possible health consequences of their behaviour and are under pressure to conform to peer norms. This is more apparent for boys. For example, a study in Tunisia found risk-taking behaviour among boys twice as common as among girls. For males engaging in risk behaviour, such as drug taking and smoking, stigma and religious prohibitions may prevent them seeking care.

While sexual behaviour in youth may be sporadic and infrequent, it is often unprotected and exposes young people to the risk of sexually transmitted diseases and HIV/AIDS. Mass media, including television, video games and advertisements, often present violent behaviour as acceptable and thus encourage aggressive behaviour, especially among males.

3.4 Emergencies

In emergency settings, men and women share common problems including the loss of education, jobs and status, and social cohesion. In the 1990s, 90% of the casualties of armed conflict were civilians, many of them women and children. The impact of conflict and disasters on populations can be measured by the extent to which they: disrupt routine health care; affect mental health in terms of increasing rates of violence and substance abuse; and lead to an increase in forced labour and prostitution. Existing vulnerabilities are exacerbated among the very young, the very old and women; for example, women suffer increased anxiety, rape, and unwanted pregnancies and sexually transmitted diseases. Men and boys are more likely to serve in the military and are therefore more likely to experience disproportionate mortality and disability in this context. Landmines have caused disproportionate death and injury among children and adult males.





Host communities can stigmatize both male and female refugees and regard them as helpless victims, rather than as previously functioning members of communities with skills. Male refugees can be stigmatized if they are unemployed and female refugees can be stigmatized if they have been coerced into commercial sex, are forced to beg, or are seen as vulnerable heads of households. Male norms of behaviour may prevent men from seeking assistance while women may not have the skills to deal with the world beyond their family. In many cases, humanitarian agencies do not consult women, which results in the inappropriate design of responses to emergencies.

3.5 HIV/AIDS

In the Eastern Mediterranean Region, HIV/AIDS is a growing problem. While all figures are estimates, almost half of people living with HIV/AIDS (PLWHA) are female. Most transmission is sexual or the result of injecting drug use. The vulnerability of all sectors of the population is changing because formerly protective social behaviours are changing, mobility is increasing and socioeconomic disparities are growing larger. There are increasing populations that are socially marginal and therefore difficult to reach, such as those engaging in risky sexual behaviour and drug use. Most sectors of the population have limited access to information about HIV/AIDS and limited access to HIV/AIDS treatment.

The vulnerability of women and girls is exacerbated by stereotypes promoting their ignorance about sex and promoting passive characteristics as desirable. Current gender norms result in women having less access to resources and having less negotiating power, even within marriage. For example, a wife may have no recourse to ask for condom use by her husband. This can be problematic in the case of sexually transmitted diseases caught via extramarital affairs. Existing gender norms create a socially acceptable environment for men and boys to take risks and have multiple partners. There is a cultural silence concerning sexual health and education which needs to be overcome to protect girls and boys from the harmful effects of gender stereotyping.

3.6 Tobacco

There is a higher prevalence of male smokers in all countries of the Region. However, increasingly aggressive tobacco campaigns targeting women and the easing of societal restrictions regarding women's behaviour and autonomy have resulted in a rise in tobacco use among women. Recent reports from Somalia show a greater use of tobacco among female youth than among male youth.

Data from the Region show that the higher the social status of women, the more likely they are to smoke. Women of higher social status are also more likely to afford regular use of tobacco. Social motivations for women smoking include showing status and independence. Studies have also shown that women and girls tend to smoke as a “buffer” against negative feelings. Additional studies show that girls and women are more likely to fear weight gain than boys, and to initiate and continue smoking for weight control. Some surveys find women gain more weight after quitting than men.

Regular collection of data on tobacco use, disaggregated by sex and age, will permit identification of trends and health effects on males and females of all ages. The clinical ways of identifying smoking prevalence, such as self-reporting, must be improved, because women may be more reluctant to report on smoking due to greater social disapproval of female smoking.

4. Gender mainstreaming in health policies and programmes

4.1 Gender analysis

Differences and inequalities between women and men and their relevance to health issues must be considered. The process needs to begin with reflection of how and why gender differences and inequalities are relevant and which require further investigation. For specific diseases or conditions, gender analysis has focused on how gender inequalities and differences influence:

- health risks and protective factors
- access to resources to protect health
- the manifestation, severity and frequency of disease, as well as health outcomes
- health-seeking behaviour
- the social, economic and cultural conditions of ill health and disease
- the response of health systems and services
- the roles of women and men as formal and informal health care providers.

4.2 Resource distribution

Given gender differences and inequalities within societies, it cannot be assumed that women and men will have equal opportunities for participation or will benefit equally from health development inputs. Special attention is needed to ensure that initiatives are not assumed to affect all people in the same manner, as this could unintentionally increase gender inequality. People respond to changes in the delivery of health services, such as the introduction of user fees, in gender-specific ways.





Gender is a major influence on access to resources and the distribution of responsibilities. Resources are often not distributed equally among household members and decision-making about the use of household resources can be unbalanced. These factors will influence the outcomes of health policies and programmes if not taken into consideration in their design.

4.3 Evidence base

Sex-disaggregated data needs to be used at all times in order to gain a more informed understanding of an issue or situation and to allow gender differences and inequalities to be identified and addressed. Disaggregating data by sex, and asking questions about who does what, allows for assessments of whether there are differences and inequalities between women and men.

4.4 Gender responsive health policy and programme design

There are differences among women and men that are related to class, religion, age, ethnicity and other factors. Women and men are not homogeneous groups. It is important not to generalize across diverse populations, but rather to consider the ways that the needs and perspectives of individuals are influenced by a range of factors, including gender.

There are often significant differences between women and men on their priorities. For example, in post-disaster situations women may place immediate priority on clean water and shelter while men may prioritize the re-establishment of economic activities. This is not to say that one priority should be privileged over another, but that there needs to be an awareness (obtained through specific investigation) of the potential differences between women and men so that all issues can be factored into an understanding of the situation. Since women's participation in decision-making is generally lower than that of men, specific strategies are generally required to ensure that women's voices are heard.

5. The way forward

Several mechanisms can be employed in integrating gender into health policies and programmes in the Region. Capacity building for health care providers and managers at all levels is critical, as well as capacity building of stakeholders in sectors relating to social determinants of health. Partnerships, collaboration and harmonization of actions in gender and health across and within sectors is necessary to carry the work forward. Expanded and enhanced databases of gender and health are also necessary. An exchange of good practices in operationalizing gender within and among countries is also useful. Resources must be mobilized and committed to addressing gender in health.

6. Conclusion

Society prescribes to women and men different roles in different social contexts. There are also differences in the opportunities and resources available to women and men, and in their ability to make decisions and to exercise their human rights, including those related to protecting health and seeking care in case of ill-health. Gender roles and unequal gender relations interact with sex and other social and economic variables, resulting in different and sometimes inequitable exposure to health risk, and in differential access to and utilization of health information, care and services. These differences in turn have clear impact on health outcomes.

A gender perspective, linked to the advancement of equity, must be incorporated into health policies and programmes. Gender analysis will help accomplish this. In order to optimize positive health outcomes for all, the special needs of girls and boys, women and men, throughout the different phases of the life cycle, must be considered. It is important that while protecting the value system of the communities in the Eastern Mediterranean Region, especially the institution of the family, there must also be flexibility in responding to existing conditions that do not favour positive health outcomes for all.

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