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Applications and development possibilities – moving beyond the WKC project to incorporate cultural diversity

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Overview

While health status, life expectancy and morbidity of populations can be largely explained by gender, region of the world and religion, this parsimonious set of variables does not adequately reflect the cultural diversity of many countries today where immigrant or ethnic status interact with social, structural and economic characteristics as determinants of health. The set of indicators for gender equity and health represent a concerted effort of leading experts in women's health, yet further work is necessary to reflect diversity since some indicators are strongly slanted toward Western notions of health and functioning. This commentary proposes additional regional indicators such as the rate of consanguineous and polygamous marriage, and the inclusion of a variety of upstream indicators of health. Furthermore, possibilities for how to link between Tiers and cycle the indicators over time are presented in order to increase applicability on the national and regional level.

Commentary

Taking a social demographical view of global health status, knowing three variables gives a good estimate of health status and longevity: gender, region of the world, and religion (UK National Government Statistics 2004; Ashford & Clifton 2005; United Nations 1995). Regarding women's health status, these three variables explain much of the variance in the probability that a woman will die in childbirth, by HIV or other infectious disease or whether she will live past the age of 70. However, this parsimonious framework does not adequately represent women's health over her life-course particularly in developing countries or those with a high proportion of immigrants and/or ethnic/cultural diversity (Ben Abdelaziz 2006 (this issue)).

Experience in promoting women's health in a multi-cultural context suggests several options that would increase the validity of the indicators, such as monitoring on a rotating fashion and reassessing others once every 5–10 years should increase their applicability in developing countries. Insisting on tying evaluation of indicators to gender-specific health promotion efforts and monitoring women's access to research funds should also increase their potency as indicators of appropriateness and research capability (Tier 3).

One way to strengthen the impact of the set of indicators is to link between Tiers, by following a morbidity indicator (Tier 1) such as lung cancer, through to its Tier 2 determinants (rate of smoking among women), connecting to Tier 3 health policy (limitations on smoking in public places, surtaxes on sales, smoking prevention programs tailored for women) and on through the Tier 4 community-based indicators (tobacco product advertising targeted to women). Other morbidity indicators that could be linked across Tiers include eating disorders, sexually transmitted diseases, violence against women, diabetes and obesity. This type of linkage is important because it sets the stage for more effective public health advocacy efforts when these upstream linkages are made salient.

Marital norms, reproductive and sexual behavior, type of marriage (e. g. polygamous), use of contraception or abortion, and female genital mutilation (FGM)) appear to vary by religion, a potent predictor of health status (Koenig et al. 2001). However, religious affiliation is not always a reliable indicator of health behaviors because of the influence of social and political processes within religious groups and nations with a dominant religion (Anson & Anson 2005). For example, consanguineous marriages or marriage between close family members is common among Muslim rural populations (Bittles & Hussain 2000), however, it is also reported in non-Muslim countries, particularly in rural areas (Vanita et al. 1999; Wasant et al. 1995; Fujiki et al. 1992; Evans et al. 1985). This demographic indicator is associated with increas-

ing maternal morbidity due to higher rates of early marriage, higher fertility and genetic disorders among offspring, increasing caregiver burden, particularly among mothers (Bittles et al. 1991). Similarly, polygamy, practiced in 850 societies around the world, has far-reaching health effects on mothers and children, some advantageous (more care-givers and distribution of family chores) and others more negative (low self-esteem and depression) (Al-Krenawi 1999; Elbedour et al. 2002; Al-Krenawi & Slonim-Nevo 2003). The rate of consanguinity and polygamy are two examples of gender sensitive indicators that have important implications for women's health in the non-Western or developing world.

Kobe documents refer to the Gender Empowerment Measure (GEM), which used five measures of women's empowerment to measure the global gender gap (Lopez-Claros & Zahidi 2005) (economic participation, economic opportunity, political empowerment, educational attainment and health/wellbeing). The highest ranking countries are Western, mostly democracies, with Costa Rica being the first developing country to break this hegemony (18th after the United States). This suggests that gender equity is defined by the prevalent values, behaviors and social structures of these white, middle-class, Western countries (Mohanty 2005). For example, if single motherhood (either by choice or through divorce, separation or widowhood) had been included, it is likely that rankings would have been different. Single motherhood is strongly related to economic stability, well-being and health among women e. g. (Young et al. 2005; Cairney et al. 2003) and common in these highly ranked countries (National Center for Health Statistics 2000). While work has been initiated to incorporate African women's concepts of power and gender (Charmes & Wieringa 2003), this work needs to be continued in other non-Western regions of the world (Latin America, Asia, the Middle East) and incorporated in the gender-sensitive health indicators.

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