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HEALTH PROMOTION: IMPROVING THE HEALTH STATUS OF WOMEN AND PROMOTING EQUITY

This paper presents the contribution of health promotion to social and economic development, to improve the health status of women and their families in Latin America and the Caribbean. The document aims to heighten awareness of the major causes of death and illness among women in the Region, and the related socio-environmental conditions. Finally, the paper proposes lines of action for PAHO and its Member Countries to take in health promotion, to move toward more people-centered/gender-equitable development and the improved health of women in the Region. It is envisioned that Member Governments will develop concrete plans of action in health promotion, based on the lines of action presented in this paper.

The Special Subcommittee on Women, Health, and Development of the Executive Committee is requested to review the document and make recommendations for future activities by the Secretariat.

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Introduction and Rationale

Despite the fact that women live longer than men, women suffer from more health problems including higher levels of disability (after 60), incidence of acute illness, and a higher prevalence of many chronic conditions. Yet there is a paucity of research on women's health.

Health is a fundamental human right and "... an essential component of social and economic development". Many women lack access to health services. Women have special health needs which receive less attention than those of men and boys, and they have often been ignored by health planners.

Many causes of women's mortality and morbidity in Latin America and the Caribbean are preventable and appear to be related to social factors that place women at risk. Females from birth are vulnerable and are often discriminated against due to socially constructed factors that influence options open to both genders.

Women are valuable resources in society. Nevertheless, men tend to hold higher status and often women's work is undervalued. Work inside the home is not recognized; subsistence farming is not defined as "real" work and informal community work is not counted. Only "productive work", largely the domain of men in developing countries is valued as work.

Women's potential contribution and role in development has for too long been undervalued and misunderstood. Evaluations of development projects over 15 years reveal that the benefits and resources of such projects have tended to go to those who are better-off, male, educated, and well-informed. Women have a key role to play as change agents and as beneficiaries of the development process. The time is right for women, together with men, to become equal partners in development.

Health Promotion: An Instrument for Improving Health Status and Promoting Equity

A theoretical framework is presented to show the linkages between many priority health issues, social and environmental risk conditions, and psychosocial risk factors that contribute to women's powerless state and are detrimental to health. A vision for the

future that focuses on empowering women by using health promotion strategies are proposed to improve health, social, and economic conditions of women.

Health Promotion, defined as "the process of enabling individuals to increase control over, and to improve, their health", can take place at a variety of levels including individuals, families, organizations, communities and governments/policy makers. It is known that to encourage the modification of lifestyles and promote health, knowledge alone is often insufficient. Knowledge must be accompanied by appropriate skills and support. In addition, the use of multiple channels and strategies; such as interpersonal networks combined with mass media campaigns and small group activities are important.

O'Donnell suggests a useful model for developing community-based health promotion programs: i)Awareness Activities to create the climate for behavior and organizational change; ii) Lifestyle Change Programs to provide skills training and support for lifestyle change; and iii) The Creation and Maintenance of Supportive Environments that includes policies and physical environments supportive of health and structures and ongoing programs.

Related Research: When planning and implementing health promotion programs it is important to keep in mind the results of research in such areas as communication, health behavior change, social support, empowerment and self-care.

Social Learning Theory, often the basis for behavior change programs, views behavior as a product of a number of environmental and personal factors. The concept of self efficacy, or a person's confidence in their ability to adopt a behavior is critical. The concept of modeling, that a person learns by observing the behavior of other people, is also frequently used.

There is a growing body of research linking social support with health. Generally, studies demonstrate that people who have social support will function better when faced with stressful life events and the lack of support during stressful times appears to contribute to physical and mental illness. Individuals with high levels of social support also tend to take more preventive health actions. Social support and social network concepts have been successfully applied to different levels of interventions at individual, group, family and community levels

Research shows that self-care plays a key role in health-related decision-making and behaviour. At the heart of self-care programs is social participation facilitating empowerment, identifying resources, and developing strategies to achieve community-based goals.

Health Promotion Strategies that Work: Successful health promotion requires a combination of strategies at different levels involving a variety of sectors addressing individual/group, organizational, community and governmental levels of action.

Individual and group actions refer to such activities as the education and training of lay workers, self-care, and support groups. Among these actions are the Health Advisor Project; Women, Health and Development Programs; Child-to-Child programs for older children taking care of younger siblings; Youth for Youth program where adolescents are trained as peer educators; and Empower Education, an approach developed by the Brazilian Paulo Freir.

Organizational actions include social and physical aspects of people's surroundings that promote and support health. These actions include workplace health promotion programs targeting occupational health and safety of women relating to environmental changes and the development of healthy practices. Model programs are the Women and Work Research and Education Society; and CAMI, a not-for-profit organization supporting domestic workers.

Community actions are processes used by health promoters and educators to assist communities to identify goals or problems, mobilize resources, and develop and implement strategies to reach their goals. These actions include locality development to build a sense of community identity, social planning stressing rational problem solving, and social action to enhance problem solving abilities of communities. Model programs are the Pawtucket Heart, Stanford Heart Disease Prevention Program, and Heartbeat Wales three programs that use community strategies focusing on organizational change; Health Promotion Resource Center, Morehouse School of Medicine, Georgia provides technical assistance and training to disadvantaged communities; Healthy Communities/Cities are being developed in Latin America and the Caribbean (Los Municipios Saludables).

Governmental actions are those in which governments play a major role such as promoting intersectoral and interdisciplinary collaboration. Governments can be advocates of priority areas, or form partnerships with private sector and nongovernmental organizations, philanthropic foundations, and international agencies. Model programs are Canadian programs Enhancing Prevention in the Practice of Health Professionals and Partners for Health; and local health boards innovative Governmental initiatives in Colombia, Mexico and Brazil responsibile for designing and implementing municipal health plans; Pactos Sociales por la Salud" (Social Agreements for Health) contract of the Ministry of Health, Colombia to provide technical and financial support to community organisations and local authorities.

Lines of Action

Lines of action and policies for future development by PAHO and its Member Governments to improve the situation of women in the region are presented relating to Policy, Health and Social Programs, Community Organization and Empowerment of Women, Education, and Research. It is envisioned that these lines of action will serve as a basis for concrete national plans of action to be developed by Governments.

<u>Policy</u>:   A focus on healthy public policy is critical to the future of health promotion and gender-equity. Health promotion policy guides government action, occurs at all levels, and mobilizes resources for health. Women's health issues need to be considered when formulating policy to assure planning processes.

<u>Health and Social Programs</u>:   There is an urgent need to shift health and social programs towards health promotion and protection. Advances in epidemiology, health promotion and protection facilitates the prevention of noncommunicable disease and injuries -- now the most important causes of mortality and morbidity in the Region. Resources must be geared to reductions in mortality, prevalence, disability, violence, abuse, powerlessness, and discrimination. Since many of the major determinants of health lie outside of the health sector, and beyond the control of individuals, it is imperative that health and social programs join forces to promote health and improve living conditions for women.

<u>Community Organization and Empowerment of Women</u>: Women's groups and health promoters recognize the importance of community-based health promotion programs to maximize effectiveness and provide consistency and continuity over time. Programs promoting lifestyle change, workplace health promotion, school health, child-to-child initiatives, self-care, healthy cities, and others are community-based programs. It is critically important that women be empowered to bring women's issues to planning and implementing community-based health promotion programs.

<u>Education</u>: The challenge is to promote and support education of women, health professionals, and of children and adolescents in school settings. The education of women in gender-equity, gender-sensitivity, and empowerment skills is vital for the achievement of all health promotion strategies directed to women. The challenge for the education of health professionals is the shift towards health promotion and protection. School health education and gender-equity programs typically encourage healthy behaviors, positive attitudes towards health and women, and skills needed to live healthfully and prevent disease and injury.

<u>Research</u>:   The diseases and conditions that are unique to women or more prevalent or serious in women or have risk factors or interventions that are different for women all need adequate research. Women have different hormones, different patterns of health and disease, and different responses to stress and treatment than men. Women face different, at times hostile, social, economic, cultural, and political realities that impact on their health. And they have a unique relationship to the health care system, partly because of their reproductive role but also because of their multiple roles in society.

HEALTH PROMOTION: IMPROVING THE HEALTH STATUS OF WOMEN
AND PROMTING EQUITY

1.   **INTRODUCTION AND RATIONALE**

In most societies, women fare less well than men. As children they have less access to education and sometimes to food and health care. As adults they receive less education and training, work longer for lower incomes, and have few property rights or none. (U.N. Development Program, Human Development Report, 1990).

It is widely recognized that development programs have been unsuccessful in improving the health status and socioeconomic situation of women. Generally, throughout the UN Decade for Women and since, the workload of women has increased, women's relative access to income, employment and resources has worsened and their nutritional and educational status and relative and absolute health have declined (Sen & Grown, 1987). Evaluations of development projects over the past 15 years have revealed that the benefits and resources of such projects in the form of training, technology, credit and improved infrastructure, have tended to go to the "haves" "... those who are better-off, male, educated and well-informed." (Coady International Institute (undated), p.11).

Health is a fundamental human right and "... an essential component of social and economic development" (WHO, 1991, Health Promotion in Developing Countries, p.5). Yet many women and their families in the region, lack access to appropriate health programs and services. Women have special health needs which "... have traditionally received less attention than those of men and boys, and they have often been ignored by health planners." (CIDA, Women and Health, 1985, p.1).

Many causes of women's mortality and morbidity in Latin America and the Caribbean are largely preventable and appear to be related to social factors that place certain groups of women in high risk situations. Females from birth are vulnerable and are often discriminated against due to their gender. "Being a woman" in developing countries makes one more vulnerable than "being a man", however, this vulnerability is not due to biology but rather to socially constructed factors that influence the range of options open to both genders. By most measures of relative status (education, earnings, health care access, social security benefits, nutrition, workload, decision-making power,) women are significantly disadvantaged compared with men, and the gaps are increasing (Canadian Council for International Cooperation, MATCH International Centre, 1991).

Despite the fact that women live longer than men, women suffer from more health problems including higher levels of disability, higher incidence of acute illness and a higher prevalence of many chronic, yet nonfatal conditions such as osteoporosis, arthritis and Parkinson's disease. Yet there is a paucity of research on women's health, in particular the causes of women's health problems, women's perceptions of their health problems and how women may be empowered to participate in solving their own health problems (Ravindran, 1992).

Women are valuable resources in society. Over and above the fact that women comprise more than fifty percent of the population, they are "... the traditional guardians of family health and the teachers of sanitation, hygiene and disease prevention to their families and immediate communities." (CIDA, Women in Development A sectoral perspective, 1989, p.111) A comprehensive study of mid-life and older women in Latin America and the Caribbean found that "... such women play a key role in both economic development and family stability ...". They fill the roles of provider, arbiter, caregiver, disciplinarian, housekeeper, cook, repair person, family representative in the community, and often decision-maker as well (Smyke, cited in The Health Exchange, Dec. 1992 / Jan. 1993).

Women are largely responsible for "reproductive work"; that done inside the home. In most societies men and women do "productive work" such as producing goods and services, although in certain situations productive work is divided between men's and women's tasks. Both sexes participate in "community work" (organizing festivities, policing); however, men tend to hold higher status tasks in communities such as chairing volunteer boards. Women tend to provide support and organization. (Moser, C. & Levy, K, 1986) Generally, women's work is undervalued. Work inside the home is not recognized; subsistence farming is not defined as "real" work and informal community work is not counted. Only "productive work", largely the domain of men in developing countries, that which contributes to national accounting systems, is valued as work. (Canadian Council for International Cooperation, MATCH International Centre 1991, p.17).

Women's activities, influence and impact in the economy, in managing natural resources, in controlling population growth, in imparting and maintaining personal, philosophical, linguistic, and cultural values that have an impact on human progress, in ensuring family well-being, and in participating in decision-making at all levels, are only now beginning to be understood and appreciated. (Canadian International Development Agency, 1992, p.3).

Women's potential contribution and role in development has for too long been undervalued and misunderstood. Women have a key role to play as agents of change and

as beneficiaries of the development process. The time is right for women, together with men, to become equal partners in development.

This paper will make a case for health promotion as a tool/instrument that has the potential to contribute to social and economic development and to improve the health status of women and their families in Latin America and the Caribbean. The document aims to heighten awareness of the major causes of death and illness among women in the region and the related socioenvironmental conditions that contribute to ill health and the reduced productivity of women. Finally, the paper will propose lines of action for PAHO and its Member Countries to take to move toward more people-centered/gender-equitable development and the improved health of women in the Region. It is envisioned that Member Governments will develop concrete plans of actions based on the lines of action presented in this paper.

1.1   Key Concepts

In this section, key terms and concepts that are critical to the thrust of the document will be defined to ensure a common language and base of understanding.

Health Promotion - "is the process of enabling people to increase control over, and to improve, their health"(The Ottawa Charter, 1986). Health promotion "encompasses diverse, though complementary, fields and approaches, including: education, information, social communication, legislation, policy-making, organization, population involvement, and efforts to reorient the health services. ... (It) is not the exclusive concern of the health sector, but becomes an intersectoral task" (PAHO, 1990, Strategic Orientations and Program Priorities).

Development - is "... a complex process involving the social, economic, political and cultural betterment of individuals and of society itself. Betterment in this sense means the ability of the society to meet the physical, emotional and creative needs of the population at a historically acceptable level... and to free human labour time from an incessant treadmill of basic needs production. It thus involves increasing standards of living but no conspicuous consumption, and it implies a form of society which allows for equal distribution of social wealth ..." (Young, undated, p.7).

Equity - refers to fairness or a system of justice (The Concise Oxford Dictionary, 1983).

Gender - "refers to the distinctive qualities of men and women... which are cultural constructs within societies. Since gender is a historical phenomenon, its content is changeable and varies through time. In other words, it is subject to

change by the conscious actions of human beings, society and institutions." (Pan American Health Organization, 1992, Regional Program of Technical Cooperation Women, Health and Development, p.1).

Empowerment - is "a social-action process that promotes participation of people, organizations and communities towards the goals of increased individual and community control, political efficacy, improved quality of community life and social justice." (Wallerstein, 1992, p.198).

Powerlessness - is lack of control over one's destiny; a phenomenon where people with little or no economic and political power lack the means to gain greater resources and control in their lives. (Albee, 1981).

Poverty - is "lack of choice. (Poverty) is lack of access - access to education, to jobs, to income, to services, and to decision-making power. Poverty is inequity in opportunities, in the distribution of benefits of growth, and in social justice. Poverty is underdevelopment of the human potential." (Landry, 1987, p.4).

Participation - is "... the active involvement of disadvantaged people to increase their power and control over resources and benefits." (Coady International Institute, undated, p. 9).

2. THE PRESENT SITUATION: PRIORITY ISSUES TO BE ADDRESSED

2.1 Main Health Problems of Women

This section will briefly highlight the major health problems of females in the region, their causes, consequences and suggestions for remedial action, where appropriate. Areas to be discussed include: lifestyle issues, reproductive health, noncommunicable diseases and mental health and violence.

2.1.1 Lifestyle Issues

Nutritional problems such as undernutrition and obesity are major concerns for women throughout the lifespan in Latin America and the Caribbean. The Pan American Health Organization revealed "... recent official statistics indicate that in nearly 50% of the Region's countries, malnutrition disproportionately affects the female population 1-4 years old, rendering this cause the most important component of excess female mortality among children recorded for those countries." (PAHO, Health Conditions in the Americas - Health of Women, 1990, p.3 & 4) A higher frequency of malnutrition among girls compared with boys can be related to cultural practices where young female

children are often the last to eat and receive poorer quality food. Poor nutrition in childhood can lead to serious problems later in life for women. Smaller or deformed pelvic bones, the result of childhood undernutrition, often cause complications during childbirth that are associated with maternal mortality.

Malnutrition has more serious consequences for women than men, as women have certain physiological needs related to their childbearing years, i.e., for iron. In women from lower socioeconomic classes in particular, "... anemia, although rarely fatal, when coupled with other types of malnutrition, render women prone to chronic fatigue, decrease their productivity, lower their quality of life, increase their vulnerability to infections, and greatly increase morbidity and mortality during delivery." (PAHO, 1990, p.11).

Smoking among women in the region is increasing. This is likely due to the increased availability of new types of cigarettes combined with targeted marketing and advertising campaigns. Studies of the prevalence of smoking among women in Latin America demonstrate wide variations between countries. However, in general "... rates are lower in the less developed, predominantly rural areas and higher in countries that have undergone modernization such as Argentina, Brazil, Chile and Uruguay" (WHO, 1992, p. 24).

According to WHO (1992), four key factors may have contributed to the increased cigarette smoking of women in Latin America and the Caribbean: increasing urbanization, increased access to education, aging of the population and the entry of women into well-paying employment.

In addition to increasing one's risk of death and illness due to respiratory and cardiovascular conditions, smoking is associated with increased infertility risks. Smoking during pregnancy. is associated with spontaneous abortion, premature delivery and fetal and perinatal death.

Smoking and nutritional problems are two lifestyle areas that require urgent attention, because they not only have a negative impact on the health of women themselves, but also on the health of future generations.

2.1.2 Reproductive Health

"In all Latin American and Caribbean countries, complications during pregnancy, childbirth, and the puerperium feature among the five leading causes of death for women in all or some subgroups of the 15-44-year-old age group." (PAHO, Health Conditions in the Americas - Health of Women, 1990, p.6) "In Latin America, one out of every 73 pregnant women die from maternal causes." This compares with one out of 6,366

pregnant women in the United States and one out of 9,850 mothers-to-be in Northern Europe. (Latin America and Caribbean Women's Health Network, Women's Health Journal, 3 (91), p.32).

The causes of maternal mortality may be grouped under two categories: direct clinical and non-medical. It is important to note that deaths from direct clinical causes that include complications of pregnancy or such interventions as induced abortion, are essentially avoidable. Non-medical causes of maternal mortality include such factors as: poverty, illiteracy, work-related causes, lack of prenatal care and low quality services. It is recognized that "... maternal mortality can be reduced through well provided and well-organized maternal care systems, even under those conditions where it is impossible to improve the overall living conditions of women of childbearing age." (PAHO, as above, 1990, p.10).

Adolescent pregnancy is a major health problem as "Fifty percent of the women of Latin America have had one child by the age of 20." (Latin American and Caribbean Women's Health Network, Women's Health Journal, 3 (91), p.36) Pregnancies in women before the age of twenty are categorized as high risk. Not only do they physiologically put the women at risk, but they also often lead to reduced socioeconomic conditions, multiple births, which put women at increased risk of mortality, and physical and psychological stress. "Women with less education know less about contraceptive methods and their use, have less access to health and family-planning services, or have fewer means to acquire these services." (Latin American and Caribbean Women's Health Network, as above, 1991, p.35) Ferguson (1992) has noted that the main cause of death in young female adolescents is childbirth.

There are increasing rates of sexually transmitted diseases (STD's) in the region, particularly in the 16-24 age group. Among these, is AIDS, the primary source for women being due to heterosexual contact. Although HIV is more common among those who engage in high risk behaviors such as multiple sexual partners, most cases of HIV in "... women in the developing world result from straightforward sexual relations within regular partnerships, usually between an infected husband and wife." (PAHO, Women and AIDS, 1992, p.3) Because STD's are transmitted more easily from men to women and because women experience more serious and frequent complications from STD's, "... there is a need to identify (preventive) methods that women can use independently of their partners. This is especially valid for many women in developing countries, where the threat of AIDS and bacterial STD begins with a lack of control over their sexual lives, or the sexual lives of their husbands outside marriage, and where young socioeconomically disadvantaged women tend to lack the interpersonal skills necessary to negotiate the use of condoms with their partners." (PAHO, as above, p.4 & 5).

2.1.3 Noncommunicable Diseases

Noncommunicable diseases such as cancer, cardiovascular disease, and diabetes are on the increase in the region. Most of the noncommunicable diseases, have their roots in unfavorable environments and unhealthy lifestyles.

Cancer of the cervix is a major public health problem in Latin America and the Caribbean. Such cancer is associated with poverty and with low coverage and poor accessibility to health services. Risk factors for cervical cancer include: the initiation of sexual activity at an early age, multiple sexual partners (both male and female), multiple pregnancies and frequent genital infections. The one proven strategy to control cervical cancer is cytological screening, with appropriate treatment if abnormalities are found. If detected early "... treatment is relatively inexpensive and almost always successful" (WHO, Cervical Cancer Screening Fact Sheet, undated). In Latin America and the Caribbean, many cases are either undiagnosed, diagnosed at an advanced stage or not treated after abnormalities are detected. (For more detail see Restrepo et al., Boletin Sanit Panam, 1987, pp.578-592).

Cancer of the breast is on the increase in the region. Risk factors associated with breast cancer are family and reproductive history, obesity and a diet high in fat. Early detection can reduce mortality. The preparation of guidelines for screening of breast cancer are necessary particularly in poorer countries with low risk populations. The Division of Health Promotion and Protection is disseminating information on the use of different screening technologies to detect early signs of breast cancer (Llanos, G., Detection of Breast Cancer: Implication For Latin America and the Caribbean, 1992, pp. 1-9).

Hypertension is a risk factor for cardiovascular diseases that is particularly associated with women and is linked to use of oral contraceptives during the reproductive years, weight gain after age 40 and hormonal changes after menopause. "... women are one of the most vulnerable population groups because they suffer from obesity, diabetes, and hypertension more frequently than men." Caribbean women have the highest rate of hypertension in the Region. (PAHO, Health Conditions in the Americas - Health of Women, 1990, p.13).

2.1.4 Mental Health and Domestic/Gender Violence

Mental health is influenced by an individual's interactions with others and the environment in which they live. Poverty, lack of power and inequality of access to educational and other resources, are all barriers or threats to optimal mental health. It is evident that women in the region are facing a number of barriers to achieving optimal mental health.

The rates for "severe depression" among women is twice as high as those among men in the region. Although no conclusive evidence exists, a number of studies point to women as disadvantaged members of society. For example, "... the discrimination against women, reinforced by socialization patterns and social expectations that counteract women's independence and self-assertion, could lead to feelings of impotence, dependency, low self-esteem, low aspirations and, ultimately, depression." (PAHO, as above, 1990, p.13).

A 1988 survey by MATCH International, a Canadian nongovernmental organization, identified violence against women as the most frequent concern among those surveyed. In response to their findings MATCH concluded that:

> ... violent acts against women the world over attack their dignity as human beings and leave them vulnerable and fearful. Conditioned to undervalue their skills and abilities and paralyzed by fears of violence and retribution, women are marginalized in society and forced out of the decision-making processes which shape and determine the development of their communities. (Cited in Latin American and Caribbean Women's Health Network, Women's Health Journal, 4 (91), p.5).

Violence against women is prevalent the world over and affects women and children of all socioeconomic and cultural groups. It not only maims and results in physical and psychological trauma to women themselves, but also affects the wellbeing and development of their children. Studies have shown that family violence has a strong emotional, psychological and social impact on children exemplified by such characteristics as aggressive behavior, withdrawal, difficulty forming relationships, low self confidence and low self esteem in children from such families (Health and Welfare Canada, Wife Abuse - The Impact on Children, 1991). Women's psychological and socioeconomic dependence on men makes it difficult for them to leave situations of domestic violence or harassment. Women in rural areas have literally no where to go.

It has been noted that "violence against women is often a direct obstacle to women's participation in development projects." A Mexican project found that wife battering increased when women became empowered through participation in a development project. (Latin American and Caribbean Women's Health Network, Women's Health Journal, 4 (91), p.10 & 11).

There are a number of theories that have been proposed to explain why violence against women is so widespread. (For a thorough analysis of causation see "Family Violence: A Review of Theoretical and Clinical Literature" by Health and Welfare Canada). However, this document supports the "structural/political analysis" that is "... based on a historical perspective of the ways in which women have been perceived and

treated in society, as reflected by the institutions that govern society." (Health and Welfare Canada, 1989, p.66) Given this perspective, violence is perceived as a learned behavior that can be "unlearned". "Gender violence can be prevented, or at least substantially reduced, if the social and political will exists to make this happen." (Carrillo, 1991, p.12)

It is apparent from a review of the major health problems of women in the region, that many of them are preventable or can be ameliorated by education and improved access to appropriate services.

2.2   Health Service Issues

Health services and programs are an area of concern for improving the health status and equity of women in the region. According to the Economic Commission for Latin America and the Caribbean (ECLAC, 1992), "... the majority of countries still fail to provide adequate free public (health) services for a large percentage of the population, and curative medicine predominates. Health services tend to be concentrated in urban areas" (p.270). The inaccessibility of health services and programs is particularly critical for women in the childbearing years and elderly women who are often widowed, socially isolated and without pensions or medical insurance. Lack of information about and accessibility to birth control methods "... leads to the rapid deterioration of women's health, as a result of several closely spaced pregnancies at a young age and illegal abortions performed in hazardous and unsanitary conditions." A paucity of educational and informational programs on basic preventive and curative measures is "... a major obstacle to the improvement of women's health." (CIDA, 1989, p.78 & 79).

Health services and programs for women where they are available, have focused on the reproductive side with little or no attention paid to chronic illness, to the needs of elderly women or to adolescents. Women's lack of participation in the planning, implementation and evaluation of health programs and services is notable.

Discriminatory treatment of women by health services personnel has been documented. Londoño (1991) in a revealing article, discusses how patriarchal male models dominate the health care systems of the region. Areas of concern she highlights, include the doctor-patient relationship where women are generally expected to be passive and accepting rather than responsible and informed consumers who are active participants in their care; the fact that women are often expected to have their male partners accompany them to medical appointments in order to explain their problems and women are often wrongly assumed to have a lot of time available to spend in waiting rooms.

The education of health service personnel in the region still has a curative focus with little or no attention given to prevention or health promotion.

In summary, there are a number of issues that require urgent action in the health services area. They include accessibility, affordability, quality, planning and emphasis of services and programs, as well as the education and training of health service personnel and women, themselves.

2.3 Labor Force Participation and Working Conditions

Women's increasing participation in the labor force, their work environments and their types of work, all contribute to their health status and the quality of their lives. The number of women in the labor force in Latin America and the Caribbean has "... increased threefold between 1950 and 1980, rising from 10 million to 32 million. ... although statistics have improved, a large number of jobs both paid and unpaid, performed by women are still not quantified nor (is) the principle of equal pay for equal work yet being observed throughout the region." (Economic Commission for Latin America and The Caribbean (1992) ECLAC, 1992, p.269).

Many women in the region are ghettoized in low paying, non-unionized, monotonous jobs characterized by unsafe working conditions. "A 1989 study of 200 women workers (in the Dominican Republic's San Pedro de Macoris export processing zone) found a high incidence of reproductive health problems, including miscarriages, premature births, birth defects and menstrual irregularities." (Latin American and Caribbean Women's Health Network, Women's Health Journal, 4 (91), p.32) Women may be harassed or mistreated by male supervisors. They are further disadvantaged as they still bear the burden of childcare and housework after working all day out side of the home (often referred to as the "double day").

In addition, societal myths further contribute to the exploitation and underemployment of women, such as: being incapable of holding administrative and management positions and having "natural" abilities such as docility and manual dexterity. Such beliefs confine women to "... monotonous jobs that demand long hours in immobile postures, with rapid, precise and repetitive movements that bring great wear-and-tear to joints, tendons, nerves and eyesight." (Latin American and Caribbean Women's Health Network, 4 (91), p.30).

2.4 Summary

It is evident from the priority issues highlighted, that women's health is not only affected by their biology. It is also affected by their social and economic status and gender-biased sociocultural beliefs and practices. Improving women's health is not only dependent on increasing their coverage and access to health services, but also depends on improving their educational levels, standards of living, working conditions and modifying ingrained cultural beliefs and practices. The following section will demonstrate

how health promotion has the potential to be a powerful tool for improving the health, social and economic conditions of women and their families.

3. HEALTH PROMOTION: IMPROVING HEALTH STATUS AND PROMOTING EQUITY

3.1 Introduction

"Equity in health" has been described as "... members of all population groups hav(ing) equal opportunities to achieve and maintain health." (Ontario Ministry of Health, Panel on Health Goals for Ontario, 1987) The Panel further points out that inequalities in such factors as education, employment and income can determine one's ability to obtain such basic needs as suitable food, housing and clothing and that these factors in turn, can contribute to an individual's health status and health behavior.

It is strikingly evident that inequalities in health clearly exist for women, particularly socioeconomically disadvantaged women, in Latin America and the Caribbean. The majority of women in the region can be described as powerless (see section on Key Terms for definition). A theoretical framework (Figure 1) has been developed to demonstrate the linkages between many of the priority health issues mentioned and socioenvironmental risk conditions and psychosocial risk factors that presently contribute to women's powerless state and are detrimental to health. A vision for the future that focuses on empowering women through the use of a variety of health promotion strategies supported in the literature, is proposed as instrumental in improving the health, social and economic conditions of women in the region.

Health Promotion is commonly defined as "the process of enabling individuals to increase control over, and to improve, their health." (WHO, 1984) Health promoting actions can take place at a variety of levels including individuals, families, organizations, communities and governments/policy makers. Health promotion is multidisciplinary and multisectoral and is based on work from such fields as the behavioral, educational, biomedical and social sciences. It also grows out of social movements such as the self-help movement and the women's movement.

It is now widely acknowledged that to encourage the modification of lifestyles and promote health, knowledge alone is generally insufficient. Knowledge must be accompanied by appropriate skills and support; both social and environmental. In addition, the use of multiple channels and strategies; such as interpersonal networks combined with mass media campaigns and small group activities in workplaces and schools; to encourage and support health behavior change, is important.

O'Donnell (1986) has proposed a useful model that demonstrates the components of comprehensive health promotion programs. Although his model was originally developed for workplace health promotion programs within organizations, it also has applicability in the community. A comprehensive health promotion program includes 3 components:

- <u>Awareness Activities</u> - to create the climate for behavior and organizational change, i.e., newsletters, radio and television campaigns, posters providing health information and health information in newspapers,

- <u>Lifestyle Change Programs</u> - to provide skills training and support for lifestyle change; such as heart healthy cooking classes and smoking cessation classes, and

- <u>The Creation and Maintenance of Supportive Environments</u> - that includes: a) Policies supporting health, i.e., non-smoking and absenteeism policies; b) Physical environments supportive of health; such as healthy food choices in cafeterias, restaurants and schools and; c) Structures and ongoing programs, i.e., childcare and recreation programs at places of work.

3.2 Related Research

When developing and implementing health promotion programs it is important to keep in mind the results of research in such areas as communication, health behavior change, social support, empowerment and self-care.

Communication research includes studies that investigate the nature of the communicator, the message and the situation in which the communication is received. According to communication research, the effectiveness of a communication campaign or message is enhanced by the perceived credibility of the communicator or communication source. Credibility is defined as competence or expertise and trustworthiness. (Zimbardo & Ebbeson, 1969; Rogers & Story, 1987) Effectiveness of the communicator is increased if he/she initially expresses views that are already held by the audience (Rogers, 1972, p.205). Therefore, it is more effective to involve highly regarded members of a given sociocultural group as health workers, since they are likely to be perceived as trustworthy and have similar views and beliefs as the audience you are trying to influence.

Roger's (1983) diffusion of innovations theory is concerned with the role of opinion leaders as change agents to transmit information and motivate others to adopt new health practices. According to this theory, when individuals are exposed to new health messages and health practices, they pass through a number of stages prior to

adopting new behaviors. There are 4 groups of adopters labeled "innovators", "early adopters", "late adopters" and "early and late majority"; and 5 stages of adoption. Rogers asserts that opinion leaders typically have many social contacts and are likely to be "early adopters". Therefore, it is useful to involve them in health promotion activities to assist in influencing others in their groups or communities to modify their behaviors. "Late adopters" are usually socioeconomically disadvantaged; "... they are socially more isolated or alienated, and tend to be suspicious of organizations, including government agencies... reaching these people and organizations requires... more labour-intensive forms of community organization, communication and outreach" (Green & McAlister, 1984). Being aware of the stages of adoption and the types of adopters in a specific community assists health promoters to identify the most effective communication methods and channels. "This allows the health educator to match the most appropriate educational strategy with the stage of the program... mass media are most efficient with innovators and early adopters, but outreach methods such as community organization and home visits are necessary with 'late adopters' " (Green et al., 1980, p.81).

Two-sided communication in which the receiver can ask questions and the source can ask for confirmation of the message and also correct misunderstandings, has a much higher chance of being successful than one sided communication. Therefore, it is important for mass media campaigns to be supported by interpersonal communication strategies (Kok, 1991, p.35).

According to group behavior change studies, an individual's attitudes are strongly influenced by the groups in which they are members or to which they wish to belong. People are generally rewarded for conforming to group standards and punished for lack of conformity. Participation by the audience; for example, in group planning, discussion and decision making helps decrease resistance to change (Rogers, 1972, p.212). Utilizing small group activities within health education programs that encourage the active participation of group members, is an important way to facilitate behavior change.

Social Learning Theory developed by Bandura (1977, 1986), views behavior as a product of a number of environmental and personal factors that must be taken into account when designing health promotion strategies. The concept of self efficacy, or a person's confidence in their ability to adopt a certain behavior, is critical according to Bandura, who believes that introducing behavior changes to individuals in small steps, allows them to build confidence in their ability to make positive changes. The concept of modeling, that a person learns by observing the behavior of other people, is frequently used in social communication programs. According to Bandura, people can learn what is appropriate by observing the successes and mistakes of others.

According to the Theory of Reasoned Action (Fishbein & Ajzen, 1975; Ajzen & Fishbein, 1980), behavior depends on an individual/Es attitude towards that behavior, as

well as the influence of subjective norms. Subjective norms are determined by what others think they should do and by how motivated an individual is to please others. The Theory of Reasoned Action emphasizes the importance of changing social norms in order to assist people to adopt and maintain new behaviors.

There is a growing body of research linking social support with health. Social Support is "... verbal and/or nonverbal information or advice, tangible aid, or action that is proffered by social intimate or inferred by their presence and has beneficial emotional or behavioral effects on the recipient" (Gottlieb, 1983, p.28). "An impressive body of evidence ... now supports the contention that social support plays a key role in promoting health, decreasing susceptibility to disease and facilitating recovery from illness." (Minkler, 1986, p.37) Researchers are increasingly discovering that social support is critical for a person to successfully handle such life stresses as unemployment, bereavement, physical illness, crisis and transition (Dean & Lin, 1977; Lin, 1979; Cobb, 1976). Generally, studies demonstrate that people who have social support will function better when faced with stressful life events than those who lack such support and the lack of support during stressful times appears to contribute to physical and mental illness (Schaefer et al., 1981, p.382). Individuals with high levels of social support also tend to take more preventive health actions (Langlie, 1977).

Another important component of social support and health is a person's social network. Social networks are " the web of interpersonal ties within which individuals are embedded" (Minkler, 1986, p.33). Social network strategies/interventions that have been shown to be effective include those that have identified and promoted lay or "natural" helpers within communities and others that have involved developing and strengthening community level networks for joint problem-solving and action. Israel (1985) in an illuminating article, discusses important aspects to consider when developing both natural helper and community level interventions. Social support and social network concepts have been successfully applied to different levels of interventions at individual, group, family and community levels (Refer to section on Health Promotion Strategies that Work for examples).

Self-care
> *... refers to unorganized health activities and health related decision making by individuals, families, neighbours, friends, colleagues at work, etc.; it encompasses self-medication, self-treatment, social support in illness, first aid in a 'natural setting', i.e., the normal context of people's everyday lives. Self-care is definitely the primary health resource in the health care system. (Hatch & Kickbusch, 1983).*

Research shows that "... self-care presently plays a central role in health-related decision-making and behaviour " (Perrault & Malo, Self-Care: A Review of the Literature, 1989). Perrault & Malo (1989) on a cautionary note state that:

> *Self-care is not a substitute for available health care resources, nor does it eliminate the need to modify socio-environmental conditions that are detrimental to health. Rather, the aim of self-care should be to develop a more efficient health-care system, one based on fuller exploitation of every component and every competence, and on the dynamic and integral involvement of people. (p.128).*

Zimmerman & Rappaport (1988, p.726) define empowerment as "a process by which individuals gain mastery over their own lives and democratic participation in the life of their community". Participation is at the heart of this process, not only as an outcome of empowerment, but also as a "mechanism for the development of psychological empowerment because participants gain experience organizing people, identifying resources and developing strategies for achieving goals" (Zimmerman & Rappaport, 1988). Socio-psychological studies have demonstrated that:

> *People with enough resources in their lives, such as decision-making power, finances, or system access, can adequately cope with the psychological and actual demands in their lives... People in low socioeconomic positions and hierarchies have greater structural constraints and fewer opportunities to gain access to resources... Extending individual-level coping (through health promotion interventions) to improve community life leads to community empowerment (Wallerstein, 1992, p.200).*

3.3   Health Promotion Strategies that Work

It has been emphasized that health promotion to be effective, requires a combination of strategies at different levels and involving a variety of sectors. This section will provide examples of successful health promotion strategies that address individual/group, organizational, community and governmental levels of action. (Refer to Table 1 for an overview of strategies and levels of action). Successful strategies or mechanisms for action, such as selfcare and social network interventions, the education and training of lay workers, community organization and health communication will be discussed. Model programs or projects under each category will be highlighted to provide a better understanding of potential strategies for action.

3.3.1 Individual/Group Actions

Individual and group level actions refer to such activities as the education and training of lay workers; and self-help and support groups. Based on the literature on social networks and social support, a fair number of model programs exist in the literature, which can be learned from and replicated. Promoting self-care is an important mechanism for empowering individuals and groups. The following model projects demonstrate the application of these 2 areas of literature.

The Health Advisor Project was originated by Dr. Eva Salber, Professor of Family and community Medicine at the Duke University School of Medicine. Salber, while Director of a health program in a low-income housing project in Boston, identified natural helpers from within the project and attempted to strengthen the communities where these natural helpers lived by providing them with training to promote health, prevent disease and to link them with appropriate community agencies and groups. Salber identified natural helpers by adding a question to a local health survey: "who do you know around here to whom people go for advice on health matters other than doctors?" In the "Health Advisor Project" 39 health facilitators (ranging in age from 16 to 70) became involved in the program. An article by Ferguson (1982) describes the program and the resources developed. 58 information packages on everything from angina to hayfever were developed by the project as well as a series of situation trigger tapes to stimulate discussion around problem areas.

The Women, Health and Development Program was carried out between 1985 and 1989 in Buenos Aires, Argentina. 249 older women were trained as health and social promoters and worked in poor neighborhoods where living conditions were poor and the residents lacked information on existing social and medical services. The elderly women received intensive training, both practical and theoretical, and worked in their communities to increase awareness and understanding of such issues as hygiene, nutrition and environmental health. The older women involved in the project not only were successful in improving people's access to health and social services and their living conditions, but the project also challenged people's views about the role of older women in their communities. In addition, the project enhanced the women's self-confidence and self-image (Payne, 1993, The Health Exchange, p.7 & 8).

A project carried out in 2 communities in British Columbia, Canada (S.P.A.R.C. 1986) that identified lay advisors, their activities, contacts and types of support given, found that "people with lower education tend(ed) to use lay advice more frequently than those with higher education" (p.6).

To sum up the success of such natural helper projects Salber states:

I've learned that health facilitators are everywhere. They can and should be used in every country, but particularly where professional services are few and there are many problems. They can inform professionals of the needs and priorities of the people they live with, they can extend services to those who need them most, they can support self-help activities among those who come to them for advice, and they can guide people to the appropriate professional care ... (natural helpers) ... are a resource that can no longer be ignored. The applications of the natural helper model are limited only by our imaginations. (Ferguson, 1982, p.21).

Child-to-Child programs are based on the fact that in communities throughout the world, many older children look after their younger sisters and brothers at home and must cook and do many of the household chores. If children learn how to protect and promote the health of their younger brothers and sisters, they can make a big difference in the well-being and development of young children in their communities. They may also grow up to be "health promoting" parents.

The key characteristics of child-to-child programs include: older children teach younger children; they employ active experiential methods such as songs, stories, drawing, puppets and sociodrama which encourage creativity and make learning fun; they encourage a sense of responsibility for family members and the community; and they involve working together and developing a spirit of mutual understanding collaboration and co-operation. (For additional child-to-child resources and information see Werner & Bower, 1982).

Thompson (1992) described a child-to-child program she coordinated in Colombia, South America. A pilot program was carried out with campesino children in a school in Northern Colombia and then was replicated in 15 area schools. Children, their parents, teachers and local nurses were involved in the project that involved training children in Grades 4 and 5 in the prevention and control of accidents culminating in "La Semana de la Seguridad" (Safety Week) where these children developed their own program of activities for their schools that included radio dramas, role plays, puppet shows, poetry and clowns that were culturally relevant and appealing to the age group.

This program emphasized prevention and health promotion. It was based on intersectoral collaboration and included involvement of the education, health and voluntary sectors. The program involved the active participation of children and their communities in its development and implementation. The program employed socially acceptable and affordable methods and technology. Examples of this include: encouraging self-care; engendering cooperation and mutual understanding between the home, school

and community and promoting effective, efficient and appropriate use of health care practitioners. The program also incorporated cultural beliefs and practices of participants, as children were taught using culturally relevant examples and materials and were encouraged to include in their own interventions, beliefs and practices that were relevant to their culture.

Another example of children teaching children is the Youth for Youth: Promotion of Adolescent Reproductive Health project that is currently underway in 6 countries and involves the International Planned Parenthood Federation and various governmental and nongovernmental organizations collaborating nationally and internationally. In each country, adolescents are trained as peer educators on a range of reproductive health topics. The youths then educate other adolescents in groups or on a "one-to-one" basis. Through National Youth Committees in participating countries, adolescents have participated in project development, implementation and evaluation. Hundreds of young people have been trained in each country. They have created songs, media messages, theater presentations to name a few examples from this innovative project. In addition, the young people involved "have developed expertise in programme development which can be used and exchanged between countries" (Senanayake, Youth for Youth - Focus on Adolescent Reproductive Health, 1992, p.4 & 5).

"Empowerment education is an effective health education and prevention model for personal and social change" (Wallerstein & Bernstein, 1988, p.379) Empowerment education (sometimes referred to as popular education) is an approach that engages people in a group process of dialogue where they identify their problems, critically assess the historical, social and cultural roots of such problems and develop strategies for action to change their social and personal lives (Wallerstein, 1992). Empowerment education is based on the work of Paulo Freire, a Brazilian educator who is internationally known for his successful literacy programs with slum dwellers in Brazil. Freire believes that the purpose of education is human liberation.

A model empowerment education program is the Alcohol Substance Abuse Prevention (ASAP) Program that has operated since 1982 through the University of New Mexico School of Medicine. "ASAP seeks to empower youth from high-risk populations to make healthier choices in their own lives, to play active political and social roles in their communities and society, and, as community participants, to effect positive changes." (Wallerstein & Bernstein, 1988, p.383) In the ASAP program, small groups of adolescents from minority high-risk communities make four visits to the County Detention Centre and the University Hospital Emergency Centre. Students have the opportunity to interact with the jail inmates, and patients and their families who have alcohol and drug-related problems. Nursing, medical and health education students have been trained as volunteer facilitators to lead groups of teenagers. During their visits to the jail and hospital, the youth interview inmates and patients and take part in a

curriculum "... that incorporates methods from other adolescent health programs: social learning and resistance to peer pressure; life skills competencies and decision-making about alternative choices; peer education strategies; and analysis of media and policies that influence consumption, such as New Mexico's drive-up liquor windows. After the four sessions, the youth receive additional training to become peer educators in their schools, younger-age feeder schools, and in community settings" (Wallerstein & Bernstein, p.384).

Participating in group analysis and decision making help people realize that they are not alone and assist them in moving from feelings of powerlessness and isolation to a sense of personal control and a feeling of community with others. The critical thinking or "conscientization" which is a central aspect of empowerment education "... unites people as members of a common community to transform inequitable social relations" (Wallerstein, 1992, p.204).

3.3.2 Organizational Actions

Organizational level actions in this context, refer to the creation and maintenance of supportive environments where people work. They include both social and physical aspects of people's surroundings (WHO, 1991, Supportive environments for health: The Sundsvall Statement). They may involve organizational changes to promote health. Organizational actions also encompass policies and programs that promote and support health.

This section will focus on workplace health promotion programs and model projects from nongovernmental and not-for-profit organizations that particularly target the occupational health and safety of women.

There is much documented, particularly in the North American literature, supporting worksite health promotion and supporting the fact that workplaces can be made healthier through particular programs and policies. Workplace health promotion involves actions aimed at changes in the organizational structure and work environment, but also changes that enable individuals to improve their health.

A study designed to develop and evaluate a theoretical model of how a number of variables influence the wellness of employees found that "... a comprehensive approach to health promotion among employees requires initiatives directed both toward environmental change in the workplace (particularly the abatement of superfluous stress), and toward the development of positive health practices (primarily through education, skill-building and remedial programming)". The researchers concluded that "... the

empowerment of individuals - whether in the area of work or personal life - recommends itself as a central strategy for enhancing wellness/(health)." (Shedhadeh & Shain, 1990, p.111).

Because the focus of this paper is on disadvantaged women in Latin American and the Caribbean, and not on white collar workers, several model programs will be outlined that may be useful, given the target audience. The Women and Work Research and Education Society recently completed a project based in British Columbia, Canada, that was developed to provide information concerning office health problems, to enhance women's skills to cope with them and to develop formal structures for correcting and preventing occupational health hazards. The 27 month project carried out a number of activities that included: establishing an advisory committee comprised of non-unionized and unionized clerical workers, counselors and educational trainers; conducting a needs assessment of clerical workers; developing a package of educational materials including information on such topics as closed-air buildings, office designs and stress; publishing a regular newsletter to inform clerical workers about project activities; conducting a series of workshops and lectures on occupational health hazards and developing and distributing a questionnaire on "work-related repetitive strain injuries (RSI)" (cited in Health and Welfare Canada, Health Promotion, Winter 1990/91, p.29).

CAMI, a not-for-profit organization based in Cali, Colombia has developed a project for domestic workers that promotes educational, legal and organizational activities in 3 Colombian provinces. The project provides training in such areas as civic rights and responsibilities, labor rights and women's issues with a health emphasis. It provides legal aid, assisting domestic workers in receiving social benefits and in some cases taking complaints to court. CAMI also provides comprehensive health care for women and is committed to civic consciousness and gender identification. (CAMI Collective, Women's Health Journal, 3 (91), 1991, p.57-62).

3.3.3 Community Actions

Community participation and community organization are important strategies to use when working with disadvantaged communities to promote healthier social and physical environments.

Community organization is a process used by health promoters and educators to assist communities in identifying, common goals or problems, mobilizing resources and developing and implementing strategies for reaching their goals (Minkler, 1990).

Rothman & Tropman (1987) identified three models of community organization or methods to encourage purposive community change. They are: 1) locality development; 2) social planning and 3) social action. Locality development is "a

process-oriented approach that seeks to build a sense of group identity and community" (Hyndman et al., 1992). With locality development a broad, cross-section of people would be organized into small work groups to identify and solve community problems. The key aspects of this model are self-help, the development of indigenous leadership, democratic procedures and educational objectives. Social Planning is "a task-oriented method that stresses rational problem solving - usually by and outside expert - to address community concerns" (Hyndman et al.). In the social planning approach, typically an expert gathers facts about the community and offers recommendations for action. Organizations usually are involved in solving the problems. Social Action is "a task and process oriented approach that tries to enhance the problem solving abilities of community member" (Hyndman et al.) This model seeks to redistribute resources, power or decision making in a community and/or to change the policies of formal organizations.

A number of models of community-based heart health promotion programs in various parts of the world have utilized community organization strategies. The Pawtucket Heart Health Program employed a combination of locality development and social planning in its approach. Pawtucket recruited and trained lay community volunteers who were involved in planning, implementing and administering various activities. For example, volunteers were involved as leaders of behavior change groups in smoking cessation, fitness, weight control and stress management. They also were risk factors screeners and counselors in addition to coordinating certain community level health promotion activities. (Roncarati et al., 1989).

The Welsh Heart Program, Heartbeat Wales, utilized a community organization strategy that focused on organizational change. They worked with national level organizations such as agricultural and women's groups and made resources available at the local level for health promotion projects based in not-for-profit organizations (Nutbeam & Catford, 1987).

The Health Promotion Resource Centre at Morehouse School of Medicine in Atlanta, Georgia provides technical assistance and training to disadvantaged communities. The Center's philosophy is that "... health promotion efforts are likely to be more successful in these populations when the community at risk is empowered to identify its own problems, develop its own intervention strategies, and form a decision making coalition board to make policy decisions and manage resources around the interventions" (Braithwaite et al., 1989, p.57). The steps Morehouse have found useful to follow when working with communities are: 1) developing a demographic and epidemiologic profile of the target area; 2) initiating appropriate community entry processes; 3) establishing community trust and credibility; 4) learning the ecological dynamics of a community; 5) organizing a consumer-dominated decision-making community coalition board: 6) facilitating community involvement in the needs assessment process; and 7) further developing community ownership through consumer participation in planning and design

of the health promotion intervention. This step is achieved by training the community coalition board to provide them with the tools they need to make policy and resource allocation decisions with regard to the intervention. (Braithwaite, 1989).

The ultimate aim of community organizing approaches is for the community to take ownership and assume leadership of such projects, enabling the health or community development workers to step back and only act as resource persons to such groups.

Health communications programs have been shown to be effective strategies for influencing health practices and activities of both individuals and communities. The focus in this section will be on the use of health communications programs as community level change strategies. Health communications programs refer to the use of mass media campaigns and social marketing strategies.

Mass media campaigns that employ television and radio, have the ability to reach large groups of people with high quality, high frequency messages at potentially low costs (measured in units of behavior change).

Kotler and Zaltman (1971) originally defined social marketing as "... the design, implementation, and control of programs calculated to influence the acceptability of social ideas and involving considerations of product planning, pricing, communications and marketing research" (p.5). Social marketing programs have played a major role in a variety of areas from mobilizing public support, to getting alcohol and smoking control policies on legislative agendas, to reaching desired target groups with appropriate messages. It is important to note that: "While a social marketing campaign cannot, on its own, be reasonably expected to change health behavior, it can nevertheless be a potent element of any comprehensive health promotion program that is intended to reach, inform and influence people" (Mintz, 1988, p.6). The same can be said for mass media campaigns. It is most effective to use health communication strategies in combination with other strategies such as community events and skill-building and support groups/classes.

Social marketing programs emphasize the "4 P's" - product; place; promotion and price. Mintz (1988) notes that "place" and "promotion" seem to be the key variables in marketing health. "Promotion" refers to communication used to provide information or to persuade others to accept new ideas. "Place" refers to the distribution channels by which a product reaches a target population. "Product" is used to refer to actual products such as a heart healthy cookbook and services, such as smoking cessation classes. "Price" refers to what the consumer must give up in order to receive the program's benefits. These "costs" may be intangible changes in beliefs or habits, or tangible like money, time or travel. (PAHO, 1991, Making Health Communications Programmes Work in Latin America and the Caribbean, A Manual for Action, p.5).

A model program that is utilizing mass media and social marketing techniques, is the Stanford Heart Disease Prevention Program. This is a community-based health promotion program aimed at reducing the risk of cardiovascular disease through community education. The original Three Community Study began in 1972. Extensive mass media campaigns were carried out in 2 communities over a 2 year period and a third community was the control. The results of the study strongly suggested that mass media education campaigns directed at whole communities can be effective in reducing the risk of stroke and heart attack. The Stanford Five City Project that began in 1978 and built on lessons learned from the Three Community Project is much larger and has been broadened. In addition to mass media, community leaders and groups are heavily involved in the campaign and conduct nutrition, smoking cessation, and exercise programs. A variety of videotapes, books and pamphlets have been developed by the project and are disseminated through a wide variety of channels. In addition, to not-for-profit groups and television and radio stations, other groups such as schools and health professionals are involved in the project (Farquhar et al., 1985).

In order for social marketing and mass media campaigns to be effective the following actions are important: identifying and understanding your target audience(s); developing specific messages; setting specific and measurable objectives; selecting channels (i.e., schools, worksites, face-to-face); developing and pretesting materials; using formative evaluation/feedback at various points in time to evaluate progress and readjust if necessary. (PAHO, 1991, Making Health Communication Programmes Work in Latin America and the Caribbean: A Manual for Action; Maccoby & Alexander, 1979; Rogers & Storey, 1987; Tanguay, 1988).

Healthy Communities/Cities projects are now alive and well in Europe and Canada and beginning in Latin America and the Caribbean (Los Municipios Saludables). Although such projects focus on community level actions, they in fact combine individual and group actions, with organizational and governmental actions along with community organization and participation strategies. A healthy city or village has been defined as a municipality or city that constantly improves its social and physical environment; one that uses and expands community resources to empower community residents to support one another in pursuing their regular functions and activities, and in developing to their full potential (Hancock & Duhl, 1988). In healthy communities, local policy-makers are concerned about the quality of life of their citizens. Developing a healthy and health promoting community requires creating public policies at the municipal level that enhance and promote health - policies not only in the health sector, but also in such sectors as transportation, housing, parks and recreation, waste management and economic development.

Healthy Cities projects have networks and usually have a country-level coordinating and support office that provides interested communities with resource materials and the criteria to "get started". The projects encourage each city to develop their own vision through workshops, of what their healthy community; one that promotes

"Health for All" and aims to reduce inequities; would look like. This is followed up by the development of specific action plans to work toward the identified vision (Hancock, 1987, p.2).

A study was carried out on the Quebec Healthy Communities project from October 1989 to September 1991. The study which had three phases, involved in-depth interviews with leaders and others involved in various Healthy communities projects, and an analysis of written documents. Through this process the researchers identified 15 conditions which are important to the success of the Quebec Healthy Cities project. These conditions refer to the need for both human and financial support at local and provincial levels and to the corresponding 3 stages of such projects which have been identified as emergence/adoption, definition, and implementation. (For specific details see Fortin et al., 1992, p.6 - 10).

3.3.4 Governmental Actions

Governmental level actions refer to those that are initiated by governments or those in which governments play a major role. This section will focus on the strategies of intersectoral and interdisciplinary collaboration and policies and programs supportive of health. It also includes research and evaluation into the effectiveness of such policies and programs. Governments also can play an advocacy role in identifying priority areas for action and promoting partnerships with private sector organizations, nongovernmental organizations, philanthropic foundations and international agencies.

Enhancing Prevention in the Practice of Health Professionals is a collaborative strategy development process involving the national Department of Health and Welfare (Canada) and 8 national health professional associations. This multi-phased, multidisciplinary process aims to encourage the development of a coordinated approach to the provision of prevention programs and services in Canada. It involved the participation of a variety of health professionals such as physicians, nurses, social workers and government representatives, researchers, academics and representatives of not-for-profit organizations including consumer and multicultural groups. 3 documents to date have been published by the initiative: "Enhancing the Provision of Prevention Services by Canadian Physicians"; "Prevention through Partnership: Collaborating for Change" and "Enhancing Prevention in the Practice of Health Professionals: strategies for Today and Tomorrow". The strategy paper which was endorsed by the 8 national health professional associations involved, identified 4 areas for action over the next decade; the education of health professionals; policy and planning; program and service delivery and evaluation and research.

A number of valuable lessons were learned from facilitating this national collaborative strategy development process. They include: the importance of a

partnership-building process that involves sharing a common vision and having commitment to that vision; the strategic use of networks to stimulate and support change; modest material resources to support the process; the importance of a dedicated central coordinating body/person to facilitate the process and a clearly delineated communication plan to widely diffuse the documents and to stimulate and support action at a variety of levels (Thompson & Stachenko, 1992).

Another example of a government level strategy is the Manitoba (Canada) Ministry of Health's initiative Partners for Health, a provincial ministry initiated project that involves Manitoba Health in partnership with 18 employers representing more than 20,000 employees. The purpose of the project is to encourage "... employers and employees to join forces in promoting healthy lifestyles and environments in the workplaces" (Health and Welfare Canada, 1990/91, Winter, Health Promotion).

In terms of evaluation and research, governments can stimulate and support innovative applied and "pure" research projects on priority health areas such as women's health issues. They also have a role to play in ensuring that innovative health promotion programs are evaluated. An example of a government program that supports the development and implementation of innovative health promotion programs is the Health Promotion Contributions program of Health and Welfare Canada. At the provincial level, a number of Health Innovations funds exist that organizations may tap to develop new approaches and to advance the field of health promotion.

A number of innovative Governmental initiatives were developed in several Latin American countries in recent years. For example, Colombia, Mexico and Brazil have enacted constitutional and legislative health changes which: (i) establish local health boards of the municipal health authority, with obligations and rights that include the design of municipal health plans to be articulated with municipal social development plans; (ii) consolidate mechanisms by which autonomous administration of health sector resources is transferred to local health boards; (iii) establish by law, the composition of local health boards providing equal representation to elected local authorities, community health committees, and health care workers. Community health committees are legally recognised organisations whose function is to represent the health interests of the population served in the design of health programmes, provision of health services and management of health resources.

The Ministry of Health of Colombia launched the "Pactos Sociales por la Salud" (Social Agreements for Health) initiative. Its purpose is to provide governmental technical and financial support to community organisations and local authorities for the development of comprehensive health plans. These plans include provision of health care based on morbidity-mortality, as well as interdisciplinary multi-sectorial actions to achieve health goals proposed in terms of quantitative reductions in morbidity and

mortality and objective improvements in living conditions. The Ministry's financial, technical and political resources are provided to aid communities develop their own health projects as well as to help them negociate agreements with other social sectors and institutions. These agreements (pactos) constitute formal contracts between communities and institutions, to carry out specified actions conducive to the achievement of local health goals. Implementation, follow-up, and evaluation of such local health agreements are carried out by the local health committee with technical support from professional staff of the Ministry of Health.

3.3.5 Building New Partnerships

The time is right for government bureaucracies to be creative and form partnerships with nongovernmental organizations focusing on women and the private sector. PAHO's "All for Health" Initiative which was launched in 1990, is "... assisting governmental and non-governmental organizations working in priority areas of health and development to systematically work together as partners in the design, planning and execution of health programs, so as to draw on one another's strengths in achieving health objectives" (Hartigan, 1992, p.8). Through this program, PAHO is acting as a facilitator and catalyst to support the forging of new partnerships, and through technical support building the capacity of nongovernmental organizations who are close to the community and know their constituencies. This project is an example of how national governments, nongovernmental and international organizations, can work together to promote health and improve the social and economic conditions in the region.

Gray (1985), who has conducted research in the area of interorganizational relations for more that a decade, states that several key factors motivate organizations to form partnerships. They are: resource scarcity; the existence of a shared vision; i.e., improved health status of women; the need to resolve conflict or a serious problem, i.e., the present situation of women in Latin America and the Caribbean; and perceived interdependence; i.e., when groups believe there is more mutual benefit to be gained from collaborating to resolve complex issues than in attempting to solve them alone. Given the current plight of women in Latin America and the Caribbean highlighted earlier in this paper, and the research on interorganizational collaboration, there is clearly a critical need for PAHO and its member countries to work in partnership to promote the health and to improve the social and economic conditions of women in the region.

3.3.6 Summary

From the diversity of projects and strategies presented, which only represents the "tip of the iceberg" in terms of model projects that may be learned from and replicated, it is obvious that health promotion is a powerful tool to empower women with the potential to contribute to social and economic development and the improved health status

of women in Latin America and the Caribbean. It is also important to note from the model programs reviewed, that nongovernmental organizations and women's associations have contributed in a large part, to the development and implementation of successful health promotion programs.

4.   LINES OF ACTION

This section will propose main lines of action and policies for future development by PAHO and its Member Governments for improving the situation of women in the region.   It is envisioned that these lines of action will serve as a basis for concrete national plans of actions to be developed by the Governments.

On the basis of the literature reviewed and the existence of a number of model projects and initiatives on which to build, the following issue areas for action are recommended: Policy, Health and Social Programs, Community Organization and Empowerment of Women, Education, and Research.

4.1   Policy

A focus on healthy public policy and the creation of supportive environments is critical to the future of health promotion in the region. Health promotion policy "... is a guide for government action and occurs at all levels of government... The purpose of health promotion policy is to mobilize resources for health and to pursue healthy public policy: multisectoral policies to achieve equity in health" (WHO, A Framework for Health Promotion Policy: A Discussion Document, Health Promotion International, p.336).

Women's health problems and issues will need to be incorporated in the formulation of healthy public policy to assure broad policy and planning processes that include concepts of gender-equity. Consumers (both men and women) should be involved at all levels of policy development in health promotion.

Among the policies of critical importance for the advancement of women, with emphasis on health promotion are:

- To promote national family health strategies such as breastfeeding, diet and nutritional information, information to promote and sustain health across all ages, and access to leisure and recreation.

- To promote women's occupational and environmental health by assuring safe working areas, air, water, food and uncontaminated land.

- To formulate communication policies prohibiting the advertising of cigarettes in the mass media and the targeting of children, adolescents and women for tobacco and alcohol advertising.

- To promote and protect women, children, and adolescence against violence, abuse, prostitution, and rape.

4.2 Health and Social Programs

There is an urgent need to shift health and social program resources toward prevention and health promotion. Given that many of the health problems in the region are preventable, shifting the system to focus on prevention and health promotion; from an institutional model, to one with a strong community base and public health focus, is critical.

In almost all countries of the Region, health program allocations have been concerned primarily with medical care, with inputs -- that is, resources -- the number of hospital beds, the number of physicians, etc. This orientation ignores the great achievements in the epidemiology and prevention of communicable disease, and the remarkable recent advances of epidemiology in making possible similar achievements in the prevention of noncommunicable disease and injuries--now the most important causes of mortality and morbidity in the Region. It is imperative, therefore, for the countries of the Americas to transform their health and social programs to be concerned primarily with outcomes instead of inputs, with results instead of resources. The inputs -- the resources -- must be geared to the planned outcomes in terms of specific reductions in mortality, prevalence, disability, violence, abuse, powerlessness, and discrimination. Since many of the major determinants of health lie outside the jurisdiction of the health sector, and beyond the control of individuals who might be affected, it is imperative that health and social programs join forces to promote health and improve living conditions for women of all ages.

Among the objectives of critical importance for the advancement of women, with emphasis on health and social programs are:

- To provide health promotion and protection and health care services and screening specific to women's health needs in areas such as reproductive health, chronic and degenerative health conditions, female cancers, and mental health.

- To promote information on and access to safe and effective reproductive technologies for child spacing, postponing of pregnancy, and for the prevention of sexually transmitted diseases.

- To provide social programs that protect adolescents against risk-taking behavior related to pregnancy, sexually transmitted diseases, use of drugs and tobacco, abuse of alcohol, and accidents and violence.

- To provide programs for child care and to meet other basic social needs.

4.3 Community Organization and Empowerment of Women

It is only during recent decades that the health sector has incorporated the concept of active community involvement and social participation as an indispensable process to assure changes at the community level. The richness of community organization movements in the current political environment of consolidation of democracy in Latin America is also part of health sector programs. Women's groups, health promoters, and community health committees, among others, recognize the importance of community-based health promotion programs to maximize effectiveness and provide consistency and continuity over time.

Although social communication programs based on the use of mass media could put health promotion topics on the public and hopefully the political agenda, it is only through interpersonal communication strategies in the community that healthy lifestyles are supported and adapted. Programs such as those promoting lifestyle change, workplace health promotion, school health activities, child-to-child initiatives, self-care, healthy city approaches, and others are community-based programs. It is critically important that women be empowered to bring women's issues to planning and implementing of community-based health promotion programs.

In an attempt to improve the situation of women in developing countries, a recent development tool that has evolved is GAD analysis or "gender and development" analysis. A GAD approach "... seeks not only to integrate women into development, but to look for the potential in development initiatives to transform unequal social/gender relations and to empower women. A long-term goal of GAD is the equal partnership of women and men in determining and directing their collective future" (Canadian Council for International Cooperation, MATCH International Centre, 1991, p.6). Tools have been developed to assist donor agencies and project officers in assessing the impact of development projects on women from a gender-equity perspective. Training has been developed to sensitize development personnel and provide them with the tools to integrate GAD analysis into their work.

Among the objectives of critical importance for the advancement of women, with emphasis on community organization and empowerment of women are:

- To support partnerships of women's groups with other voluntary organizations.

- To support the development of a wide variety of voluntary organizations in areas such as self-care, self-awareness, and empowerment of women.

- To promote the use of instruments such as GAD to assist donor agencies in assessing the impact of development projects on women.

- To develop mass media radio, television and print programs presenting role-models of empowered women from varying socio-economic levels.

4.4   Education

The challenge in this area is to promote and support education of women, health professionals, and of children and adolescents in school settings.

The education of women in gender-equity, gender-sensitivity, and empowerment skills is vital for the achievement of all health promotion strategies directed to women. In this area, the challenge will be to educate men and women to be conscious of the inequity of current gender arrangements and the need for change. Whatever the balance of equity and efficiency arguments, the desired outcome is change in thinking/understanding at both the individual and institutional levels. At the individual level, these changes are indicated by written and spoken comments. At the institutional level, a major indication of this change in thinking is the adoption of explicit policies on gender equity. Educational programs should include (i) gender appropriate implementation skills including the development of gender equitable plans and (ii) gender awareness assisting women professionals to become effective advocates for women.

The challenge for the education of health professionals relates to the shift and orientation towards health promotion and protection since many of the causes of death and illness in the region are preventable. The role of health professionals is changing, not only from a focus on institutional-based practice to more of a community-based orientation but also in terms of their relationship with clients/patients. In many countries health professionals are no longer viewed as experts but rather as resource persons, client advocates and facilitators. More and more they are working together on multidisciplinary teams. All these changes require new knowledge, skills and new ways of "looking at the

world". Health professionals have a valuable role to play in raising awareness of the inequities that exist such as the health status of women. They can work together with disadvantaged groups and assist them in taking control of their health.

School health education and gender-equity programs typically encourage healthy behaviors, positive attitudes towards health and women, and skills needed to live healthfully and prevent disease and injury. In some countries educational modules are developed around specific addictive behaviors such as the use of drugs, tobacco, and alcohol; or concerning normal body functions such as reproductive health, physical exercise and nutrition; gender-equity issues and empowerment; or perhaps an analysis of risk-taking behavior such as those related to violence or traffic safety. These educational programs are provided to young people during the critically important formative years with the hope they develop healthy habits and attitudes for the remaining years of their lives. (Pan American Health Organization (1992), Implementing the Health Promotion Strategy in the Pan American Health Organization, Washington, D.C. PAHO)

Among the objectives of critical importance for the advancement of women, with emphasis on education are:

- To promote and provide educational programs in gender-equity, gender-sensitivity, and empowerment to women and men in the workplace, school, and through community organizations.

- To prepare educational modules for the curriculum health professionals on community-based health promotion in women's health.

- To prepare educational modules for primary and secondary schools promoting health and gender-equity.

4.5 Research

The diseases and conditions that are unique to women or more prevalent or serious in women or have risk factors or interventions that are different for women all need adequate research. Recent reports indicate that women are not getting their fair share of the research dollar. Women have different hormones, different patterns of health and disease, and different responses to stress and treatment than men. Additionally, women face different, at times hostile, social, economic, cultural, and political realities that impact on their health. And they have a unique relationship to the health care system, partly because of their reproductive role but also because of their multiple roles in society.

Among the objectives of critical importance for the advancement of women, with emphasis on research are:

- To provide research grants and multi-country proposals to study diseases and conditions unique to women, more prevalent or serious in women, or with risk factos or interventions different for women.

- To provide research grants and multi-country proposals to study the impact on women's health related to social, economic, cultural, and political realities.

- To provide research grants and multi-country proposals to study the health care of women.

4.6 Summary

In all of the proposed issue areas for action, there is a focus on working in partnership; the active participation of women; the interdisciplinary and intersectoral nature of health promotion, the belief in building on what we know and on celebrating our successes.

5. CONCLUSION

Improving the health status and social and economic conditions of women in Latin America is complex, and development is a long range process that involves social change. However, a number of positive steps can and should be taken now to improve the "lot" of many disadvantaged women in the region. As we move forward together into the future, it is important to keep in mind the following:

> *The empowerment of women is a long-term process. (However) it cannot and need not wait until basic needs are addressed. Refining our vision for the future and creating the conditions for it to exist are part of the process of redesigning development agendas from the perspectives of women and social movements (Canadian Council for International Co-operation, MATCH International Centre, 1991, p.22).*

Let us also not lose sight of the fact that the "goal of development is to create an environment which enables people to enjoy long, healthy and creative lives" (Carrillo, 1991, p.7). It is also a vision of "people able to meet their own needs, solve their own problems, and control the use of outside and internal resources for their own benefit". (Coady International Institute, undated, A Handbook for Social/Gender Analysis, p.19).

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