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EDITORIAL

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Equity, gender and health: A cross road for health promotion

We are in unprecedented times. Climate change, fake news, COVID-19, media monopolisation and armchair scientists who are ensuring that the pursuit of gender equity within societies is a difficult road to traverse for health promotion practitioners, policy writers and researchers. However, the topic of gender equity is more important than ever. In fact, it has become urgent.

Globally, women are experiencing increasing inequities in job losses, gendered violence, disability and career opportunities according to the World Health Organization.[1,2] All of these inequities can negatively impact health and well-being and prevent growth, productivity and flourishing—not just of and for women, but of society in general.[2] However, in the pursuit of gender equity in health in Australia, there is a requirement to channel resources into a better understanding of and challenging the complex issues that result in gender equities through established health promotion infrastructure. This editorial follows from Smith et al[3] editorial that looked at equity, gender and health—new directions for global men's health promotion. In this current issue we discuss women's health and equity issues and highlight some examples of women's health promotion programs. Women's health and equity are a broad topic for one editorial-therefore we will tackle the topic in two editorials—this one followed by an editorial on gender equity and violence against women. In this editorial, we argue that health promotion practice, interventions and policies need a greater focus on gender for a healthier society and that gender equity, as a concept needs to be unpacked and addressed.

WHO identifies gender as a social and structural determinant that has a significant influence on the health outcomes of women.[4] A gender equity approach to health acknowledges that men and women do not function on a level playing field; and this often prevents women from fully benefitting from what society has to offer.[5]

Internationally, the third Millenium Development goal and the fifth Sustainable Development Goal identified gender equality as a human right, advocating for an equitable balance of welfare resources, roles and lifestyles between women and men worldwide.[6] Australia, however, has a limited focus on driving gender equity in practice, interventions and policies beyond that of women's health and men's health programs and identified policies such as the Women's Health policy now incorporated into the National Women's Health Strategy 2020–2030.[7]

1 | EQUITY, EQUALITY AND VALUES

Gender equality means that women and men have equal conditions and opportunities for realising their full human potential through exercising their rights to contribute, and benefit from economic, social, cultural and political development.[8] We are not saying that men and women should be the same and share similar aspirations, rather that human rights and access to resources and opportunities is not dependant on a person's biological sex.[9] Strategies and actions need to be implemented to tackle gender inequality to ensure equal population health outcomes. The relationship between gender and health is complicated. Gender norms and health inequalities as social determinants of health are essential considerations for health promotion interventions and practice.

The root causes of health inequities are systemic, socially stratifying drivers such as history, socio-political environment, place, ethnicity, culture, and language, occupation, gender/sex, religion, education, socio-economic status and social capital.[10] The root causes of inequities between the genders emanate from unbalanced power relations and unequal status. While exceptions can be found, in almost all global societies women have lower status than men and their roles are sometimes perceived as being of lesser value.[11] Access to power and status is important because they determine the ability of women to take control over their lives, and consequently their health.[1,12] Historical norms and values about the role of women in society and the way that organisations are structured, and programs are delivered, each influence women's opportunities to access resources such as income, education, employment and the health care system.[1,13,14]

1.1 | Social and economic circumstances

Gender inequality means that women in Australia are disadvantaged, discriminated against and not equally represented in many areas of society. They are underrepresented in business leadership, political leadership (32% are women) and as culturally diverse leaders.[15] These become inequities if they are considered to be unfair or unjust. The full-time average weekly earnings for women are 14.6% less than for men, with average superannuation balances for women at retirement being 42% lower than those for men.[15] Women are more likely to do unpaid domestic work each week, and almost one and a half times more likely to aid a person with a disability, long-term health condition or problems related to old age, over any given fortnight.[16] Gender inequality also exposes women to disadvantages such as unequal pay for work of camparable worth, precarious work conditions, unemployment, unstable housing, homelessness, financial insecurity and poverty.[17]

Power and privilege operate between different cohorts of women too. As such, some groups of women experience greater

social disadvantage and subsequently have poorer health outcomes. Groups that experience such disadvantage include migrant and refugee women; culturally and linguistically diverse women; women living with disabilities; women in rural regional and remote locations; gender and sexually diverse women; Aboriginal and Torres Strait Islander Women and older women.[15] When systematic inequities are addressed disparities can be improved. Take for example the profound 50% reduction in preterm birth for Aboriginal and Torres Strait Islander women and babies when maternity services are redesigned to meet their needs.[18]

So how can we shift the mainstream narrative of improving unequal power and privilege? Mainstreaming or assimilation of women's health into generalist policies and services facilitates a selective approach to gender, rendering political dimensions of inequity invisible.[19] There is also heterogeneity within different groups of women, which also need to be considered otherwise these also have the impact of mainstreaming or assimilating within the broader group defined as women. In other words, getting the privileged few (women) to recognise and challenge these differences, is fundamental for preventing the status quo.

1.2 | Health risks and impacts

Gender inequality has a profound impact on both the physical and mental health outcomes of women.[4] The Australian Women's Health Network (AWHN)[20] notes that gender, or how we live our biological sex as women and men in accordance with prevailing society norms, institutions, expectations or behaviours, position men and women differently in society. This differential positioning results in unequal distribution of power, resources and prestige between the genders and hence shapes differences in the material circumstances of women and men. This in turn exposes women to unique and specific risks for poorer health outcomes compared to men, and has consequences for women's health and illness in ways that are unique to them as women.[20]

Women's exposure to unequal socio-economic, cultural and political positioning are evidenced by poorer health outcomes in several areas. Overweight and obesity, tobacco smoking, poor diet and nutrition and insufficient physical activity are more prevalent in lower socio-economic groups.[21] These risk factors can lead to chronic diseases such as heart disease, cancer, liver disease and Type 2 diabetes. Poor physical and mental health is closely related to unstable housing, particularly with young single mothers. Health outcomes for women are tied to financial security, participation in the labour market and financial literacy.[22] While women have longer life expectancies than men; they also have higher rates of disability and poorer health for a range of physical, social and mental health outcomes.[23] Some researchers suggest that these differences are primarily attributable to gender inequalities, underpinned by gendered relations of power.[22] Societal structures that underpin people's lives based on whether they are male, or female or a gendered minority[24,25] sustain a hierarchy of power in that society, and in sub-sets of that society, including sub-sets of women. For example, women with a disability and Indigenous women.

1.3 | Health literacy

Health literacy is one area in which health promotion practitioners, programs, policy and researchers can help to shift the status quo and can be used as a tool that contributes to addressing disparities and improving equity between and among the sexes[26] Health literacy is integral to being in control of one's health because it includes the capacity to improve decision making to navigate the health care system for appropriate and timely care. Approximately, 40% of Australians have low to inadequate health literacy levels with women over the age of 65 having the lowest levels of health literacy.[27] That is, health literacy is a gendered social determinant of health.[28] Indeed, the National Women's Health Strategy 2020-2030 (NWHS) has a number of priorities, including health literacy, maternal, sexual and reproductive health; healthy ageing; chronic conditions and preventive health; mental health and health impacts of violence against women and girls.[7]

In this issue of the journal, we focus on a range of programs and resources that target pregnancy and women's health. There are two articles targeting pregnancy and health. A brief report by Brown et al,[29] reviewed smartphone apps for information to women during pregnancy. A total of 76 android apps were included in the final analysis if they were in English, they were free, they looked at quality, cost, were designed for pregnant women, and contained nutrition or dietary information. The quality of each app was also measured on four subcategories—engagement, functionality, aesthetics and information quality using a 5-point Likert scale. This review recommended that there should be some regulations of health and medical apps currently available on the market, as there is a large number of poor quality apps available. In particular, it notes that pregnant women should be protected from exposure to unsound nutrition advice. Importantly health professionals, health researchers and app developers need to co-design pregnancy nutrition apps that are of high quality and contain evidence-based nutrition information.

A letter to the editor by Rissel et al[30] reviewed a recent paper by Brownbill et al[31] on the use of the health star rating (HSR) system in Australia on nondiary or nonalcoholic drinks. Brownbill et al[31] found that only a third of beverages displayed the HSR and called for a mandatory display of HSR on beverages providing readlily understood nutrition information. This system assists consumers to make healthier choices and was developed in partnership with industry, government and consumers. The HSR was introduced in 2014. A cross-sectional survey was conducted to better understand the recall of and confidence in using the HSR. Some questions about HSR were included as part of a larger randomised control trial: The Communicating Healthy Beginnings Advice by Phone (CHAT) study. Although these pregnant women had higher recall of HSR on packaged foods there are some anomalies—more awareness from first time mothers, and women not speaking English at home and women with lower household incomes. The findings were that the HSR

system has the potential to aid healthier choices among similar products, but at present it is only on a limited number of products and should be mandatory for all packaged foods.

In this issue, we present three articles about cervical and breast-screening. Although Australia has excellent public health screening availability for women, there are still ways to improve these screening rates particularly for women experiencing socio-economic disadvantage, homelessness and refugee women from Bhutan. Nagendiram et al,[32] conducted a systematic review of Australian women's self-perceived barriers to participation in cervical cancer screening. A new screening program for cervical cancer has recently been introduced in Australia and there has been a decline in the partication rates for cervical screening finding as a variety of personal, practitioner, test-related and logistical barriers negatively impact cervical screening. Lovell et al,[33] suggested that although there has been benefits not all women have experienced this. Women experiencing homelessness and socio-economic disadvantage in Sydney benefited from increasing workforce capacity in this sector so sustained mulitfacedted health promotion efforts are required to increase access for these women. Parajuli et al,[34] explored what a refugee health screening program would look like if the views of Bhutanese refugee women were incorporated into service design and the approaches to targeting access to cervical and breast cancer screening. They found that available cervical and breast cancer screening services are not attuned to refugee womens' needs and the role and practices of doctors in preventive health for refugee women. Refugee women who resettle in high-income countries are less likely to attend so we must work together with these women to improve service delivery and motivate them to seek regular checkups.

Also, Lambert et al,[35] as part of the Osteoporosis Prevention through IMPACT and Muscle- loading Approaches to Exercise (OPTIMA-Ex) trial conducted a three arm RCT comparing musculoskeletal outcomes from two supervised high intensity exercise programs (impact and resistance training) with an unsupervised, low intensity exercise control. A mixed methods approach was used, including quality of life and physical activity enjoyment questionnaires and qualitative analysis of semi structure interviews. It seems that the two supervised exercise groups had greater levels of physical activity enjoyment. Motivations for participation, barriers to physical activity and desired continuation of participation differed for all groups. As physical activity is the most effective lifestyle strategy to improve bone health, young adulthood is an important time for increasing convenience, accessibility and understanding of osteoporosis.

Brooks et al[28] conducted a qualitative evaluation of Artspace—a innovative clinical program combining creative arts with physical and mental health care for young women. This program has been available since 2004 and the evaluation was conducted between 2016 and 2017. The positive impact of this artist-led program was particularly beneficial for those clients who had considerable exposure to social adversity and trauma, and were experiencing related serious health impacts. Artspace facilitated their recovery by enabling equitable access, facilitation, social inclusion and creating a "holding environment", and through the directly therapeutic benefits of artist-led arts processes. Youth health researchers have been recommending arts programs in health services for over 15 years as a way to engage young people in health care, however, it remains an underutilised approach in primary health care.

Of course there are many more articles in this issue; in this editorial we have decided to concentrate on those specifically targeting women. However, when you are reading the other articles, we challenge you to think about the women, and gender more broadly, in those studies; did the authors mention the gender of the participants beyond stating their sex? Health promotion practitioners, policy makers and researchers need to consider the different needs of these groups. We can see that those women in different groups—be they Aboriginal and Torres Strait Islander women, or refugee women or LGBTI and transgender women—need to have a participatory role in the co-development of the services designed for them. To reach any kind of health, social or gender equity, all people need to be considered for their specific needs and these needs should to be incorporated into health service delivery, the policies we make and the research we do.

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