Gender Mainstreaming in Health Governance: Exploring the Inadequacies in Addressing Women's Health Issues

Manila Khisa[1]

Abstract

Gender mainstreaming in health sector is a commonly applied strategy for providing equal health benefits to men and women by incorporating various implications of social construction of gender with health policies. However, gender mainstreaming, to a large extent is insufficient to address the rapidly growing health problems and frequently transforming health trends- such as ageing, increase of non-communicable diseases, mental health issues, environmental hazard borne diseases etc. While women's reproductive health is the major concern of health governance both in the national and international levels- especially in developing countries, the newly emerging health issues of women remain almost invisible and unexplored. Using secondary data analysis method, this article has opted for qualitative approach to examine data collected from existing literature and tried to find out these changing health trends of women, the reason why they are undervalued and limitations of gender mainstreaming in addressing them. At the end, it has also suggested some potential policy approaches for the national and international health governing bodies to meet the limitations.

Keywords: Women, Gender mainstreaming, Demographic trends, Health governance, Determinants of health

1. Introduction

Ever since the social scientists have recognized the difference between "Sex" and "Gender" and their different implications, focus on societal-gendered role related research has increased. It has been a couple of decades that the concern of international communities has shifted from "women" to "gender" specific policies, technical and financial assistance and development programs. According to the Council of Europe (1998:15), 'Gender mainstreaming is the reorganization, improvement, development and evaluation of policy processes, so that a gender equality perspective is incorporated in all policies and at all stages, by the actors normally involved in policy-making'. The idea of mainstreaming gender in various sectors first emerged in 1980s; when it was officially defined in the 1995 Beijing Platform for Action and in the United Nations Economic and Social Council (ECOSOC) as a global strategy and planned action in legislation, policies and programmes (Payne, 2011; Ravindran & Kelkar-Khambete, 2008; True, 2003). Gender mainstreaming is widely believed to promote gender equity and justice by addressing discrimination and vulnerability originating from various gendered roles constructed and policed by and within the society.

[1] Lecturer, Department of Development Studies, Bangladesh University of Professionals (BUP), email: khisa.manila@yahoo.com

Health governance, or management of health issues at the global, national and local level through application of the soft laws, norms and expectations - both legally binding and customary (WHO, 2016), too has embraced gender mainstreaming, especially in the reproductive health care services where women need special attention. However, while being evidently successful, the application of gender mainstreaming approach in health governance has also been criticized for its inadequacy in terms of dealing with the newly emerging women's health problems related to demographic changes. In this paper, efforts have been given to explore these inadequacies and ways to address them.

2. Problem Statement

It is only recently, especially since the declaration of the Sustainable Development Goals (SDGs), that the changing health trends are gaining attention in the research, policy and program arena. The goal 3 of the SDGs pledges to ensure healthy lives and promote well-being for all at all ages by focusing specifically on newly emerging health concerns such as ageing, increase of non-communicable diseases, mental health issues, environmental hazard borne diseases etc. along with other common diseases. However, for women, reproductive health remains the major concern of health governance both at the national and international levels, especially for the developing countries and the newly emerging health issues of women remain almost invisible and unexplored. In order to meet the targets of health-related goals of the SDGs within its timeframe, it is therefore crucial to undertake in-depth studies in this area. In an effort to do so, this article will be focusing on the contemporary health trends brought forth by various demographic changes of the globalized world.

3. Objectives

This study aims to find out the changing health trends of women, the reason why they are undervalued in policies and programs and limitations in the process of gender mainstreaming in addressing them. In doing so, first, the study is going to explore various demographic factors associated with women's health. Then it examines how changes in socio-economic and environmental attributes result into changes in the demographic factors- ultimately shaping women's health condition. Finally, the study identifies the existing gaps and limitations of gender mainstreaming in terms of women's health and provide some recommendations in this regard. This study has been done in such manner so that the findings can be useful in the designing, planning and implementation of SDG's health related policies and programs.

4. Literature Review

Health is a state of complete physical, mental and social well-being and is one of the basic human rights of people. Since the last couple of decades, global health sector has become one of the accentuated sectors in terms of gender mainstreaming. It is used as a strategy to improve the health condition of the women through 'increasing coverage, effectiveness and efficiency in all health care interventions that do not promote or perpetuate inequitable gender roles and relations (Ravindran & Kelkar-Khambete, 2008: 122-23). To do so, the aim of gender mainstreaming in health sector is to address

the health conditions and discriminations derived from differentiated gender roles and social position. Gender mainstreaming in the health sector has occurred in two dimensions:

1. Operational mainstreaming: policies, programs, projects and trainings on health
2. Institutional mainstreaming: institutional structures of managing and delivering health care services (Payne, 2011; Ravindran & Kelkar-Khambete, 2008).

Even though there are many evidences of positive outcomes from gender mainstreaming in the health sector (the health related MDGs in the developing countries for the betterment of maternal health, for example), however, there are arguments that gender mainstreaming in the health sector is inefficient in terms of achieving equitable health for women.

Firstly, most of them to a great extent are shaped by social judgement. Gender is a social construction, where it is the given societal, cultural and historical context which is responsible for giving masculine and feminine identities to the male and female bodies and for defining, constructing and shaping their values, roles and responsibilities, behaviors, activities and power relations according to how it is considered appropriate in the given context (Hawkes & Buse, 2013). Therefore, while, biological distinctions between males and females are crucial for determining their health, the social construction of gender also plays an important role in shaping the health condition of individuals. Narrow focus on women's differentiated experiences from their gender role within the society and gender stereotyped health services provision have led the attention of gender mainstreaming health programmes and policies towards only reproductive and maternal health issues of women instead of looking at the newly emerging health issues at the same time (Doyal, 2001; United Nations, 1995).

Secondly, lower levels of economic autonomy cause higher mortality and morbidity amongst women (Annandale & Hunt, 2000; Phillips, 2005; Sen & Östlin, 2008). The amount of resources held by a person depends on employment and income opportunities and people who are in paid work, tend to have better health than those who are not (Annandale & Hunt, 2000). According to WHO estimation, 70% of the 1.2 billion people living in poverty are female (WHO, 2002: 6). Women tend to be poorer because they have limited access to resources and resource earning opportunities. Gender inequalities in income and wealth make women especially vulnerable to poverty and therefore to diseases (Doyal, 2001). The Literacy rate is relatively lower amongst women than men. Because of not being able to receive education or facing interruption in their education, women are unable to attain formal employment and therefore, unable to accumulate savings to use for health care services.

Thirdly, the power relations between genders is an influential determinant which is simultaneously determined by what happens within the household and community (Moss, 2002: 652). It determines to what level women have the accessibility to job sector so that they can earn and save money for themselves, accessibility to health care services i.e., to what extent they have the ability to decide for themselves in seeking

health care, and to what extent they have control over resources (Hawkes & Buse, 2013; Sen & Östlin, 2008; Standing, 1997; Vlassoff & Moreno, 2002). 'Women in the third-world countries have 'needs' and 'problems', but only a few have 'choices' or the freedom to act' (Mohanty, 1988: 72). For instance, women in many societies are also less likely to be able to negotiate with their male partners for safe sex, which is one of the reasons behind the increasing rate of women affected by HIV/AIDS. The issue of domestic violence against women is one of the major reasons women suffer from poor health. 'Studies have estimated that 19% of the total disease burden carried by women aged 15 to 44 is the result of domestic violence and rape' (Annandale & Hunt, 2000; Doyal, 2001). Gender mainstreaming policies and programs tend to have paid less attention on these issues.

In the fourth place, comes individual's behavioral context towards health. According to the socio-cultural and historical contexts in majority of the societies, women are considered to be physically and emotionally weaker than men. Because of the social conception about motherhood, women are taken for granted as the health care gatekeeper and upholder of the household activities in the family. This sort of social construction of gender specific roles directly and indirectly shape women's physical and mental well-being and their health seeking behaviors. The unpaid role of women as care givers (even by disregarding their own health at times) within the family is usually taken for granted and is ignored. Education also ensures better knowledge about health, nutrition and basic health care functions. Hence, education is a crucial determinant as to how women behave towards their own health as well as their children's.

Fifthly, social inequality and discrimination is not limited to gender aspects, rather it is attributed with age as well (Sen & Östlin, 2008). In majority of the gender mainstreaming health policies and programs, women receive significant care and aid only during their childbearing years (Doyal, 2000) and this care towards them tends to decrease with age, whereas other health problems related to older age become acute.

Sixthly, another major barrier for women in achieving the highest attainable standard of health through gender mainstreaming is inequality among women in different geographical regions, social classes and indigenous and ethnic groups (Annandale & Hunt, 2000; McCracken & Phillips, 2012; United Nations, 1995). Vulnerability is a relative term and therefore, the level of vulnerability in women living in the urban and developed areas might differ from the ones living in the rural and poor areas (Standing, 1997). The universalism of gender mainstreaming disregarding differentiated vulnerability degrees and forms faced by women around the world cannot bring positive outcomes.

Finally, it is argued about mainstreaming gender in policies, programs and institutional actions that, it isolates women's position throughout the whole process by drawing initiatives directly towards the women which is quite distant from promoting gender equality and thereby creates a gap between actions and intentions (Daly, 2005: 440).

Although, substantial effort in the past has been put to identify various societal aspects of gender and their impacts on health very exclusively, rigorous and systematic studies that specify the continuous changes in these aspects and their impacts on health is still lacking. Additionally, insufficient light has been projected on the role of gender

mainstreaming in dealing with these changes. The results of this study will try to explore this arena and meet the gap by suggesting new avenues for the national and international governing bodies regarding gender mainstreaming in the health sector.

5. Methodology

The paper mirrors a rigorous exploration in the area of gender mainstreaming in health governance by studying existing literature, information and data recorded in difference sources. Using secondary data analysis method, this paper has opted for qualitative approach to examine data collected from relevant scientific and academic articles, books, national and international reports, surveys and newspapers. For the purpose of the study, this paper has adopted the framework of the determinants of health, an idea initially provided by the World Health Organization (WHO), and later used by many scholars for research on health. A brief explanation of the framework is given in the next part of the paper.

6. The Framework of the Determinants of Health

The determinants of health framework mainly comprehend that, besides individual's biological condition (which includes one's age, sex, genetic factors and ability to cope with health problems etc.), the individual's health is shaped by other various contexts and circumstances in which people are born, grow, live and work. These are called the determinants of health which are responsible for differentiated health conditions experienced by people and are unlikely to be controlled and determined by individuals (CSDH, 2008: 2; United Nations, 1995: 34). This conceptual framework helps to identify the socio-economic and environmental attributes needed be taken into consideration for the research.

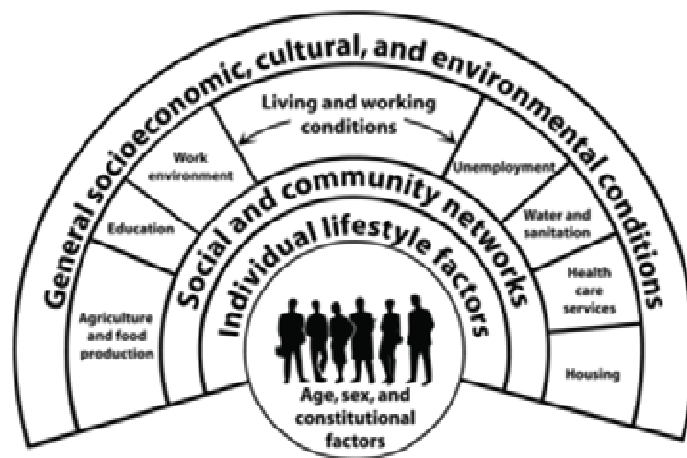

Figure 1: Determinants of Health
(Source: Dahlgren & Whitehead, 2007: 11)

For the convenience of this research, the following determinants have been considered:

1. Economic context such as employment condition and income status
2. Policy context such as national and international trade policies, health policies etc.
3. Physical and natural context such as climate change, disasters, availability of physical resources, housing condition, water supply etc.
4. Social context and networks such as social support, community bonding, interaction and association
5. Health care services context such as availability of health care services, health care expenditure, health insurance coverage etc.
6. Individual characteristics and behavioral context that are directly or indirectly shaped by the society such as risk-taking behaviors, diet, physical activities etc.

7. Findings

Since the beginning of the 1980s, the emergence of globalization has brought changes in socio-economic, political and cultural practices. These changes are materialized through employment, production, people's mobility, education, family and household structure and people's consumption patterns. Along with the increase of economic mobility and expansion of global market, demands and needs of people are changing too. These changes have mirrored people's health condition as well. The significant ones are as follows:

7.1 Industrial Development and Rapid Urbanization

Ongoing trends in a country's economy, market, nature of public and private financing and international financial assistance etc. on one hand, can benefit health sectors through new forms of technologies, goods and services. On the other hand, it can also directly or indirectly affect health through unequal income distribution, resource depletion, unfair working conditions and environmental pollution (CSDH, 2008).

7.2 The Longer the Lives, the Higher the Health Expenses

The life expectancy of a big proportion of the population around the world is increasing gradually due to availability of nutritious food and safe drinking water, people's accessibility to health services, proper infrastructural environment including decent conditions of housing, accommodation and sanitation. However, this increased life expectancy is coming at a big price. Conservative estimates show that people are living longer but getting sicker with chronic and non-communicable diseases.

By 2020 non-communicable diseases including cardiovascular diseases, cancer, respiratory diseases, digestive diseases, mental disorders, and conditions related to injuries and violence will account for nearly 80% of the global burden of disease and three out of four deaths worldwide will be due to non-communicable diseases (WHO, 2002: 5). While, a couple of decades ago non-communicable diseases were common mostly among men and in the developed countries; these days, women in the developing countries as well are increasingly pacing up with the rate (McMurray,

2004). According to a WHO report, ‘Of the 27 million deaths worldwide of women each year, almost 10 million result from cardiovascular diseases and of these, two third occur in developing countries’ (WHO, 2002: 13). Breast cancer is significantly growing amongst women in both developed and developing countries. However, the women living the low and middle-income countries are more vulnerable to chronic problems because of their higher fertility and lack of access to nutritious diet. Moreover, majority of the women in developing countries do not even have access to primary and emergency health care services due to financial and infrastructural barriers, let alone health care services for chronic and non-communicable diseases. Studies have evidence that, more women report long term disabilities due to chronic health problems than same aged men (Verbrugge, 1985).

Ageing has become a global health concern resulting from people’s increased life span, changes in family and marriage pattern and extensive career orientation. Now a days, women are becoming more carrier oriented because of the change in their education level and job opportunities which results into changes in their marriage pattern. Changes in marriage pattern are linked with higher rate of widowed and divorced women (Annandale & Hunt, 2000). Inadequate financial resources and lack of savings make women more insecure under these circumstances as diagnosing and treating chronic diseases is extremely expensive and most women are unlikely to be able to pay the fees by themselves.

There are also evidences that women are treated by some doctors less seriously (Doyal, 2001). For example, mental health problems, eating disorder, stress etc. are not considered as illness in many countries. Moreover, doctors tend to ignore cardiovascular health problems amongst women as sexual and reproductive health is normally considered the major health concern for them (Bulletin of the World Health Organization 2013). In Sen and Östlin’s words, ‘Women’s health has been beset by ‘resounding silences’ and has been misdirected or partially approached’ (2008: 7).

7.3 Changing Consumption Pattern

Increasing migration from rural to urban areas is associated with people’s exposure to modern lifestyle and changes in consumption pattern; which include tobacco, alcohol and fast food consumption that are responsible for causing cardiovascular diseases, diabetes, obesity etc. Chronic diseases like eating disorder are seen mostly among young females who are usually influenced by the media’s heavy interpretation and presentation of a slim body. Lucrative advertising of the multinational companies as well as the socially constructed ideas about modernity as results of globalization are largely responsible for the increase in women’s tobacco and fast food consumption. Even though, the percentage of women consuming tobacco usually is lower than the men’s, through involuntary smoking, a lot of women join the rapidly increasing tobacco consuming community which heightens their risks of being affected by cardiovascular diseases, chronic lung diseases, abortion, bronchitis and premature menopause (WHO, 2002).

7.4 Increased Human (Women) Mobility

Nowadays, women are coming out of their invisible role of working as homemakers and joining the workforce. These changes have both direct and indirect impact on people's health. As a result of globalized world and people's increased mobility, women are working abroad as health care giver and domestic workers. There are differences between experiences faced by women and men working overseas. Studies have evidences that women are more vulnerable to human rights violations because of the nature of their work (informal sector) which may not be highly valued by host countries (Borak, 2005: 8). As a result, women in their workplaces overseas face mistreatment in forms of physical abuse, gender biased payment, and lack of attention towards their mental and physical well-being. Moreover, due to sex segregated marginalized employment and salary structure, women are doubly affected, first as women and second as migrants (Borak, 2005).

7.5 Increased Mental Health Issues

Even though, there has been great advancement in the employment sector, due to the socio-economic hierarchical pattern, women still do not receive the job of their preference and qualification. Income structure still reflects the patriarchal hegemony. Studies show that, women are 40% more likely to develop mental health conditions such as depression and anxiety disorder (Ball, 2013) which are related to marginalization, racial and ethnic discrimination, social disintegration, powerlessness and poverty, along with overwork, physical and mental stress and domestic violence (Moss, 2002; United Nations, 1995). Mental health issues and suicidal behaviour have become significant health problems for girls and women worldwide and studies show that, women's low status in society, their burden of work and the violence they experience are some of the biggest contributing factors behind it (WHO, 2009).

7.6 Climate Change and Environmental Degradation

Climate change and environmental degradation are two very frequently talked about topics nowadays, which do not only affect the environment, but also people's health. Numerous health issues including both communicable and non-communicable diseases arise from unhealthy environment and environmental problems like soil, air and water degradation. Moreover, climate change induced events change the weather pattern, reduce food and water quality and quantity and have negative impacts on the ecosystem, agriculture and livelihoods. Internal and external displacement resulting from climate change and environmental events also accelerate people's ill health and diseases. These problems induced from environmental change affect women and men differently (Asia pacific Forum on Women, Law and Development, 2015) and women being one of the poorest andmost vulnerable groups of the society lacking coping capacity and sufficient resources, suffer the most (Preet et al., 2010).

7.7 Globalization and New Dimensions of Inequality and Discrimination

It is argued that complex change in the socio-economic dynamics are opening scopes for new forms of economic inequality and creating new dimensions of gender

discrimination (Annandale & Hunt, 2000; Moss, 2002). These sorts of newly emerging problems are also intertwined with diversities and inequalities generated by social divisions including class, ethnicity and region. However, health policies and programs are largely influenced by the western values and ideas and voices from the south barely reflect on them.

8. Discussion and Recommendation

In order to meet the limitations of gender mainstreaming in health governance, firstly, it is important to emphasize on the input which are the basis of human development, instead of focusing on the health outcomes themselves.

Secondly, in this stage of globalization, it is crucial to think beyond women's reproductive health problems. While the pathways of the MDGs have explicitly focused on maternal and reproductive health, SDGs have addressed non-gender specific health problems in the agenda. Besides promoting adequate care and services for the maternal and reproductive health; prevention of non-communicable diseases, treatment for mental health, prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol, reduction of the number of death and injuries caused by road accidents, death and illness resulted from environmental pollution, tobacco control etc. also have received attention this time in the sustainable development goals framework. These goals should be reflected in the international financial assistance policies and national policies.

Thirdly, an important fact that needs to be realized is that, women are affected by many health problems similar to men's; however, they experience them differently (United Nations, 1995: 35). Therefore, health care services need to be ensured for women throughout their entire life cycle, instead of stressing only on the prenatal and postnatal period. Lifelong health financing facilities, pension and tax reform, lifelong social protection and safety nets directed towards women with special focus should be arranged so that at any age, their vulnerability to diseases can be reduced.

Fourthly, opportunities for the protection, promotion and maintenance of health and health care services differ from country to country, region to region. This should be considered when forming policies and programmes. Policies and programmes should be designed in a way so that, regardless of gender, age, race, class, ethnicity and geography, everyone can equally benefit from them.

Fifthly, as the public sector resources, especially in the developing countries are scarce, hence, initiatives to form innovative ways for health financing, broadening health financing sectors, establishing social, private insurance scheme and exemption mechanism for extremely vulnerable women etc. should be taken. Moreover, the health sectors of developing countries still function in traditional ways and need reform in order to cope with the changes. While reforming the health sector, in addition to considering equity and women's rights issues, the newly emerging health concerns should also be prioritized.

Sixthly, it is apprehensible from the discussion of this paper that, health policies alone cannot achieve their goals. Shared agenda from the economic, political, environmental, agricultural and infrastructural sectors is needed in order to address the newly emerging health problems. Commitment from both the government and international communities and their extended partnerships and collaboration is needed to ensure strong global governance of health.

Seventhly, further research for integrated approaches to address newly emerging health problems and women's health condition with regard to their social position is necessary. By using ethnographic techniques and social and political variables; health data can be collected, monitored and reported.

Finally, community and social network building and awareness raising is necessary in order to get people informed about the social determinants of health. Mental health issues are indiscernible and sometimes neglected; therefore, information about these issues can be disseminated through community awareness. Media can also play a crucial role in spreading awareness about safe and healthy working environment for women's mental and physical well-being.

9. Conclusion

While undertaking programs and policy measures are crucial for health governance both in the national and international levels to bring gender mainstreaming out of its conventional approaches, it is also important to consider that, above all the measures, the main responsibility lies within the society that needs to come out of the stereotypical conceptions about masculinity and femininity. Improvement of women's health at all levels can only be possible when women are empowered to raise their voices about their needs and rights regarding health care services and can actually enjoy the results of it.

References

Annandale, A. and Hunt, K. (eds.). 2000. *Gender Inequalities in Health.* Buckingham & Philadelphia: Open University Press.

Asia Pacific Forum on Women, Law and Development. 2015. Climate Change and Natural Disaster Affecting Women Peace and Security, [online] Available at: http://apwld.org/climate-change-and-natural-disasters-affecting-women-peace-and -security/ [Accessed 1 Nov: 2015].

Ball, J. 2013. Women 40% More Likely Than Men to Develop Mental Illness, Study Finds, *The Guardian,* [online] Available at: http://www.theguardian.com/society/ 2013/may/22/women-men-mental-illness-study [Accessed 1 Mar: 2016].

Borak, J. 2005. Women Migrant Workers: Embracing Empowerment over Victimization. *IWPR's Eighth International* Women's Policy *Research Conference, Central Virginia Legal Aid Society,* pp. 1-23.

Bulletin of the World Health Organization. 2013. The New Women's Health Agenda. *Interview with Ana Langer,* 91(9).

CSDH. 2008. Closing the Gap in a Generation: Health Equity through Action on the Social *Determinants of Health.* Final Report of the Commission on Social Determinants of Health. Geneva: World Health Organization.

Dahlgren, G. and Whitehead, M. 2007. Policies and Strategies to Promote Social Equity in Health. *Institute for Future Studies,* pp. 1-67.

Daly, M. 2005. *Gender Mainstreaming in Theory and Practice.* Oxford University Press, pp. 433-450.

Desai, M. 2002. Transnational Solidarity: Women's Agency, Structural Adjustment and Globalisation. In: N.A. Naples and M. Desai, ed., *Women's Activism and Globalisation: Linking Local Struggles and transnational Politics,* New York & London: Routledge, pp. 15-33.

Doyal, L. 2000. Gender Equity in Health: Debates and Dilemmas. *Social Science and Medicine,* 51, pp. 931-939.

Doyal, L. 2001. Sex, Gender and Health: The Need for a New Approach. *BMJ,* 323, pp. 1061-1063.

Hawkes, S. and Buse, K. 2013. Gender and Global Health: Evidence, Policy and Inconvenient Truths. *Lancet,* 381, pp. 1783-1787.

McCracken, K. and Phillips, DR. 2012. *Global Health: An Introduction to Current and Future Trends.* New York: Routledge.

McMurray, C. 2004. Globalization and Health: The Paradox of the Periphery. *Perspectives on Global Development and Technology,* 3(1-2), pp. 91-108.

Mohanty, CT. 1988. Under Western Eyes: Feminist Scholarship and Colonial Discourses. *Feminist Review,* 30, pp. 61-88.

Moss, NE. 2002. Gender Equity and Socioeconomic Inequality: A Framework for the Patterning of Women's Health. *Social Science and Medicine,* 54, pp. 649-661.

Payne, S. 2011. Beijing Fifteen Years On: The Persistence of Barriers to Gender Mainstreaming in Health Policy. *Social Politics,* 18(4), pp. 515-542.

Phillips, SP. 2005. Defining and Measuring Gender: A Social Determinant of Health Whose Time Has Come. *International Journal for Equity in Health,* 4(2), pp. 1-4.

Preet, R., Nilsson, M., Schumann, B. and Evengard, B. 2010. The Gender Perspective in Climate Change and Global Health. *Global Health Action,* 3, pp. 1-7.

Ravindran, TKS., and Kelkar-Khambete, A. 2008. Gender Mainstreaming in Health: Looking Back, Looking Forward. *Global Public Health,* 3(S1), pp. 121-142.

Sen, G. and Östlin, P. 2008. Gender Inequity in Health: Why it Exists and How We Can Change It. *Global Public Health,* 3, pp. 1-12.

Standing, H. 1997. Gender and Equity in Health Sector Reform Programmes: A Review. *Health Policy and Planning,* 12(1), pp. 1-18.

True, J. 2003. Mainstreaming gender in Global Public Policy. International feminist *Journal of Politics,* 5(3), pp. 368-396.

United Nations. 1995. Report of the Fourth World Conference on Women: Beijing 4-15 September. New York.

Verbrugge, LM. 1985. Gender and Health: An Update on Hypotheses and Evidence. *Journal of Health and Social Behavior,* 26(3), pp. 156-182.

Vlassoff, C. & Moreno, CG. 2002. Placing Gender at the Centre of Health Programming: Challenges and Limitations. *Social Science & Medicine,* 54, pp. 1713-1723.

WHO, 2002. *Women and the Rapid Rise of Non-Communicable Diseases.* Office of Executive Director, Non-Communicable Diseases and Mental Health: Geneva, Switzerland.

WHO, 2009. *Women and Health: Today's Evidence, Tomorrow's Agenda.* Geneva, Switzerland.

WHO, 2016. The Determinants of Health. [online] Available at: http://www.who.int/hia/evidence/doh/en/ [Accessed 1 Jan 2016].