WOMEN & STROKE
Integrating Gender into Health Promotion Exercise

British Columbia Centre of Excellence for Women's Health

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http://promotinghealthinwomen.ca

OVERVIEW

1. Introduction to the Gender Integration Continuum
2. Gender Integration Small Group Exercise
3. Large Group Discussion

LEARNING OBJECTIVES

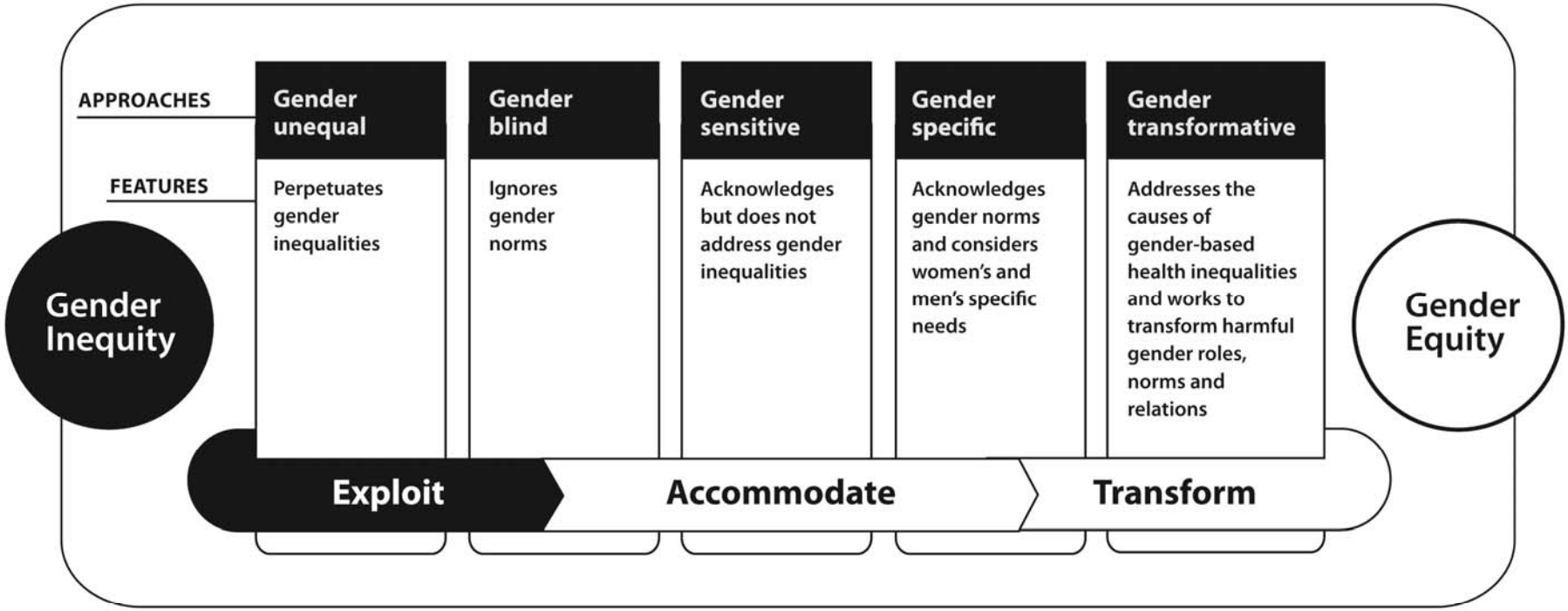
1. Increased knowledge about different approaches to gender integration in health promotion
2. Experience with using the *Gender Integration Continuum* as a tool to assess the current level of gender integration in programs and policies
3. Increased confidence in applying principles of gender transformative health promotion to your own work

Gender Integration

* Gender integration refers to strategies that take gender norms into account and compensate for gender-based inequalities.
* By assessing our current level of gender integration, we can ask **"How can we improve health as well as move towards improving gender equity?"**

Continuum of Approaches to Action on Gender and Health

A Continuum of Approaches to Action on Gender and Health



Inspired by remarks by Geeta Rao Gupta, Ph.D, Director, International Center for Research on Women (ICRW) during her plenary address at the XIIIth International Aids Conference, Durban, South Africa, July 12, 2000:

1. Gender-unequal

* **Gender unequal initiatives perpetuate gender inequalities by reinforcing unbalanced gender norms, roles and relations.**
* These approaches may consider sex and gender differences but may sustain traditional stereotypes and inequities.
* **Example:** A program may encourage women to quit smoking or reduce alcohol use due to concerns about their appearance.

2. Gender-blind

* **Gender-blind programs ignore gender norms, roles and relations and may therefore reinforce gender-based discrimination, biases and stereotypes.**
* The most common argument for gender blind initiatives is that they are 'fair' because they treat everyone the same, but by ignoring structured barriers faced by some program participants, the program may contribute to inequities.
* **Example:** Many teen pregnancy/STI prevention programs do not acknowledge how gender may influence behaviour change; while these programs may "do no harm", they may unintentionally support current inequities and miss an important opportunity to address a determinant of health that would increase the impact of the program

3. Gender-sensitive

* **Gender sensitive programs acknowledge but do not address gender inequalities.**
* While sex differences and gender norms and roles are considered, they do not necessarily involve action to address them.
* **Example:** A program to reduce maternal-child transmission of HIV would likely acknowledge that women may not have the status, rights nor decision-making authority to practice safer sex, insist upon the use of condoms, or adopt safer child-feeding strategies, though they would be encouraged to do so nonetheless.

4. Gender-specific

* **Gender-specific programs acknowledge gender norms and considers women's and men's specific needs.**
* Recognize that gender norms, roles and relations exist and have an impact on access to or control over resources. This may mean targeting a program specifically at women or men, and accommodating gender norms but not working to address or change them.
* While obviously an important approach, gender specific programs do not necessarily address the root causes of gender imbalances in power, resources or opportunities.
* **Example:** Programs that provide child-minding and offer women-only spaces can be gender-specific but not necessarily gender-transformative because they do not challenge why women are responsible for children when they need their own health care or why mixed spaces are unsafe or deemed unsuitable for women.

5. Gender-transformative

* **Gender transformative health promotion focuses on the dual goals of improving health *as well as* gender equity.**
* Acknowledges different norms and roles for women and men and their impact on access to and control over resources
* Considers women's and men's specific needs
* Includes ways to transform harmful gender norms, roles and relations
* **Example:** Programs to promote sexual and reproductive health that engage men and women in identifying and challenging harmful notions of masculinity and femininity

SUMMARY: Gender-responsive Continuum for Assessing Programs and Policies

1. GENDER UNEQUAL	*Perpetuates gender inequality by reinforcing unbalanced gender norms, roles and relations * Privileges men over women or women over men * Leads to one sex enjoying more rights, privileges and opportunities than the other
2. GENDER BLIND	* Ignores gender norms, roles and relations * May reinforce gender-based discrimination * Ignores differences in opportunities and resource allocations between women and men * Often constructed on the principle of being 'fair' by treating everyone the same
3. GENDER SENSITIVE	* Considers gender norms, roles and relations but offers no remedial action to address them * Does not address inequality arising from unequal gender norms, roles or relations
4. GENDER SPECIFIC	*Acknowledges different norms and roles for women and men and their impact on access to and control over resources *Considers women's and men's specific needs *May intentionally target a specific group of women or men to achieve policy or program goals or to meet their needs *May make it easier for women and men to fulfill duties assigned to them based on their gender roles *Does not address underlying causes of gender differences
5. GENDER TRANSFORMATIVE	* Acknowledges different norms and roles for women and men and their impact on access to and control over resources * Considers women's and men's specific needs * Addresses the causes of gender-based health inequity * Includes ways to transform harmful gender norms, roles and relations * Promotes gender equality * Fosters changes in power relationships between women and men

Reflection/Group Discussion

* In your stroke-related work, what sex and gender issues do you see?
* How, if at all, has gender influenced the development of interventions to prevent, treat, and support recovery following stroke?
* Do you believe that these approaches have been successful in addressing stroke-related differences between men and women?

SMALL GROUP EXERCISE
~ Facilitator Instructions ~

1. Divide the audience into small groups of approximately 3-5 people.
2. Assign two program examples to each group.
3. Ask the group members to:

   (i) Determine where on the gender integration continuum they would place each example (i.e., gender-unequal, gender-blind, gender-sensitive, gender-specific, gender-transformative)

   (ii) Explain their reasoning

   (iii) Suggest ways that the program could move further along the continuum, i.e., "How could this program become more transformative?"

PROGRAM EXAMPLES
WOMEN & STROKE

EXAMPLE #1 : Representation of Women in Stroke Clinical Trials (USA)

Historically, clinical trials have generally excluded women and this has limited the generalizability of findings. In 1993, the National Institutes of Health Revitalization Act (public law 103-43) was passed to require the inclusion of women in clinical trials of diseases affecting women. In 2014, it appears that the legislation has had little impact as the overall rate of enrollment of women is at roughly 25%. With respect to stroke, the National Institutes of Health reports that women have accounted for less than half of all subjects enrolled in stroke prevention clinical drug trials in the past decade. The percentage of women enrolled in recent stroke prevention trials of carotid disease and antiplatelet agents ranges from 25% to 53%, with an average of 34%, which is generally below the stroke prevalence rates by sex.

EXAMPLE #2 : WISEWOMAN program (USA)

The WISEWOMAN (**W**ell-**I**ntegrated **S**creening and **E**valuation for **WOM**en **A**cross the **N**ation) program from the Centers for Disease Control and Prevention provides low-income, under-insured or uninsured women ages 40-64 with chronic disease risk factor screening, lifestyle programs, and referral services in an effort to prevent cardiovascular disease. WISEWOMAN programs provide standard preventive services including blood pressure and cholesterol testing. WISEWOMAN programs also offer testing for diabetes. Women are not just tested and referred, but can also take advantage of lifestyle programs that target poor nutrition and physical inactivity, such as healthy cooking classes, walking clubs, or lifestyle counseling. Women who smoke are encouraged to quit and are referred to proactive quit lines or quit-smoking classes. The interventions vary from program to program, but all are designed to promote lasting, healthy lifestyle changes.

EXAMPLE #3 : Make Death Wait Campaign, Heart and Stroke Foundation of Canada

In 2011-2012, the Heart and Stroke Foundation of Canada ran a multimedia awareness campaign called “Make Death Wait.” The print and video ads stated: "Death loves menopause. He loves that menopause makes women more vulnerable to heart disease and stroke. And that women are far more likely to die of a heart attack. Most of all, he loves that heart disease and stroke is the #1 killer of women. Please donate, and make death wait.” The campaign reached 87 per cent of Canadians; motivated more than 100,000 people to complete the online Risk Assessment; and built new relationships such as 50,000 new fans for the HSF Facebook page. It also generated controversy as it was argued that the campaign exploited women's fears of rape and sexual violence. One woman commented: “[It's] like they had a good idea at first (conversation about women's risk) but degenerated into awful stalker ad.“ Others were concerned at how the campaign made use of stereotypes of women as weak and men as aggressors.

EXAMPLE #4 : Moms Clean Air Force (USA)

Moms Clean Air Force (www.momscleanairforce.org) is a national movement of more than 280,000 moms (and dads) who are working to protect children's right to clean air by providing information and solutions through online resources, articles, action tools and on-the-ground events. The organization has developed resources to promote heart health and explicitly connects heart health to air pollution ("Healthy Hearts Need Clean Air.") The group promotes individual action (e.g., avoiding exposure to high levels of air pollution) as well as political action (e.g., campaigns to defend the Clean Air act) and partners with a wide range of organizations, including health organizations such as Alliance of Nurses for Healthy Environments, Asthma and Allergy Foundation of America, Breast Cancer Fund, and Physicians for Social Responsibility. They also actively engage with Latino communities (racial/ethnic minorities remain at higher risk for stroke). The grassroots approach emphasizes women's voice and opportunities for leadership.

EXAMPLE #5 : Lighting a Billion Lives (India)

In March 2014, the World Health Organization reported that, in 2012, around 7 million people died as a result of air pollution exposure – 40% of outdoor air pollution-caused deaths and 34% of indoor air pollution-caused deaths were related to stroke. The report highlighted higher risks in women, children and other vulnerable groups such as the elderly (e.g., women spend more time at home breathing in smoke and soot from leaky coal and wood cook stoves). Although women experience higher personal exposure levels than men (and thus greater risk), the absolute disease burden is larger in men due to underlying disease rates in men. The 'Lighting a Billion Lives' (http://labl.teriin.org) is a energy access program to enable (eventually) a billion people to access light from solar technologies. The initiative works across rural India to replace the kerosene lanterns with solar lighting lanterns to reduce indoor air pollution - allowing children to study at home, provide smoke-free environments, etc. The entrepreneur model also creates opportunities for women to be trained to run solar charging stations (creating opportunities for women's empowerment within their villages).

EXAMPLE #6 : Women's Health Circles, Ontario Women's Health Network (Canada)

Women's Health Circles (http://www.owhn.on.ca/healthcircles.htm) are a health promotion/stroke prevention strategy for women who are marginalized, with the objective of decreasing women's risk of stroke. The Circles are group meetings that offer women space to discuss a health topic they have selected and link these discussions to social determinants of health. The program recognizes that Women who have limited access to the social determinants of health – like secure income, safe, affordable housing, strong social support networks and culturally appropriate or responsive health services – are at a greater risk for stroke. Women's Health Circles are:

* **Collective education forums for women**: participants determine the health topics of discussion, and engage with other women to learn from each other's thoughts and experiences.
* **Learning spaces for health and social service professionals**: in turn health and social service professionals who participate in the circles learn about the lived experiences of women. This is intended to create more appropriate and sensitive care, specifically for women who experience marginalization.
* **Resource bases:** participants learn about the social determinants of health, ask questions of health and social service professionals, and learn about resources in the community from everyone participating.

EXAMPLE #7 : Salt Reduction Initiatives (United Kingdom)

Since 2003-2005, the United Kingdom has undergone a series of voluntary salt reduction initiatives with collaboration from the Consensus Action on Salt and Health, the Food Standards Agency, and the Department of Health. Mean estimated salt intake for adults fell from 9.5g in 2000-2001 to 8.1g in 2011, with a predicted saving of almost 9000 lives a year from stroke and heart attack. This was done partly by (1) setting progressively lower salt targets for different categories of food, with a clear time frame for the industry to achieve; (2) working with the industry to reformulate food with less salt; (3) clear nutritional labelling; (4) consumer awareness campaign; and (5) monitoring progress by frequent surveys and media publicity of salt content in food, including naming and shaming. The public awareness campaign in 2004-2009 was developed for all adults but targeted at women ages 25-65 as women are considered to be the main gatekeepers when it comes to food and health.

Summary – Gender Integration Continuum

* There may be differences in how various programs are classified on the continuum – remember, this is simply a tool to help us further our thinking
* At a minimum, health promotion activities should strive to "do no harm" in terms of gender norms and relations. (There is no viable rationale for designing a project that deliberately exploits gender inequality).
* Sometimes, programs will have unintended outcomes (good or bad); gender blind programs are more likely to cause unintentional harm or to miss opportunities to enhance program outcomes because they have not considered gender at all
* Programs may opt to conform to existing gender norms in order to enhance outcomes or as an interim step to 'buy time' until a better solution can be reached, but the goal is to move towards more transformative programming
* Transformative elements can be integrated into ongoing programs without having to start over again

Summary – Gender Transformative Health Promotion

* There is no ‘how-to’ manual for doing gender transformative health promotion. Gender transformative health promotion may include challenging traditional gender norms, promoting critical thinking, supporting women's economic empowerment, engaging men in women's health issues, advocacy, addressing power imbalances between health care providers and patients, etc.
* Gender transformative health promotion requires strategy, creativity, critical thinking, and use of the available evidence base

Reflection/Group Discussion

* What existing projects and activities are you currently involved with?
  * How would you classify them along the gender continuum?
  * How can they be further developed to become more "gender transformative"?
* Considering the examples discussed today, which approaches might be transferable to your own work? What else might be considered?

Notes for Facilitators

* You may want to create a handout from the example slides to distribute to each group. Ideally, each group will have program examples from more than one category of "gender blind," "gender specific," etc.
* Alternately, you might consider giving common examples to two or more groups – some groups may classify the examples differently and this may result in interesting discussion.
* Remember that in some cases that there is no "correct" answer for the examples. Participants will have alternate contexts or scenarios that influence their interpretation of the project's intention and design and will make assumptions based on limited information. Provide space for diverse answers and encourage participants to explain their assumptions and decision-making process.

Acknowledgements

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