



## Handout 1.1 – Flash card facts

Below are the flash card facts discussed in Module 1; some explanatory factors have been included. Keep these handy with you throughout the workshop – and compare with your own discussions.

### Flash card 1

Q: Can household responsibilities, such as food preparation, pose a risk to health?

A: Yes. The fact that women tend to be in charge of cooking in most contexts puts them at higher risk of respiratory illness than men as a result of their household responsibilities.

#### Why?

Acrid smoke deposits are responsible for 511 000 of the 1.3 million deaths due to chronic obstructive pulmonary disease (COPD) among women worldwide per year versus 173 000 of the total of 1.4 million deaths from COPD among men. Inefficient household energy practices may significantly affect the health of pregnant women such as pelvic organ prolapse during pregnancy due to heavy loads carried during fuel collection and low birth weight – even stillbirth – as a result of exposure of the developing embryo to harmful pollutants.

*Fuel for life: household energy and health.* Geneva, World Health Organization, 2006  
(<http://www.who.int/indoorair/publications/fuelforlife/en>, accessed 23 November 2009).

### Flash card 2

Q: Do more men than women die from road traffic injuries?

A: Yes. Almost three times as many men die from road traffic injuries as women. This is true especially for men younger than 25 years. In fact, a study in Pakistan found 22.4 road crashes per 1000 male population versus 6.9 per 1000 female population. In Tehran, a hospital-based study of road traffic victims found the male-to-female ratio for road crash victims was 4.2:1, while a survey of road traffic victims treated in a hospital in Saudi Arabia showed a male-to-female ratio of 9:1.

#### Why?

Higher risk from road traffic injuries and fatality is associated to a significant extent with greater exposure to driving, in addition to patterns of high-risk behaviour among men when driving. Gender role socialization and the association of masculinity with risk-taking behaviour and a disregard of pain and injury may be factors leading to hazardous actions by men. Men may spend substantially more time in moving vehicles than women and may be more likely to own cars than women in some contexts. Men are also more likely to be employed as drivers and mechanics.

Ghaffara A, Hyderc AA, Masudb TI. The burden of road traffic injuries in developing countries: the 1st national injury survey of Pakistan. *Journal of the Royal Institute of Public Health*, 2004, 118: 211–217.

Moutaery KA, Akhdar F. Implications of road accidents in Saudi Arabia. *Pan Arab Journal of Neurosurgery*, 1998, 2:2  
(<http://www.panarabneurosurgery.org.sa/journal/oct1998/ImplicationOfRoadAccidents.htm>, accessed 23 November 2009).

Roudsari BS, Sharzei K, Zargar M. Sex and age distribution in transport-related injuries in Tehran. *Accident Analysis and Prevention*, 2004, 36:391–398.

Toroyan T, Peden M, eds. *Youth and road safety.* Geneva, World Health Organization, 2007  
([http://www.who.int/violence\\_injury\\_prevention/publications/road\\_traffic/youth\\_roadsafety/en](http://www.who.int/violence_injury_prevention/publications/road_traffic/youth_roadsafety/en), accessed 23 November 2009).

*Gender and road traffic injuries.* Geneva, World Health Organization, 2002 ([http://www.who.int/gender/other\\_health/en](http://www.who.int/gender/other_health/en), accessed 23 November 2009).



### Flash card 3

Q: Do boys and girls have the same access to high-quality health care?

A: Not always. Boys and girls do not always have the same access to high-quality health care. For example, surveys conducted in Bangladesh, India, Indonesia, Nepal, Sri Lanka and Thailand found that, even when girls were vaccinated at comparable rates to boys, they were often not taken to a health provider or care facility for illness episodes.

#### Why?

While there may be varied explanations across contexts, especially in low-income contexts, social norms such as son preference and lower social status for girls often affect the prioritization of their health.

*Women of South-East Asia: a health profile.* Delhi, WHO Regional Office for South-East Asia, 2000 ([http://www.searo.who.int/en/Section13/Section390/Section1376\\_5513.htm](http://www.searo.who.int/en/Section13/Section390/Section1376_5513.htm), accessed 23 November 2009).

### Flash card 4

Q: Are women and men equally represented among new cases of HIV?

A: No. HIV trends over the past decade have shown significant increases in the numbers of women living with HIV. Globally, the percentage of women among people living with HIV has remained stable at 50% for several years. However, women's share of infections is increasing in several countries.

#### Why?

While the numbers of men living with HIV continue to be of international concern, women are more susceptible to infection during heterosexual intercourse due to a greater area of mucous membrane exposed during sex. In many cases world-wide, men are allowed multiple partners, which increases infection among spouses. Further, violence and gender inequality create a greater vulnerability to infection.

*2008 AIDS epidemic update.* Geneva, Joint United Nations Programme on HIV/AIDS (UNAIDS) and World Health Organization, 2008 (<http://www.unaids.org/en/KnowledgeCentre/HIVData/EpiUpdate/EpiUpdArchive/2007/default.asp>, accessed 23 November 2009).

### Flash card 5

Q: Do smoking-cessation programmes have the same effects on men and women?

A: No. While smoking rates among men tend to be 10 times higher than among women, the rapid rise in tobacco use among younger females in low- and medium-income countries is a worrying trend. Women generally have fewer successful smoking-cessation attempts and more relapses than men, and nicotine replacement therapy may be less effective among women.

#### Why?

Current evidence is inconclusive as to why smoking-cessation interventions appear to be less effective among women. However, some explanatory factors include:

- sex differences in the metabolism of nicotine;
- decreased confidence among women to quit smoking; and
- psychosocial stressors such as single parenting, concerns about body image, low levels of education, caring burdens and poverty.

*WHO report on the global tobacco epidemic 2008: the MPOWER package.* Geneva, World Health Organization, 2008 (<http://www.who.int/tobacco/mpower/en>, accessed 23 November 2009).

*Sifting the evidence: gender and tobacco control policy.* Geneva, World Health Organization, 2007 (<http://www.who.int/tobacco/mpower/en>, accessed 23 November 2009).



### Flash card 6

Q: Do men and women experience violence in the same places and by the same types of perpetrators?

A: No. Women experience physical, sexual and psychological violence in their homes, often from intimate partners, in conflict settings and in communities, often by people they know. Sometimes they die from these situations; sometimes they remain in unsafe settings. Men who experience violence, in contrast, often experience violence at the hands of strangers and tend to die as a result of homicide by unknown perpetrators.

#### Why?

Normalized, unequal gender relations between women and men and an accepted lower social status of women contribute to the numerous cases of interpersonal violence experienced by women. Gender norms that normalize male violence – towards women or other men – further serve to encourage male violence as an accepted problem-solving technique and exercise of control over others.

García-Moreno C et al. *WHO Multi-country Study on Women's Health and Domestic Violence against Women: initial results on prevalence, health outcomes and women's responses*. Geneva, World Health Organization, 2005 ([http://www.who.int/gender/violence/who\\_multicounty\\_study/en](http://www.who.int/gender/violence/who_multicounty_study/en), accessed 23 November 2009).

### Flash card 7

Q: Do males and females differ in mortality related to lung cancer?

A: Yes. More men than women die of lung cancer. GLOBOCAN 2000 data reveal gender differences in lung cancer incidence, prevalence and mortality, with about 10 female deaths and 31 male deaths per 100 000 population being attributed to lung cancer, more than a threefold difference!

#### Why?

For many years the marketing of tobacco was aimed at men, and lung cancer was predominantly a male disease. Smoking in several cultures is seen as a rite of passage for young men and has historically been male centred. As smoking habits have changed over time, the disparity between men and women is smaller than in the first half of the 20th century.

Payne S. *Gender in lung cancer and smoking research*. Gender and Health Research Series. Geneva, World Health Organization, 2005 (<http://www.who.int/gender/documents/LungCancerlast2.pdf>, accessed 23 November 2009).

### Flash card 8

Q: Do women generally live longer than men?

A: Yes. In most countries women do live longer than men but have higher levels of disability or illness.

#### Why?

There is no clear answer as to why *men die quicker but women get sicker*. Men's shorter life spans may be due to increased exposure to certain risk factors such as tobacco or alcohol use, road crashes, homicide, suicide or cardiovascular disease. Hormonal differences have also been postulated as a protective factor among women.

Sen G, George A, Östlin P. *Unequal, unfair, ineffective and inefficient: gender inequity in health. Why it exists and how we can change it*. Final report to the WHO Commission on Social Determinants of Health. Geneva, World Health Organization, 2007 ([http://www.who.int/social\\_determinants/resources/csdh\\_media/wgekn\\_final\\_report\\_07.pdf](http://www.who.int/social_determinants/resources/csdh_media/wgekn_final_report_07.pdf), accessed 23 November 2009).

*Gender, health and ageing*. Geneva, World Health Organization, 2003 ([http://www.who.int/gender/documents/en/Gender\\_Aging.pdf](http://www.who.int/gender/documents/en/Gender_Aging.pdf), accessed 23 November 2009).



### Flash card 9

Q: Are adult women and men equally vulnerable to malaria infection?

A: Mostly. Available evidence suggests that, if adult men and women were equally exposed, they would be equally vulnerable to infection. An exception to the rule is pregnant women, who are at greater risk of severe malaria in most endemic areas.

Of the 247 million cases of malaria reported in 2006, the majority are among children in Africa. In general, high-risk groups include infants and young children (from six months to five years of age), pregnant women, non-immune people (such as travellers, labourers and populations moving from low-transmission to high-transmission areas) and people living with HIV.

#### Why?

In some settings, men are at a greater risk of contracting malaria than women if they work in mines, fields or forests at peak biting times or migrate to endemic areas for employment purposes. Women who often do household chores before dawn may be exposed to mosquitoes in early hours. In other societies, the activities of men and women during peak biting times may result in equal risks of infection. A study in Myanmar on activities that enhance human–vector contact revealed that the ways that women and men spend their time during peak biting periods – both for leisure and for work – placed them at equal risk of contracting malaria through exposure to mosquitoes.

Tolhurst R, Nyongato FK. Looking within the household: gender roles and responses to malaria in Ghana. *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 2006, 100: 321–326.

*World malaria report 2008*. Geneva, World Health Organization, 2008 (<http://apps.who.int/malaria/wmr2008>, accessed 23 November 2009).

*Gender, health and malaria*. Geneva, World Health Organization, 2007 (<http://www.rollbackmalaria.org/globaladvocacy/docs/WHOinfosheet.pdf>, accessed 23 November 2009).

### Flash card 10

Q: Did the 2004 tsunami affect men and women in the same way?

A: No. A review of deaths from the 2004 tsunami in locations in India, Indonesia and Sri Lanka showed that many more women than men died as a direct result of the tsunami.

#### Why?

The different societal roles of and norms relating to women and men determined their response and ability to survive. In some communities, men had learned to swim and to climb trees, whereas women had not, so when the tsunami struck, men were able to climb above the water or stay afloat. More men swept up by the tsunami were probably able to survive than women and children because they had the strength to hold on to something stable or stay afloat in the powerful waves. More women, as primary caretakers of children, focused on saving their children and were unable to save their own lives as a result.

*The tsunami's impact on women*. London, Oxfam, 2005 ([http://www.oxfam.org.uk/resources/policy/conflict\\_disasters/downloads/bn\\_tsunami\\_women.pdf](http://www.oxfam.org.uk/resources/policy/conflict_disasters/downloads/bn_tsunami_women.pdf), accessed 23 November 2009).

### Flash card 11

Q: Do armed conflicts affect men and women in similar ways?

A: No. Although men and boys are often more likely than women to be recruited into or to join armed forces – exposing them to the possible risks to health this role brings – civilian women and girls often bear the brunt of conflicts today. Women and girls may be combatants or associated with fighting forces, and the impact on their well-being may differ from that of their male counterparts depending on their roles. Further, women and girls are more likely than men and boys to experience sexual violence in conflicts, which has additional implications for their physical and mental health and social well-being.



### Why?

Of the millions of people displaced by armed conflict worldwide, at least 65% are estimated to be women and girls, who face daily deprivation and insecurity. Many face the threat of violence, including sexual violence, when they engage in daily tasks such as fetching water or gathering firewood. They lack access to health services that address the physical and mental consequences of conflict and displacement and may die in childbirth because basic reproductive health services are often not available. Violence against women – including sexual violence – is increasingly documented, particularly in crises associated with armed conflict. In these circumstances, women submit to sexual abuse by gatekeepers in order to obtain food and other basic life necessities. Rape is used to brutalize and humiliate civilians, as a weapon of war and political power and as a tactic in campaigns of ethnic cleansing. The violence and the inequality that women also face in crises do not exist in a vacuum. They are the direct result and reflection of the violence, discrimination and marginalization women face in times of relative peace.

Shoemaker J. Women and wars within states: internal conflict, women's rights and international security. *Civil Wars*, 2001, 4(3):1–34.

García Moreno C, Reis C. Overview on women's health in crises, *Health in Emergencies*, 2004, 20:2 ([http://www.who.int/hac/network/newsletter/Final\\_HiE\\_n20\\_%20Jan\\_2005\\_finalpdf.pdf](http://www.who.int/hac/network/newsletter/Final_HiE_n20_%20Jan_2005_finalpdf.pdf), accessed 23 November 2009).

### Flash card 12

Q: Do natural emergencies affect the mental health of population groups in the same way?

A: No. A population-based study of survivors of the Bam (Islamic Republic of Iran) earthquake found that those suffering from the most severe mental distress were older, less educated, divorced, widowed and unemployed groups – especially women in these groups.

### Why?

Women's particular vulnerability to depression after emergencies may be due to their responsibilities for caring for children, sick people, older people and injured family members, with severe shortages of resources and support. Their vulnerability increases with the loss of male family support due to death, disruption of the social structure and other conflict factors.

Montazeri A et al. Psychological distress among Bam earthquake survivors in Iran: a population-based study. *BMC Public Health*, 2005, 5(4) (<http://www.biomedcentral.com/content/pdf/1471-2458-5-4.pdf>, accessed 23 November 2009).

### Flash card 13

Q: Does blindness prevalence differ between men and women?

A: Yes. Trachoma infection rates are higher among girls and women, as are repeat infections that can lead to blindness. Available studies indicate that females have a significantly higher risk of being visually impaired than males in every region of the world and at all ages. Nevertheless, women often do not have equal access to surgery for eye diseases due to inability to travel to a surgical facility unaccompanied, differences in the perceived value of surgery for women and lack of access to health information.

### Why?

As primary caregivers, young girls and mothers are more exposed to the infectious agent present in the eye secretions of infants. Delays in access and utilization of blindness prevention services are attributed to several gender variables such as lack of disposable income, gender inequality in decision-making and lack of priority given to their health concerns.

Fuad D, Mousa A, Courtright P. Sociodemographic characteristics associated with blindness in a Nile Delta governorate of Egypt. *British Journal of Ophthalmology*, 2003, 88:614–618.

Khandekar R et al. The prevalence and causes of blindness in the Sultanate of Oman: the Oman Eye Study (OES). *British Journal of Ophthalmology*, 2002, 86:957–962.

*Preventing chronic diseases: a vital investment. WHO global report.* Geneva, World Health Organization, 2005 ([http://www.who.int/chp/chronic\\_disease\\_report/en](http://www.who.int/chp/chronic_disease_report/en), accessed 23 November 2009).



#### Flash card 14

Q: Do men and women differ in the prevalence of depression?

A: Yes. In the Islamic Republic of Iran, the prevalence of mental disorders was 1.7 times higher among women than among men: 29% versus 15%. A population-based study in Rawalpindi, Pakistan estimated that 24% of women and 10% of men had depressive disorders.

#### Why?

Biological factors may contribute to the higher prevalence of depressive disorders among women. However, studies in the WHO Eastern Mediterranean Region have found that social factors, such as physical abuse by a spouse, illiteracy, financial insecurity, lack of access to family planning and lack of autonomy also contribute significantly to vulnerability to depressive disorders, and these social factors tend to be more common among women.

Noorbala AA et al. Mental health survey of the adult population in Iran. *British Journal of Psychiatry*, 2004, 184:70–73.

Mumford DB et al. Stress and psychiatric disorder in urban Rawalpindi community. *British Journal of Psychiatry*, 2000, 177:557–562.

#### Flash card 15

Q: Does male involvement influence maternal and child health outcomes?

A: Yes. Male involvement improves physical and psychosocial maternal and child health outcomes. It also leads to positive social outcomes for men themselves. Studies in Scandinavia have shown that men's involvement in maternal and child health programmes can reduce maternal and child morbidity and mortality, such as:

- fewer low-birth-weight infants in low-income families
- improved cognitive outcomes for preterm and low-birth-weight babies
- shortened labour time and rate of epidural use
- obstetric emergencies may be alleviated.

#### Why?

Although current literature is limited to Europe, data indicate that the relationship between men's various roles as husbands or partners, fathers and breadwinners influence their health and behaviour. Fathers who are equally involved in all aspects of domestic life – including their children's lives – are more likely to engage in less risky behaviour and demonstrate better health outcomes. The psychosocial support offered to female partners during pregnancy and childbirth has also been shown to decrease pain and stress levels – leading to better overall maternal health outcomes.

*Fatherhood and health outcomes in Europe*. Copenhagen, WHO Regional Office for Europe, 2007  
([http://www.euro.who.int/GEM/publications/20070506\\_10](http://www.euro.who.int/GEM/publications/20070506_10), accessed 23 November 2009).