



**World Health Organization**  
REGIONAL OFFICE FOR **Europe**



WHY USING A  
**GENDER APPROACH  
CAN ACCELERATE  
NONCOMMUNICABLE DISEASE  
PREVENTION AND CONTROL  
IN THE WHO EUROPEAN REGION**

WHO EUROPEAN HIGH-LEVEL CONFERENCE  
**ON NONCOMMUNICABLE DISEASES**

Time to Deliver: meeting NCD targets to achieve  
Sustainable Development Goals in Europe  
9-10 April 2019, Ashgabat, Turkmenistan



## → ABSTRACT

Noncommunicable diseases (NCDs) are the main causes of ill health for women and men in the WHO European Region. NCD indicators in all countries reveal important differences between men and women across the life-course. Biology is important in shaping these differences, but it does not explain them all. Gender norms and roles put women and men at different levels of exposure and vulnerability to NCD risk factors and impacts the way men and women use services and the responses they receive. Gender stereotypes and inequalities affect access and use of health resources and may be perpetuated by health promotion efforts. Recent political commitments call for better integration of gender in NCD policies, programmes, research and interventions. The *Strategy on women's health and well-being in the WHO European Region* and the *Strategy on the health and well-being of men in the WHO European Region* provide a comprehensive working framework for improving health and well-being in Europe through gender-responsive approaches.

## → KEYWORDS

NONCOMMUNICABLE DISEASES  
GENDER  
SOCIAL DETERMINANTS OF HEALTH  
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## → CONTENTS

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Acknowledgements ii

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What does a gender approach to noncommunicable diseases mean? 1

---

### KEY MESSAGE 1.

**NCDs constitute the main burden of disease for both women and men in the WHO European Region, but there are important differences** 2

### KEY MESSAGE 2.

**Risk factors for NCDs are strongly influenced by gender and the links with other social determinants of health** 4

### KEY MESSAGE 3.

**Gender impacts the way men and women use services and the responses they receive** 6

### KEY MESSAGE 4.

**Gender inequality impacts access and use of health resources** 7

### KEY MESSAGE 5.

**Gender stereotypes may be ignored, perpetuated or challenged by health promotion efforts to prevent NCDs** 8

### KEY MESSAGE 6.

**Recent global and regional political commitments highlight the need for better integration of gender in NCD policies, programmes, research and interventions** 9

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References 12

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We will integrate an equity-based approach across the health system response to NCDs to address the impact of gender norms and roles and the social determinants of health on the differential exposure to risk factors between men and women, on their health-seeking behaviours and on the responses from health-care providers. We will aim to implement gender-specific interventions and other specific approaches to address the disproportionate morbidity among women and disproportionately high mortality among men, building on the growing knowledge provided by gender-based medicine and research. We will seek to eliminate gender stereotypes in health promotion, disease prevention and management interventions that may perpetuate harmful aspects of masculinities and femininities, particularly among adolescent boys and girls. We will work towards demonstrating leadership in health systems to promote gender equity in the health sector workforce and tackling the gender imbalance in unpaid care.



**Outcome statement from the High-level Regional Meeting, Health Systems Respond to NCDs, Sitges, Spain, 16–18 April 2018<sup>1</sup>**

<sup>1</sup> WHO Regional Office for Europe (2018). High-level Regional Meeting, Health Systems Respond to NCDs: Experience in the European Region. Sitges, Spain, 16–18 April 2018. Outcome statement. Copenhagen: WHO Regional Office for Europe ([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0020/370325/outcome-statement-sitges-eng.pdf](http://www.euro.who.int/__data/assets/pdf_file/0020/370325/outcome-statement-sitges-eng.pdf), accessed 22 March 2019).



## → WHAT DOES A GENDER APPROACH TO NONCOMMUNICABLE DISEASES MEAN?

In all countries, indicators for noncommunicable diseases (NCDs) reveal differences between men and women among socioeconomic groups and across the life-course in:

- health outcomes
- exposure to main risks
- adoption of healthy behaviours
- access to, and use of, services
- responses from providers
- use of formal and informal care.

Biology is important in shaping these differences, but it does not explain them all. This paper focuses on why using a gender approach can accelerate NCD prevention and control in the WHO European Region.

### Box 1. Gender definitions

**Gender is a social construct** that interacts with, but it is different from, biological sex. It refers to the socially constructed norms, roles, behaviours and attributes that a given society considers appropriate for women and men. When individuals or groups do not “fit” established gender norms, they often face stigma, discriminatory practices or social exclusion.

**Gender equality** refers to the same opportunities for groups of women and men to access and benefit from social, economic and political resources such as health services, laws and policies, and education.

Source: WHO (1).

### Using a gender approach to NCDs:

- acknowledges that while biological differences between men and women are clearly important in shaping male and female patterns of morbidity and mortality, their overall impact can only be understood when gender and social differences are also included in the analysis; the links between biology and gender in NCD risk and experience are important to understand and analyse – for example, biology shapes different symptoms of myocardial infarction in men and women;
- builds on the interconnections between Sustainable Development Goal (SDG) 5 on gender equality and empowering of women with NCD-related targets under SDG 3 on ensuring healthy lives and promoting well-being; this is also relevant for Europe since none of the countries of the WHO European Region has achieved gender equality;
- recognizes that women and men are not homogenous groups and that their health opportunities and risks vary according to social, economic, environmental and cultural influences throughout their lifetime;
- considers how gender intersects with other factors behind social inequalities, such as sexual orientation, gender identity, ethnicity, disability or place of residence; and
- highlights the need to address masculinities as gender norms that impact on the exposure of men to risk behaviours, on the responses they receive from the system and on perpetuating gender inequalities, such as the unbalanced distribution of paid and unpaid care.

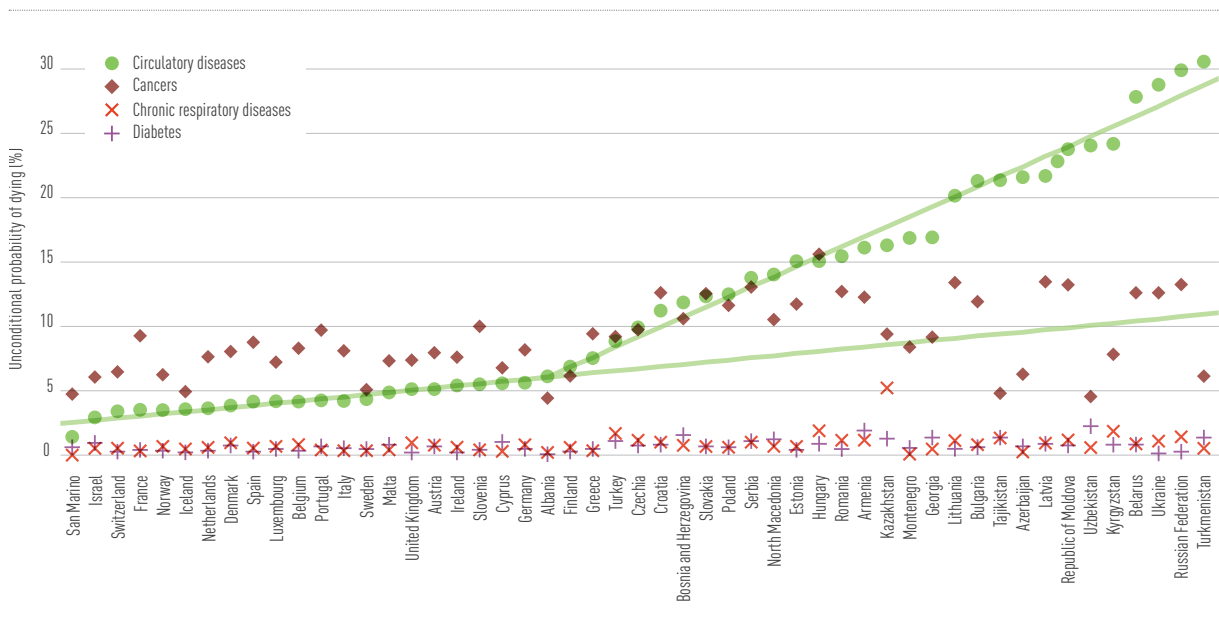
Without aiming to provide a comprehensive picture of the links between gender and NCDs, this background paper presents some key messages from evidence gathered in WHO reports on *Women’s health and well-being: beyond the mortality advantage* (2) and *The health and well-being of men in the WHO European Region: better health through a gender approach* (3).

## KEY MESSAGE 1.

# → NCDS CONSTITUTE THE MAIN BURDEN OF DISEASE FOR BOTH WOMEN AND MEN IN THE WHO EUROPEAN REGION, BUT THERE ARE IMPORTANT DIFFERENCES

NCDS are the main cause of ill health for both women and men and are currently responsible for 89% of deaths and 85% of disability in the European Region (4). Across the European Region, particularly in the eastern part, men's higher levels of premature mortality (due mostly to cardiovascular diseases) puts them at the centre of efforts to achieve SDG target 3.4.1. Fig. 1 clearly illustrates this.

**Fig. 1. Probability of premature mortality from NCDs for men in countries of the WHO European Region, latest available data**



Source: WHO Regional Office for Europe (3).

Ischaemic heart disease and stroke are also the main causes of mortality for women and cause the biggest burden of disability (Fig. 2).

Mental and behavioural disorders, including substance abuse, are among the main public health challenges in the European Region and affect men and women differently.

Evidence also emphasizes the increased level and persistence of depression among older women in all countries, and it is also important to highlight that intimate-partner violence is a major contributor to women's mental health problems, with women who have experienced it being almost twice as likely to develop depression than those who have not, and having almost double the risk of alcohol-use problems (2).

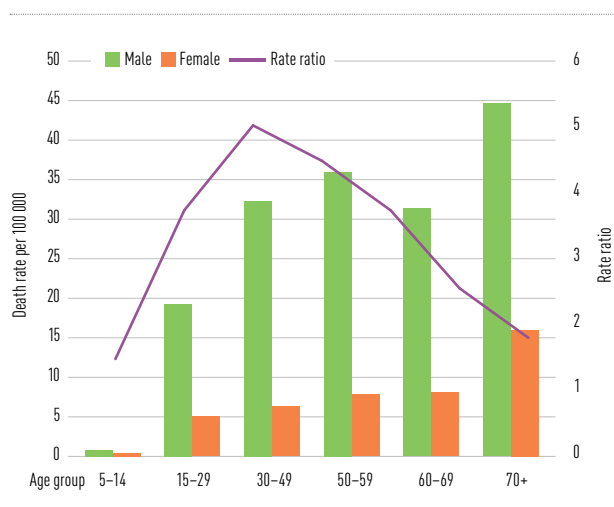


**Fig. 2. Burden of disease for women, all countries of the WHO European Region, expressed through disability-adjusted life-years**



Source: WHO Regional Office for Europe (2).

**Fig. 3. Estimated death rates from suicide by age and sex, WHO European Region, 2016**



Source: WHO Regional Office for Europe (3).

Self-harm and suicide comprise a significant cause of death and disease burden among men in the Region: 127 882 deaths were attributed to self-harm and suicide in 2015, equivalent to a crude rate of 14.1 deaths per 100 000 population, which is the highest rate among all WHO regions (3). Self-harm ranks second among causes of death of young women aged 15–19 in the Region. Taken together, depressive and anxiety disorders account for the highest percentage of disability-adjusted life-years in this age group (2) (Fig. 3).

**KEY MESSAGE 2.****→ RISK FACTORS FOR NCDs ARE STRONGLY INFLUENCED BY GENDER AND THE LINKS WITH OTHER SOCIAL DETERMINANTS OF HEALTH**

Gender norms and roles put women and men at different levels of exposure and vulnerability to NCD risk factors and gender norms can predict current and future NCD risk.

Women's and men's levels of physical activity, diet, tobacco and alcohol consumption are heavily influenced by norms on what constitutes masculine and feminine behaviours and links with structural factors, such as place of residence, income and education (Fig. 4) (3). Globally, and in the European Region, men have more harmful smoking practices, unhealthier dietary patterns, heavier alcoholic drinking habits and higher rates of injuries and interpersonal violence than women. WHO estimates that the proportion of NCD deaths attributable to tobacco use in Europe is 18%, with the proportion being four times higher for men (28%) than for women (7%). However, while male smoking prevalence is declining in the European Region, the situation for women is mixed and, in some countries, prevalence is even on rise (5). Research shows that in most societies, males are less abstemious, tend to be greater so-called big drinkers and cause more problems as a result of these intensive consumption patterns: these behaviours are connected to norms defining masculinities.

Research among young people shows that girls are adopting so-called masculine patterns of alcohol consumption and boys are not necessarily defining their masculinity through risk-taking. Pervasive gender norms and roles nevertheless continue to influence the health and well-being of young people (2).

The tobacco industry has specifically been targeting women as a future client group with enormous potential through diverse forms of marketing. Industry is using packaging and communication to reach out to women, in addition to keeping prices low and affordable (5).

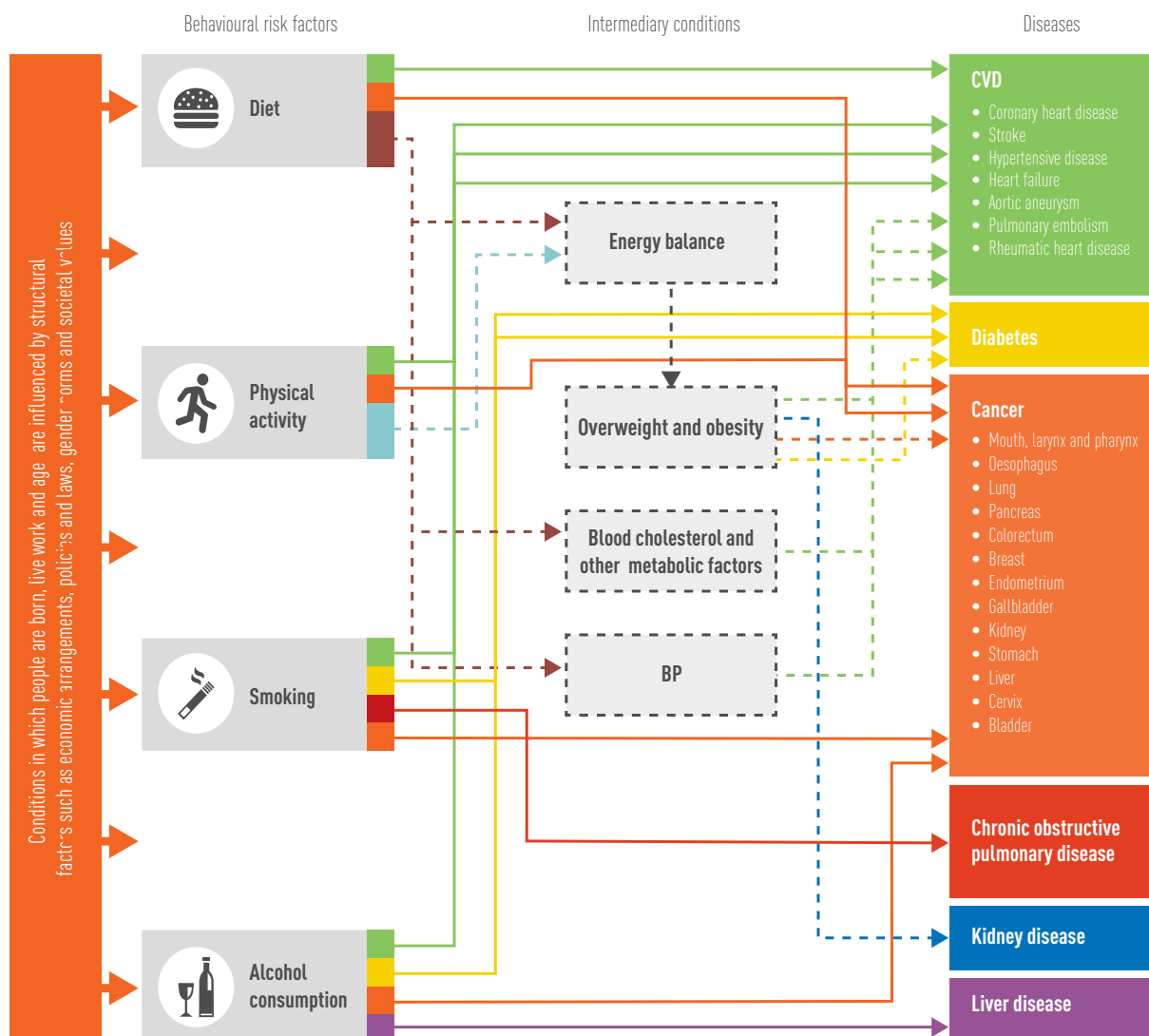
Physical activity and diet are also strongly influenced by societal expectations of masculinities and femininities. Evidence gathered in the WHO men's health report (3) shows, for example, that men are less responsive than women to foods promoted or labelled as healthier options and are less familiar with labelling schemes. Changes across the life-course, the prioritization of traditionally masculine sports in schools and concerns about safety in cities limit physical activity among women, particularly during adolescence.

Social determinants, such as education and income, do not necessarily have the same effect on exposure to risk factors on women and men. The link between education and tobacco, for example, seems to be more pronounced for women. Affluent women are the first to start and the first to quit smoking, but in countries with the longest histories of smoking, it is now associated with low socioeconomic status.

Men and women with low education levels are more likely to develop diabetes, but women with low education levels have higher mortality rates from diabetes than men of a similar education level. This is attributed to higher risk but may also be related to lower levels of care.



**Fig. 4. The impact of behavioural risk factors on NCDs: causal pathways**



Source: WHO Regional Office for Europe (3), using calculations from the WHO European Office for the Prevention and Control of Noncommunicable Diseases, adapted from Scarborough et al. (6).

**KEY MESSAGE 3.**

## → GENDER IMPACTS THE WAY MEN AND WOMEN USE SERVICES AND THE RESPONSES THEY RECEIVE

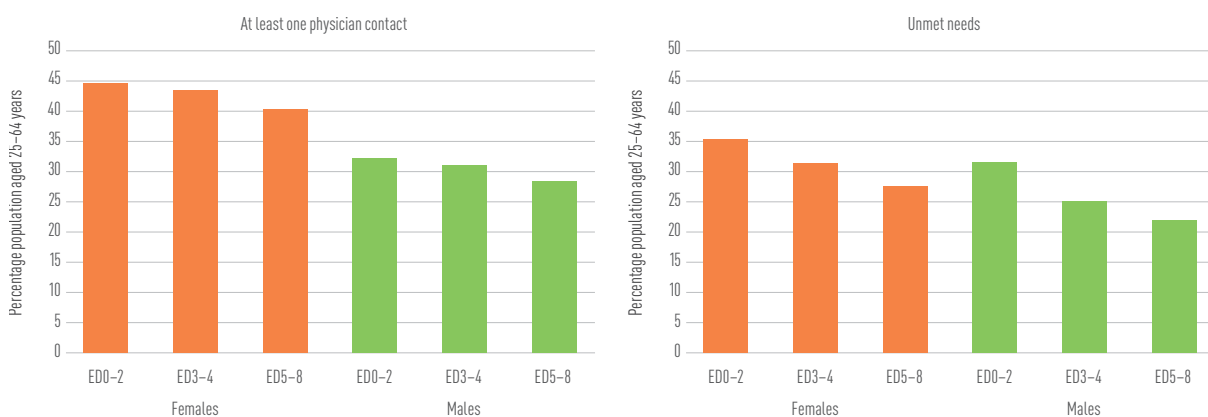
Gender norms and roles also affect women's and men's health-seeking behaviours and the responses they receive from services.

Women's health needs often tend to be reduced to those related to reproductive and maternal health. It is now well documented that the perception of risk for cardiovascular disease among women is low, despite it being the main cause of mortality for women in the Region. Awareness of differences in physiological risk profiles and symptoms presented by women and men are not fully integrated into health services' responses in many countries.

Traditional masculinities may act as a barrier to men accessing primary health care and managing self-care. Men in Europe from all age groups and educational levels report less unmet health needs than women and are less likely to seek health services (Fig. 5) (3).

The impact of masculinities in the use of services is particularly relevant for the detection, management and control of high blood pressure. Men from some countries in central and eastern Europe have the highest mean systolic blood pressure readings in the world. While this seems to have decreased in women in central and eastern Europe, and more recently in central Asia, there has been little or no change in men. Evidence from the recent WHO STEPwise approach to Surveillance surveys (STEPS) conducted in several of these countries indicates that detection, treatment and control of hypertension are suboptimal (3).

**Fig. 5. Consultations and unmet needs by educational level, men and women, latest available data<sup>a</sup>**



Source: WHO Regional Office for Europe (3), using data from Eurostat (7,8).

<sup>a</sup> Education levels: level ED0-2 = less than primary, primary and lower-secondary education; level ED3-4 = upper-secondary and post-secondary non-tertiary education; level ED5-8 = tertiary education.

The impact of gender in the use of services is not limited to individuals' health-seeking behaviour; gender biases also influence the provision of services. Overall, health professionals' competence in understanding gendered health-care-seeking patterns is weak. The selection, design and organization of services do not consider gender norms, roles and power relations to respond to the health needs of women and men.

## KEY MESSAGE 4.

# → GENDER INEQUALITY IMPACTS ACCESS AND USE OF HEALTH RESOURCES

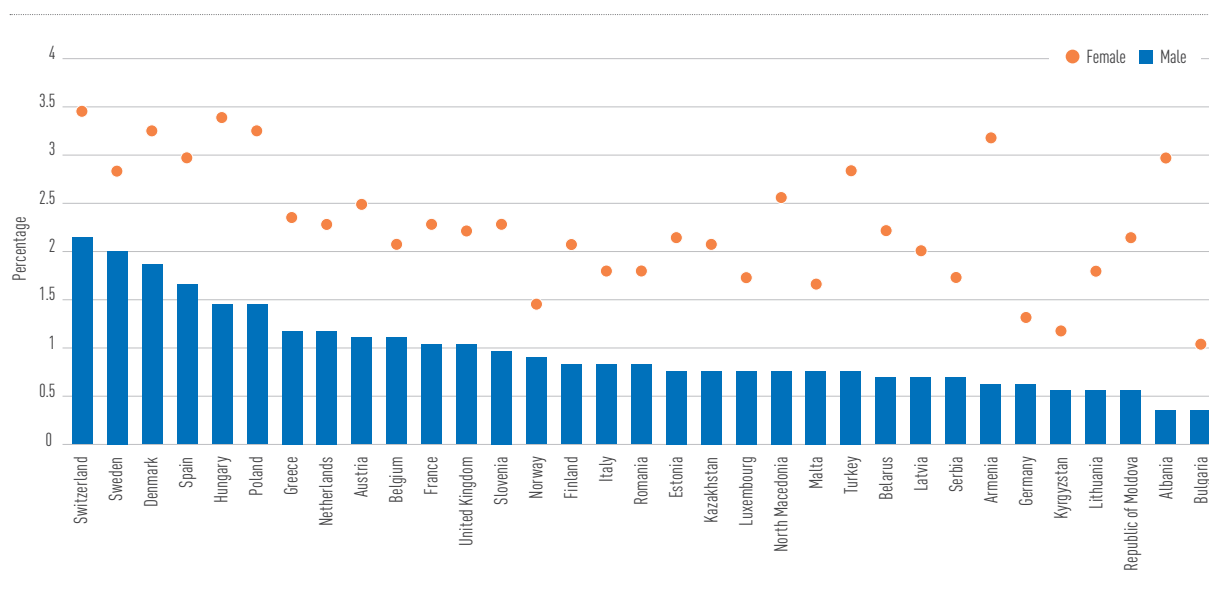
Gender relations include how power and access to, and control over, resources are distributed between the sexes across the life-course and how this can be transformed over time to become more equitable.

Women live longer than men, but the years lived longer are often characterized by ill health or disability and usually with less social protection than men, as reflected in the gender pension gap. Women in Europe live on average 10 years in ill health, while for men the figure is six years. With an ageing European population, and with 70% of the 14 million people currently over 85 being women, this population group can only be expected to grow (2).

Gender equality is not yet a reality in Europe, but older women in more gender-equal countries have a lower risk for poverty and social exclusion.

An important factor influencing inequality is the gendered distribution of unpaid care functions (Fig. 6) (3). Women make up a majority of the paid health workforce, but as wives, daughters, sisters and relatives, are also the main unpaid health-care providers. Unequal distribution of unpaid caregiving affects women's health, economic empowerment and quality of life, particularly in older age, while it perpetuates the lower participation of men in care.

**Fig. 6. Proportion of time spent on unpaid care work, selected countries, latest available data**



Source: WHO Regional Office for Europe (3), using data from the United Nations Statistics Division (9).

A specific SDG target (SDG 5.4) has been dedicated to recognizing and valuing unpaid care work through the provision of public services and social protection policies, and a more gender-equal sharing of responsibilities for unpaid care work.

**KEY MESSAGE 5.**

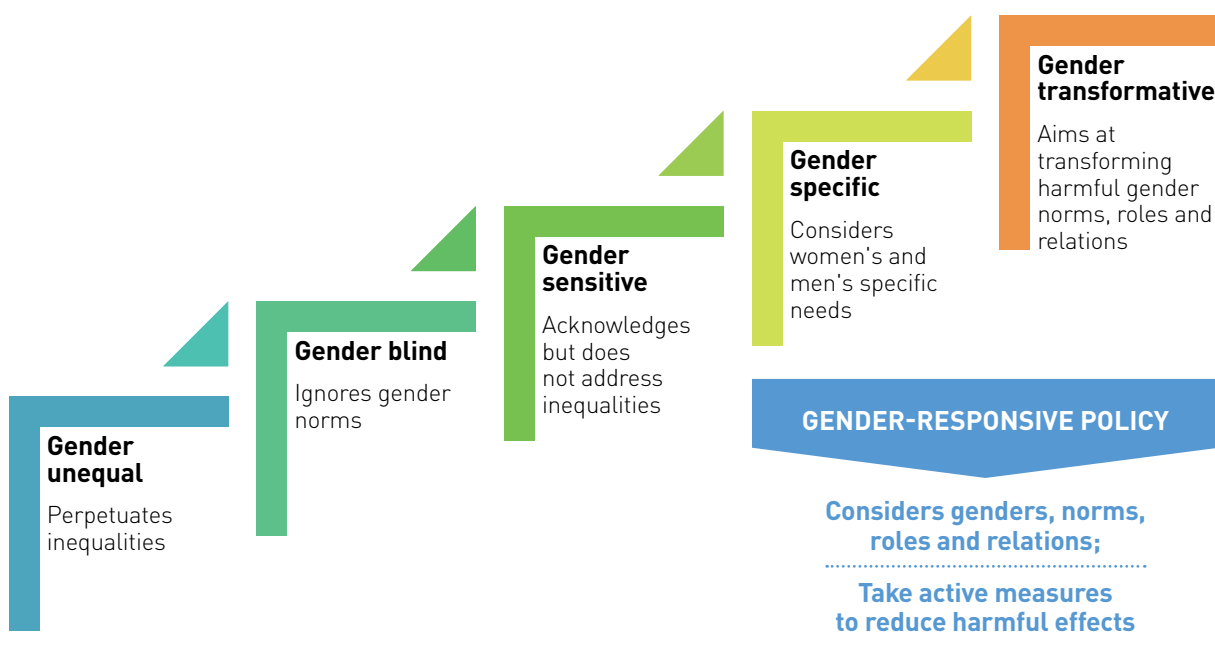
## → GENDER STEREOTYPES MAY BE IGNORED, PERPETUATED OR CHALLENGED BY HEALTH PROMOTION EFFORTS TO PREVENT NCDS

Health promotion initiatives often rely on gendered norms and stereotypes in conveying key messages, such as women being primarily concerned with body image, and men with their sexual capacity. Anti-tobacco and anti-alcohol campaigns commonly target women by highlighting the links between consumption, weight and appearance, while the same campaigns targeting men focus on sexual dysfunction. These types of health promotion may have a direct effect on the target audience, but at the same time perpetuate gender stereotypes that are harmful to health.

Public health campaigns also may ignore links between gender and other social and economic determinants of individual behaviour. Campaigns targeting healthy living during pregnancy, for example, may place the sole responsibility on women, take a judgemental approach or ignore socioeconomic status.

There are, however, increasingly promising health promotion examples that use a gender transformative approach, such as encouraging young girls to take part in sports and young men to challenge violence. Gender transformative health promotion (Fig. 7) should be the clear ambition overall and has a dual goal of focusing on improving health and gender equality.

**Fig. 7. WHO gender-responsive assessment scale**



Source: WHO (1).

**KEY MESSAGE 6.**

## → RECENT GLOBAL AND REGIONAL POLITICAL COMMITMENTS HIGHLIGHT THE NEED FOR BETTER INTEGRATION OF GENDER IN NCD POLICIES, PROGRAMMES, RESEARCH AND INTERVENTIONS

With the adoption of the 2030 Agenda and the SDGs, governments have made the indivisible nature of economic, social and environmental development clear and highlighted that gender and rights-based approaches are imperative to accelerate transformative and sustainable progress.

The *Strategy on women's health and well-being in the WHO European Region (10)* and the *Strategy on the health and well-being of men in the WHO European Region (11)* strengthen the links between SDGs 3 and 5 in the WHO European Region, while providing a comprehensive working framework for improving health and well-being in Europe through gender-responsive approaches.

The commitments are further reflected in statements made by Member States at high-level meetings and other fora, including the outcome statement from the high-level regional meeting, Health Systems Respond to NCDs, in Sitges, Spain in April 2018 (12), a quotation from which opens this paper.

The Second European high-level conference on the prevention and management of NCDs and mental health conditions, to be held on 9–10 April 2019 in Ashgabat, Turkmenistan, provides an important knowledge exchange forum for Member States to discuss evidence and recommendations from WHO strategies on women's and men's health that are most relevant for accelerating action in reducing NCDs and improving mental health and well-being in the European Region. Table 1 presents some examples of potential actions based on the recommendations from both strategies.

**Table 1. Examples of potential actions**

PRIORITY AREA	EXAMPLES OF RELEVANT NCD ACTIONS
<b>Informed policies</b>	<ul style="list-style-type: none"> <li>• Systematic collection, use and analysis of sex- and age-disaggregated data to inform policies and interventions addressing tobacco, alcohol, nutrition, physical activity, injuries, violence and mental health</li> <li>• Gender analysis of STEPS, the WHO European Childhood Obesity Surveillance Initiative, the Health Behaviour in School-aged Children study and other relevant survey data</li> <li>• Quantitative and qualitative evidence of links between gender with other determinants of health, such as education, income and place of residence</li> </ul>
<b>Participation of women and men</b>	<ul style="list-style-type: none"> <li>• Platforms linking communities of knowledge working in NCDs, in risk factors, in women's health and in men's health</li> <li>• Focus on places such as workplaces, cities and rural places to overcome gender barriers to participation in policies, programmes and services</li> </ul>

PRIORITY AREA	EXAMPLES OF RELEVANT NCD ACTIONS
<b>Working across sectors</b>	<ul style="list-style-type: none"> <li>• Gender-responsive school health programmes to challenge gender stereotypes that increase exposure to NCD risk factors, particularly in adolescence, including healthy use of social media</li> <li>• Intersectoral mechanisms with social welfare and labour to transform the gender imbalance of unpaid care</li> </ul>
<b>Research</b>	<ul style="list-style-type: none"> <li>• Equal participation of women and men in research and clinical trials to ensure appropriate care and access to medicines</li> <li>• Research and innovation that eliminates sex and gender bias in detection and treatment of NCDs</li> </ul>
<b>Service delivery</b>	<ul style="list-style-type: none"> <li>• Building capacity on gender-based medicine, linking biology and gender in preventing, detecting and treating the main NCDs and their risk factors across the life-course</li> <li>• Design, capacity and organization of primary health-care services to improve detection, treatment and control of high blood pressure, with a focus on the most at-risk men in countries with high premature mortality</li> <li>• Primary health care addressing the impact of NCDs on women across the life-course</li> </ul>
<b>Health promotion</b>	<ul style="list-style-type: none"> <li>• Promotion of positive images of boys and men, girls and women, regardless of age, sexual orientation, gender identity, ethnicity, culture and religion</li> <li>• Using important life transitions, such as adolescence, becoming a parent or retirement, to promote positive health messages and encourage healthy habits</li> </ul>
<b>Gender equality</b>	<ul style="list-style-type: none"> <li>• Addressing the links between mental health, alcohol and substance abuse as both risk factors and consequences of interpersonal and intimate-partner violence</li> <li>• Taking positive measures for a more gender-balanced health workforce to ensure gender-equitable and sustainable models of care, and combat job segregation that perpetuates stereotypes and unequal pay</li> </ul>







The Regional Committee requests the Regional Director to support Member States in implementing the actions identified in the strategy on the health and well-being of men in the WHO European Region, alongside those identified in the Strategy on women's health and well-being in the WHO European Region.



**WHO Regional Committee resolution on the *Strategy on the health and well-being of men in the WHO European Region, 2018***

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1 All weblinks accessed 25 March 2019.



## The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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