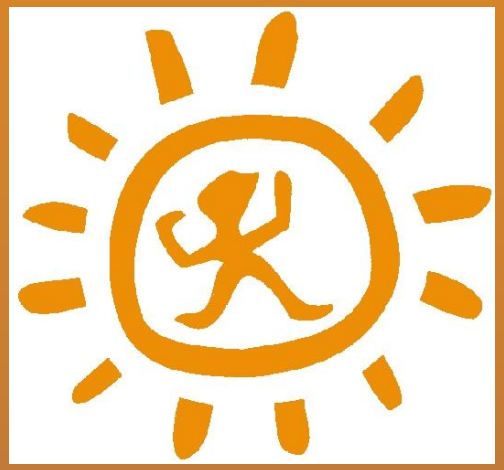

Copenhagen Conference 2012

Gender and Health through Life
Getting it Right

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Outline

- EPHA
- Gender(ed) health inequalities
- Gender and Life-course in disease prevention and health promotion
- Economic and social case for *getting it right*
- Gender equity and wider social determinants of health
- Public health, advocacy and Civil Society
- Recommendations

European Public Health Alliance (EPHA)

- EPHA is the **European Platform** bringing together public health organisations **representing** health professionals, patients groups, health promotion and disease specific NGOs, academic groupings and other health associations. Our **membership** includes representatives at international, European, national, regional and local level.
- As the largest network of European NGOs working in the field of public health with a **mission** to protect and promote public health in Europe, we **facilitate** shared learning and information and bring a public health perspective to European decision-making.
- Our aim is to **ensure health is at the heart of European policy and legislation**.

Gender(ed) health inequalities and inequities

- **Health inequalities**: differences in health status or in the distribution of health determinants between different population groups; when not attributable to a chance or biological variations but rather to the external environment and conditions of systematic uneven distribution of power and resources, and therefore unnecessary, avoidable and unfair we call them **health inequities** (WHO 2005);
- Gender/sex and age, although attributable to biological variations and unavoidable health differences, much often social roles and norms, economic position assigned to them and governing laws and policies behind are of greater impact on differentiated health outcomes for men and women, along their lifespan;

Gender(ed) health inequalities and inequities

- Life expectancy gap vs. healthy life expectancy (12 y for men vs. 8 y for women & average 19 y gap HLE)
- Recap from the conf intro: Disease and conditions such as e.g. CVDs, asthma, cancers, suicides and depression, CommDis (TB and HIV+ increase under the crisis among (young) men (GR), Sexual and Reproductive Health e.g. STIs (chlamydia, HPV)) or teenage and unwanted pregnancies; injuries and (road) accidents (no.1 killer of children, esp. boys, carries on to adulthood)
- Factors behind – wider key determinants of health such as tobacco smoking (men 40% vs. 22% women vs. 31% of population, the highest in the world; teen smoking inc. (19%) and girls uptake alarming: last 30 days cigarette for LV boys 63% vs. girls 56%; EST boys 63% vs. girls 51%), alcohol consumption (more boys drink on average but in IC, LV, SE it's more girls), diets (fats, salt and sugar), physical inactivity, physical and social health-promoting/harming environments

Gender(ed) health inequalities and inequities

- Factors behind factors – conditions in which people are born, grow up, live, work and age; health-promoting or hampering political choices in virtually all areas of human life, distribution of power and resources, access, empowerment and participation in social life
- Poverty and social exclusion put people in biological and social vulnerability (along the lifecourse); women most likely to live longer and in poverty
- One of the key determinant of health is gender and economic equality and it is generally acknowledged that "there's a strong correlation between a country's level of economic inequality and it's social outcomes" (Wilkinson & Pickett "The Sprit Level" 2009)

Economic and social costs of inequalities

- Inequality related losses in the EU are estimated at 1 trillion euro or 9.5% of GDP
- For every 0.05 more in GINI coefficient of income inequality, 7.8% rise in mortality for both genders with estimated 1.5 mln excess deaths over the last 30 years in OECD countries
- In 2010, World Economic Forum estimated that NCDs will cost us 197 trillion $ until 2050 if left uncontrolled

Disease prevention and health promotion gender and life-course

- Men and women have different social and economic resources available to shape their health outcomes, maintain health or fall into disease (access to healthcare, food, responsiveness to advertising, risky behaviours, biological vulnerability etc) – and these change along one's life-course (children, pregnant women, older women in poverty, young and middle-class men under economic crisis)
- So as the industry (tobacco, alcohol, pharma, food and drink, marketing) know it very well, public health professionals know it too and therefore can act upon these by adequate and targeted interventions to prevent specific disease and promote concrete pro-health behaviours across genders and age-groups

Disease prevention and health promotion gender and life-course

- Help-seeking behaviour, accessing healthcare services (incl. preventive and SRH) diff. for men and women (frequency, late, co-payment)
- Admission to hospital (for all type disease and health problems) higher for men than women
- Level of knowledge/awareness of health and risk factors
- Message content, mode (visual, audio), sender (credibility, trust – sport organisations, local pharmacy), channel (TV – soap operas, internet - men), passive or active
- Benefits and beneficiaries clearly stated
- Often, women's social role of caregiver in a family utilised but when embeded into whole family and the gender and generation relationships greater effect

Why lifecourse?

- Current focus and attention shift to Healthy and Active Ageing due to alarming demographic changes on account of lack of attention to early years of human development – no specific action on Children's Health and Wellbeing as such at EU-level
- It is **never too early to prevent** and tackle chronic diseases. Healthy practices, health capital and resilience to diseases begin in infancy or even *in utero.* Lifecourse approach would not only benefit **patients** who already developed a disease but mainly protect **healthy people from early on** from developing it in the first place.
- Early years development and interventions/prevention in this crucial period are of 20-80 ration cost effective, build up resilience and health capital, literacy, empowerment

Gender in Health Promotion

- Health promotion policies and initiatives taking women's and men's, boys' and girls' 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
- Multi-sectoral approach - gender health promotion within the wider social and economic arena (finance, taxes, labour market, social services, housing, environmental protection, water and sanitation, transport, road safety, education, research) beyond the reach of the health sector but led by it, providing evidence when policies, systems, programmes planned and implemented so that an action impacts both genders equally (however, sometimes need for positive discrimination..)

Examples

- promotion strategies aim at reducing risky behaviours, such as smoking, while ignoring the material, social and psychological conditions within which the targeted behaviours take place. There is a strong association between smoking prevalence, material hardship, low SES, stressful work or life. Gender roles and linked health-related behaviours in many strategies led to focusing on behavioural change at the individual level (eg. Different specific stress coping strategies for both genders to be learnt instead of taking up risky behaviour)
- However, the individual level is not enough and on a longer run generic strategies aimed at population and macroeconomics level are needed, eg. Smoking bans, plain packaging
- Another good practice is monitoring and collecting gender aggregated data to inform planning, implementation and evaluation of gender health promotion and disease prevention programes

Getting it right

- **Gender equality** and diversity in research topics, urgency and importance, application, accessibility
- Strengthen individuals in capacity to respond to, control determinants of, gaining access to economic and social resources
- Strengthening communities and civil society which main function is to provide a collective mutual support and benefit
- Strengthen **partnership** between civil society and academic institutions: firsthand knowledge of the most pressing research needs, users and disseminators, tuned to health problems and SDOH neglected or emerging, connected to hard-to-reach groups

Role of Civil Society and organised actions

- CSOs and user organisations' involvement ensure that **real** needs and problems are addressed, developed policies/solutions of increased **acceptability**, **sustainability** and **accessibility** when entering 'the market'; increase the sense of **ownership** and **trust**
- Timely information on policy making developments at EU level
- Communication and exchange of useful information, advocacy strategies, entry points to different levels of political arena – for coordinated and complimentary actions ('many drops of water make a hole in a rock')
- Bringing evidence from the ground to policy makers for good public health outcomes that are gender sensitive from a lifecourse perspective
- Representing public health voice in many non-health for a which might be discussing gender-related issues not realising its importance for health

Thank you for your attention

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