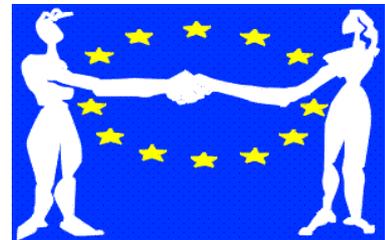




EWHNET
European Women's Health Network



Women's Lives and Health in Europe – A Dialogue Across Borders

Learning Models, Developing Strategies

**Documentation of the Conference in Bad Salzuflen,
Germany**

28th September – 1st October 2000

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Preface

Health is more than the absence of disease; promoting health is more than a medical approach can offer. This was the credo of the conference "Women's Lives and Health in Europe - a Dialogue Across Borders". The conference aimed at presenting models of good practice and developing strategies for women's health in Europe. Speakers from the World Health Organisation and eight European countries and an audience from even more countries around the world drew a picture of the health situation and the health needs of women in the different areas. Remarkable differences became evident between the western and eastern European countries.

All the organising and co-operating organisations emphasised the social model of health. This view of women's health includes its social, economic and environmental determinants. The conference referred to this model and invited people to risk looking across borders and to experience new approaches in the field of women's health in the areas of prevention, health promotion and health care. It also stressed the urgent need to think about strategies on how to reduce the gender bias and the resulting negative effects in the health systems of the different countries.

The conference was organised by the "Arbeitskreis Frauengesundheit in Medizin, Therapie und Gesellschaft" (AKF) ("Association of Women's Health in Medicine, Psychotherapy and Society") and the Internationales Zentrum für Frauengesundheit (IZFG) (International Centre for Women's Health) and funded by two German ministries: the Ministry of Women, Youth, Family and Health, State of North Rhine Westfalia, and the Federal Ministry of Family, Senior Citizens, Women and Youth.

The AKF concentrates critical forces within and without the health system, promotes multiprofessional approaches and, since 1993, has grown into a significant organisation in Germany. It offers independent information to women about a series of questions concerning health and provides expertise within the political arena.

The International Centre for Women's Health (IZFG) is an initiative of women's health experts which was founded in 1997 and is located in Bad Salzuflen. Coming from different professional backgrounds the IZFG-women initiated and work on several projects which consider the fact that women need a different kind of (medical) care. The intention of the IZFG is to support women in their specific needs and to work in political organisations in order to build a strong women's health network. An important goal of the IZFG is to implement innovative forms of women specific prevention and rehabilitation into the regular health care system.

The European Women's Health Network (EWHNET) as a cooperation partner provided themes for the programme and links to nine countries in Europe. It also motivated the EWHNET-members to take part and introduce models of good practice and political strategies they had developed in their countries. EWHNET is a multiprofessional and interdisciplinary network of organisations and projects from nine countries. The network is coordinated by the Association for Health Promotion in Lower Saxony, a non-profit, independent, state-wide association for health promotion, health education and prevention.

Conferences like this offer ways of learning from each other, improve our mutual understanding and motivate us to reproduce models of good practice, thus forming the base for a lasting, sustainable European co-operation.

Dr. Claudia Schumann
(AKF)

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Global Programmes for Women's Health - What do They Mean for Europe?

Assia Brandrup-Lukanow, Regional Adviser, Regional Office for Europe of the WHO

It is a great pleasure for me to address you here today on behalf of the Regional Office for Europe of the World Health Organization (WHO) and to have the opportunity to present and discuss with you the proposed European Action Plan for Women's Health. Before speaking of the Action Plan itself, I would like to address a few of the fundamental points, which form the basis of the Action Plan. I will also take a few historical steps back to review the main outcomes of international summits and consultations which have an impact on our thinking on issues of women's and reproductive health today.

At the centre stands the Social Model of Health, in which health is viewed not as a product or outcome of strong or weak, appropriate or inappropriate health services, but as the outcome of a variety of social and economic determinants in people's lives. The health status of an individual is determined by the social, economic, work and physical environment, in which he or she lives and works in. Of course, the quality of health services will affect health and health care seeking behaviour of the population, as well as the outcome of illness when it occurs. However, in order to achieve a more sustainable health status of a population it is necessary to intervene at all levels of the basic determinants, as well as to make respective investments in the sectors impacting health. Investing in health services alone will have only a limited success if other measures are not taken. An extreme example of this is, let us say, an investment into a big immunisation campaign for children in a situation of drought and starvation. All investments into the immunisation could be lost if children later die of malnutrition, starvation, or thirst. Providing food and water are therefore equally important - making provisions and changes towards preventing future food and water shortages will have a more sustainable impact on the health of these children as they grow.

Many studies both from developing as well as from richer countries show that the education of a woman influences her own health status - with regard to, for example, reproductive choices - but also the health status of her children. Investing in the education of men and women gives people the capacity to judge and make self-determined decisions about their lives. It also provides them with the potential for improving their own economic situation, factors that influence both the objective and subjective conditions of well-being. The influence of the environment, work places, and dwelling/housing conditions on health is well known and documented. In addition to all these, the balance and distribution of power between men and women in society and the gender imbalance affect women's health and well-being specifically, best reflected perhaps in the many more frequent and chronic mental health problems of women.

Investing in health means investing in education and economic development and other areas, and it means that social and gender equity have to be provided. What were the international milestones that raised these issues? I have only selected a few; there are many more.

- The Ottawa Charta for Health Promotion has underlined the importance of building healthy public policy, of creating supportive environments, of strengthening community based action, of developing personal skills of individuals in order to enable them to make decisions concerning their own lives, and of reorienting health

services a little bit away from the pure curative perspective to a more health promotion perspective. Health promotion in this context has been defined as the process of enabling people to increase control over and to improve their health through the strategies just mentioned.

- The 1987 Nairobi Conference on Safe Motherhood, which looked globally at the situation of pregnancy and childbirth and maternal mortality world-wide, made a set of recommendations which many agencies signed such as UNICEF, the WHO, the International Planned Parenthood Federation, the World Bank and many Non-Governmental Organisations (NGOs) working in the field. Every year there is a World Health Assembly that brings together the Ministers of Health of the whole world. In the past ten years there have been a number of resolutions making recommendations on the priority of women's health and reproductive health, among the World Health Assembly.
- A major milestone was the International Conference on Population and Development in Cairo in 1994, which brought reproductive health on the agenda. At this conference, a comprehensive concept of reproductive health in a life span approach was introduced which included the right to reproductive choice and to safe pregnancy. This was a step away from the previous vertical focus on family planning, which had been introduced as a means of social and economic development especially in the poor countries of the world where the fertility rates were very high. There was a lot of resistance against this concept at one point, so the transition to a health-oriented approach to reproductive health was a very important step. In the context of this conference countries committed themselves to making investments in the protection of reproductive health. Another very important decision made at this conference was the discussion concerning abortion and the right to having a safe abortion in situations where abortion is legal. This was seen as an essential step to preventing maternal deaths world-wide.
- The UN Summit on Women in 1995 in Beijing has again underlined the importance of health of women as a vital component for development. Apart from underlining the reproductive health issues, the health needs of adolescent girls and older women were emphasised.
- In 1994 the WHO organised a regional conference in Vienna, which was called "Women's Health Counts". At this conference a set of recommendations was made:
 - investment in health
 - human rights
 - life-span health, empowerment
 - woman-friendly and appropriate services
 - changes in gender relationship
 -

Six policy mechanisms for their implementation were recommended:

- establish an office for women's health
- create national women's health forums, consisting of an interdisciplinary force
- develop a reliable information base, containing gender disaggregated data on disease and health
- publish comprehensive reports on women's health
- develop research strategies for women's health
- present women's health reports at the UN Conferences
- The Convention on the Elimination of All Forms of Discrimination Against Women is a very important convention. It was already signed in 1979 by many countries. The Convention included reference to ill-health effects of gender discrimination.

As a consequence of these conferences and international consultations, many countries embarked upon making in-depth analysis in women's health and published Women's Health Profiles in collaboration with the WHO, the European Community and other organisations. However, the design of regional and national interventions remained a step behind. Therefore the Women's Health Action Plan sets out to give a framework, and sets a number of preliminary conditions as a guide for the development of national action plans based on the analysis of what we know today, on research and on evidence.

Member States committed to improving women's health must be committed to:

1. Implementing human rights legislation and instruments already existing and signed by the WHO member states.
2. Ensuring equity in women's status across Europe and within the European countries through empowerment, education and women's participation in decision making processes. Even where equal access to education at all levels exists, this is not always reflected in career options, the labour market, wages, decision-making and economic power. Promoting the sharing of family responsibilities through appropriate legislation and changing social attitudes will make a significant contribution to reducing inequity. Among women in Europe, migrants and refugees, women belonging to ethnic minorities, elderly women and disabled women are groups with an especially low socio-economic status.
3. Elimination of discrimination against women. All women are likely to face discrimination in some aspects of their lives. Furthermore, women are not a homogenous group. Race and ethnicity, socio-economic status, disability or sexual orientation often compound the inequalities facing them as a result of their sex. Implementing the Convention on the Elimination of All Forms of Discrimination against Women and monitoring its implementation are important prerequisites to protecting and promoting the health of women.
4. Action to alleviate poverty. Poverty is recognised as affecting health profoundly and is experienced by many Europeans, also in richer countries of the region. Women are, however, over-represented amongst the poor in all European countries - estimated at 120 million women living in poverty. This marginalises them even more than men from influencing the economic and health agendas. As poverty is a major determinant of ill health, the elimination of poverty will have a health benefit on the population as a whole. Formulation of laws governing entitlements to free health care must ensure that those most in need are covered and have equal access. Introducing bodies or working groups at ministries of health and other public health structures to specifically monitor and address how well the systems are responding to the health needs of poor populations and the effects of socio-economic developments on health, are important instruments in taking this commitment forward and ensuring that policies for economic regeneration do not undermine social and health services that promote equity and support for low-income groups.

An example of a transition problem is the access to essential drugs. Essential drugs are a set of drugs that have been agreed upon as being the most vital drugs, and should be available to every public health service provision. In 1987 over 95% of the population of our region had access to essential drugs. In 1997 this percentage sank to 50-80% in the eastern part of the region, and in Central Europe it sank to 81-95%. This shows us also regionally where we need to focus in order to create equity between countries.

Key issues

This section aims to highlight the main issues to be taken by any action plan on the health of women, which is to be developed at the country level. It is not meant as a comprehensive list of issues but as an indication of what the main concerns are on the health of women in Europe. For a more comprehensive collection of the main issues related to women's health, an effort has been made to produce a supporting document to Health 21, which enables the targets to be considered from the perspective of women. So what are the priorities of the Health Action Plan?

Approach

Throughout the course of their lives women's health needs vary. Applying the life course approach means that not only the period of motherhood is important but also aims at protecting the health of young girls and adolescents as well as elderly women. Identifying the most important potential and threats to health at each stage is essential to creating the right prevention and effective intervention. This includes protecting unborn girls from prenatal sex selection, ensuring that infant girls receive the same vaccination coverage as their brothers, and ensuring that good food is distributed equally in households. It also includes protecting girls from sexual violence, unwanted pregnancies and abortions, sexually transmitted infections and harmful traditional practices. It includes promoting girls' self esteem and their capacity to fully develop their physical potential through equal access to education; participation in sports and recreation is also an important prerequisite for women's health.

Later on in life, women of reproductive age obviously require the conditions for good prenatal care, safe childbirth, post-partum care and family planning. They also require economic and social protection for the role that they play in child and family care.

The context of women's health in the post-reproductive years still carries the residua of the burdens of earlier reproductive ill-health to which is added the physiological changes associated with menopause, which leads to skeletal, cardiovascular and other problems. Among the elderly, women form the majority, and this greater female longevity requires strategies for both prolonging active life and providing long term care for the burden of functional disability and chronic disease such as osteoporosis, cardiovascular disease, mental disabilities, and certain malignancies. Social support systems are needed, as the carers are often young elderly women.

Causes of Death and Patterns of Morbidity

Women have the advantage of disease resistance biology but also the disadvantage of a lower social status and less access to wealth. Thus men and women have - to a certain degree- different disease patterns. This is due to their different biology, to women's reproductive function, and to the fact that their life styles and risk factors differ because their gender roles are different. In many instances, there is a need for both gender specific prevention of disease as well as gender specific treatment schemes.

Diseases of concern are:

1. Diseases that frequently contribute to women's mortality such as cardiovascular diseases and cancers. These diseases are also common in men
2. Diseases that affect women almost exclusively such as diseases related to pregnancy, birth and fertility and malignant and not malignant diseases in the reproductive organs (cancer of the breast, cervical cancer, etc)

3. Diseases that are more frequent in women than in men such as rheumatism and anaemia
4. Mental diseases such as depression and eating disorders

We need to give special attention to the health problems of the more than 4 million women belonging to migrant groups, refugees and ethnic minorities who live in Europe, sometimes coming from other European countries, sometime from other parts of the world. Women's health priorities across Europe may differ from one country to another. Socio-economic transition in certain parts of the region has resulted in previous improvements in the health of women being lost and has generated greater disparities between countries in this respect. Morbidity and mortality differentials within the region are significant. In the countries of Central and Eastern Europe and the newly independent states (NIS) poverty has seen a reduction in women's fertility accompanied by an increase in maternal mortality and abortion. Female life expectancy is also declining in those countries.

A map of the European region of WHO might show you how diverse the needs are from a country like Portugal to a country like Kyrgyzstan, which is on the Chinese border. Therefore an action plan like the one we are developing has to have a very general framework. Which parts are chosen by a country to develop their own priorities is a national or even regional decision.

To underline the differences in the regions: The statistics of maternal deaths in the EU average show the progress made in the past 25 years from maternal mortality rates of 35 per 100,000 life births down to around 7 per 100,000 through very big efforts that have been made in prenatal and perinatal care, but also through general socio-economic development. In Central and Eastern Europe, there have been high rates of maternal mortality until the early nineties. Through concerted action and investment in key areas of public health, there has been a significant improvement in maternal health indicators. But in the most eastern countries of the former Soviet Union we still see mortality that is higher than the one we observed in Western Europe 25 years ago. This problem needs to be tackled with a degree of urgency through improving women's socio-economic status, improving their education, ensuring effective family planning, prenatal care and adequate nutrition for the mother in the prenatal period, workplace protection of pregnant women and the provision of mother and baby-friendly hospitals. The Safe Motherhood/Making Pregnancy Safe Initiative is a vital component in any strategy to improve the health of women.

We see similar patterns for the infant mortality rates, and of course infant health is a direct reflection of the health of the mother before or during the pregnancy. This also tells us something of women's health needs, and again you see the massive improvements made within the Western European countries during the past years.

Another problem we face in the region is the problem of sexually transmitted infections in the East, and this is a problem which is increasingly carried across borders, and women, of course, are particularly infected. Even at WHO, we do not have gender disaggregated data, for example, for syphilis. We do, however, see now new cases of congenital syphilis, which is a sign of deterioration. And there are many reasons why sexually transmitted diseases are growing in that part of the region.

Another area of concern is cancer of the cervix. Standardised death rates from cancer of the cervix from some selected countries of the region show very high rates in Rumania and Kazakstan compared to lower rates in western countries of the region. And this is also thanks to the introduction of screening, early detection, and early treatment services.

To speak a little bit of the issue of abortion in our region: I already referred to the recommendation made in Cairo. I would like to show you an example how the situation looks world-wide. The estimated annual mortality due to unsafe abortion is 10-29 per 100,000. In many countries, we have very low contraceptive prevalence rates, compared to 60-70 % contraceptive prevalence in Western Europe, and this is part of the reason for the high recourse to abortion as a means of fertility regulation.

Health Care Practice and Service

All health care services should be sensitive to women's health needs. Measuring outcomes in terms of quality of care should include the degree to which women have been provided with appropriate information to allow them to make meaningful decisions about their health care. Guaranteeing that health services meet international quality standards and ensuring that the right to privacy and confidentiality are also key components in the delivery of services, which treat women with respect, should be accomplished within the whole region. The role of women in all spheres of health should be re-examined. Women are one of the strongest means for improving health and closing the gaps at the different levels: individual, family and health services. Women form the huge majority of those working in health care, and large numbers of them are in under-paid jobs with serious occupational hazards.

Empowering women and avoiding medicalisation are health-promoting strategies that should be integrated into health care organisations. Self help and patient rights should be institutionalised as central interests.

The partial dismantling of health care in the course of health care reforms in the countries with economies in transition has led to an exclusion of certain women's health services from the public health sector. Within the ongoing health care reforms, countries should consider essential packages of women's health care that should be financed through the public sector, e.g., preventive care, maternity care. Within the existing health insurance schemes, care must be taken to ensure that unemployed women, married or not, have sufficient access to services. Evidence is needed on qualitative research regarding access to, and utilisation of, health services and health care seeking behaviour.

Measures to Address Violence

Another area of priority is the introduction of measures to address and combat violence, to provide prevention and support. We know that gender based violence constitutes a significant public health problem in Europe with about 20% women Europe wide having been affected by violence at some point of their lives, and most of them were affected by family violence or attacked by their partners. Migrants and refugee women are particularly vulnerable to gender based and sexual violence, because of their relative distance to their normal environmental social protection. This is also an issue in the context of prostitution trafficking across borders, which is presently taking place in Europe, and on which we have very little reliable information.

In addition to physical injuries, women who have experienced gender-based violence are at greater risk of problems such as chronic pain, disability, unwanted pregnancies, sexually transmitted infections, miscarriage, abdominal symptoms leading to surgical interventions and somatic disorders. The psychological and emotional sequelae of abuse are often manifested in the higher levels of depression, anxiety, panic attacks, substance abuse, eating disorders, and psychiatric disorders amongst abused women. Suicide attempts and self-inflicted injury are also more common. The use of rape as an instrument of war increases women's vulnerability during times of upheaval and dislocation. Traumatized women are extremely vulnerable, thus comprehensive policies to protect women and prevent violence should include working with the police and judicial system so that they become woman friendly.

These are the prerequisites and the main focuses of the Action Plan. It is based on the 21 targets of Health for All. These are targets that have been endorsed by the European Member States, by the Ministries of Health of Europe in 1998. What we have done in the working group is to look at these 21 targets, and to see how relevant they are and how they can be applied and operationalised for women's health. I just selected a few of the targets as examples. The responsibility of the member states in the implementation of the targets would be to have national based co-ordinating committees and the already mentioned country based Action Plan. The responsibility of the WHO is to work as clearing house to have joined actions with other agencies and to provide evidence, especially monitoring and evaluation after the implementation of the Action Plan.

Examples of some of the most relevant targets:

Target 2 - Equity in Health

By the year 2020 the health gap between socio-economic groups within countries should be reduced by at least one fourth in all Member States by substantially improving the health of disadvantaged groups.

Even in the richest countries in the region, there are differences and differentials in health for women and men, which are not taken into account. Although women live longer than men do, they suffer a greater burden of morbidity. They utilise the health care system more than men do and female income is on average only 70% of male income. Women obviously require the conditions for safe childbirth but also require not to be penalised economically for the role that they play in child and family care.

Ensuring that laws on equal opportunities and equal pay are implemented and that women's employment is promoted and facilitated by the availability of childcare and support with elderly and disabled family members are important prerequisites for equity in health. Tackling the social and economic conditions that affect women's health is not only important for the health of women but is fundamental in creating strong, vital and just individual Member States. Special measures such as positive discrimination (in, for example, employment and social welfare) may be in order to address past inequities and to prevent perpetuating current inequalities.

Target 3 - Healthy Start in Life

By the year 2020, all new-born babies, infants and pre-school children in the region should have better health, ensuring a healthy start in life.

The health of babies and young children is largely dependent on the health of the mother. There still remains a widely held view that the needs of babies are of primary concern and that the mother is merely the 'incubator'. Not only is this perspective inequitable but can be dangerous because if women's health needs are not seen as distinct from the needs of the foetus, the new-born or the child, there is the possibility of delivering inadequate health care to women. Whilst policies are required which create a supportive family, the unequal burden of care which falls to women needs to be recognised and addressed both by their male partners and by Governments.

Target 4 - Health of Young People

By the year 2020, young people in the region should be healthier and better able to fulfil their roles in society.

This is an area that generally, we believe, requires more attention. The health of young people is usually being addressed in pilot projects, in small projects or through NGOs; and generally young people use the health services that are available, but they use them reluctantly. We feel that it is time to focus more on the needs of this group and to develop strategies on services which will be attractive and will be used by teenagers.

The health of young women is associated with the role and position of women in the society they inhabit. Recent research has shown that in some Member States young men consider it acceptable to physically and sexually abuse young women and young women consider that this is a fact of life which they have to endure. Improving the general health and sexual health of young women has to be linked to improving their status and working with boys to educate them about their responsibilities in emotional and sexual relationships. Preventing unwanted teenage pregnancy also has to be planned in the context of promoting greater equality for girls and young women in addition to the provision of comprehensive sex education, affordable and accessible health care and contraception for young women and access to safe abortion and counselling.

Creating a positive self image in young women is made difficult by the extent to which success and glamour in women is often portrayed as being associated with an excessively slim body, being sexually available, and with smoking. Addressing eating disorders, STDs and the increased prevalence of smoking amongst young women by placing the emphasis on changing the behaviour of young women will only have limited effect in the absence of wider strategies to combat existing norms.

Target 5 - Healthy Ageing

By the year 2020, people over 65 should have the opportunity of enjoying their full health potential and playing an active social role.

Research has indicated that women care for their partner for five years on average at the end of his life and then live an average of eight years afterward without a similar level of intensive care and support. Older women are often responsible solely or partly for care of children and other relatives. They are also often to be found as the mainstay of community activities and community life. But they tend to be excluded from the main line activities from society through the fact that they are usually economically less well

off as men in that age group. The preponderance of women in the older community should mean that their needs should be made explicit in the planning of health and social care. Certain stereotypical images of women as either frail or confused still exist as does the view of older women having no desire to express their sexuality and these need to be overcome. Where these signs and symptoms do exist they are often the result of underlying mental health problems such as depression which can often be effectively treated when medical practitioners have had appropriate training in the diagnosis of health problems in older people.

Target 6 - Improving Mental Health

By the year 2020, people's psychosocial well being should be improved and better, comprehensive services should be available to and accessible by people with mental health problems.

While patterns in morbidity in men and women and their significance are still a matter of debate, the excess of female psychosocial distress is undisputed. Women across the world have significantly higher presentations of mental health problems than men, and the types of disorder generally differ. Women are more likely to be afflicted with depression, anxiety and other neuroses. There is also a greater prevalence of para-suicidal behaviour in women. Addressing mental health needs in Member States requires appreciation of the differences in aetiology, manifestation, and duration of problems experienced by women. The preponderance of depression, for example, has been linked to the greater stresses experienced by women in poverty, which heightens their isolation and social exclusion. The double burden of motherhood and work has been identified as a contributory factor in the poor mental health of disadvantaged women.

Much of the female excess in mental health problems is attributable to the pervasiveness of gender inequality, which includes direct and indirect discrimination, and the cultural devaluation of the female. In relation to employment, for example, women experience discrimination in the workplace such as unequal pay, greater job insecurity, more part-time work and sexual harassment. Similarly the endemic nature of violence against women across all societies also has a major impact on their mental health.

The identification and implementation of measures to reduce gender inequality are thus prerequisites for sustainable improvements in women's mental health. In relation to health services, there has to be a shift in recognition of the above factors contributing to women's mental health problems. There are training needs for all medical professions to learn about the specific patterns of female psycho-social distress, to learn about the reasons for psycho-tropic drug use in women and to learn about appropriate intervention to prevent and to address depressive disorders.

Target 7 - Reducing Communicable Disease

By the year 2020, the adverse health effects of communicable diseases should be substantially diminished through systematically applied programmes to eradicate, eliminate or control infectious diseases of public health importance.

Preventing communicable diseases seems to be a target that, when you look at it at first, applies to everybody. But there are a number of issues here, too, which are specific for women. Infections in pregnancy are perhaps the most obvious. Pregnancy can affect the immune system of women, making them more susceptible to infectious diseases such as malaria. Recommendations regarding malaria prophylaxis should be specific for pregnant

women. Childbirth itself can also be a time of risk for both mother and child, and it is important to prevent sepsis in birth. Certain infectious diseases affect women disproportionately or differentially, and this needs to be considered when planning comprehensive prevention programmes. Women may also transmit infectious disease such as hepatitis to their unborn children or, as the result of their experience of disease, affect the health of their children. Women contracting rubella or toxoplasmosis are examples of this. Health care seeking behaviour for communicable diseases can also be different for man and women and this has been well documented, for example, for the treatment of tuberculosis. Women comprise the majority of health care workers and are also at risk of infection as a result of their employment.

The way that women become infected with sexually transmitted diseases (STDs) and the implications for their health and that of their families are important to consider specifically. Male sexual behaviour may be a major contributory factor to women's ill health as with the transmission of the HP virus and its subsequent association with cervical cancer or when women are forced into prostitution. Whilst safe sex practices would help to protect women and men alike, the means for women to protect themselves through barrier contraception may not be readily available, or they may find themselves in vulnerable situations in terms of their relationships with men. In order for prevention campaigns against STDs and HIV/AIDS to be successful, women will need considerable support to ensure that their rights to protection from disease are taken seriously by their male partners.

Target 8 - Non-communicable Diseases

By the year 2020, morbidity, disability and premature levels of mortality due to major chronic diseases should be reduced to the lowest feasible levels throughout the region.

The prevalence of non-communicable diseases across the Region constitutes a major problem. Such conditions, however, can affect women and men differently. Some conditions are more prevalent in women, for example, breast cancer, osteoporosis and rheumatoid arthritis, whilst others are sex-specific, e.g. cervical cancer. Cancer screening programmes are required at a primary care level to ensure the early detection of such conditions.

There are important sex and gender differences in major conditions such as coronary heart disease. The traditional research focus on male subjects has meant that possible sex differences in symptoms, diagnostic indicators, prognosis and relative effectiveness of different treatments have been largely ignored. As a result, the findings have suffered from a lack of inclusivity, comprehensiveness and have limited use in reaching generalisations. To be effective, preventative strategies have to address these issues. Both the general population and health professionals still largely perceive heart disease as a male condition despite the fact that it is the major killer of women as well as of men. Raising awareness has to be a priority. The risk factors identified in contributing to such conditions, such as smoking and alcohol, require different interventions for women and men. The growing incidence of smoking amongst younger women, particularly women in poverty, for example, has led to an increase in lung cancer and associated conditions. This needs to be tackled through specific targeted measures. In a similar way, with other rising risk factors such as stress, the circumstances have to be acknowledged and addressed.

Target 9 - Violence & Injuries

By the year 2020, there should be a significant and sustainable decrease in injuries, disability and death arising from accidents and violence in the region.

Gender-based violence encompasses a number of different forms of abuse, including domestic violence, rape, sexual assault, childhood sexual abuse, trafficking, prostitution, sexual harassment and harmful traditional practices such as female genital mutilation. Much of this violence is under-reported and under-recorded, yet its consequences for health and development are profound. The abuse of women is embedded in the cultural norms and mores of society, which historically have legitimised female subordination. Health services cannot act alone in seeking to eliminate such abuse but they have an important role to play. Training is required for workers to ensure that abuse is identified and responded to appropriately. Strategies to address violence should be incorporated into health policy and integrated into models of health care, for example in reproductive health programmes. To eradicate gender-based violence requires challenging the structural inequality that gives rise to and sustains it.

So to come to the end of this short review: To illustrate the application of this Women's Health Strategy, I would like to suggest that we go through an example of an intervention for a particular women's health problem: the problem of coronary heart disease which has been rising among women in many countries of Western Europe over the past 5 years. In order to reduce it effectively, a logical framework approach can be applied.

- We would first look at the determinants: What are the external determinants, how is the environment, what are the work areas, what are the specific stresses, what are the life style issues? Do we have sufficient health promotion activities, how effective are they, and how does our health care provision deal with chronic heart disease?
- The next step would be to define the respective contributions of these determinants, and to choose the area of intervention. This means to decide, for example, on the city or part of the town where we know that this problem exists. Let's do research on why it has happened, and let's focus on the main determinants, let's try to change work conditions, environmental conditions, health promotion or health care conditions.
- An important step then is also to choose partners for intervention. These partners can be very much outside, they can include the media, employers, NGOs, self-help groups, and so on.
- The next step would be to define monitoring and evaluation strategies, and also a time line of expected results. It may take longer to see a result than if one focuses just on a specific intervention in the health care sector, but the result will be more sustainable.

What I want to show with this array of examples from the Action Plan and the data we have available is that it is really important to see women's health and women's health promotion as an intersectoral task which cannot remain only in the area of health care or of women's health initiatives. But those, of course, are very important in the area of awareness raising, initiation of the discussion and initiation of policies that are relevant to improving women's health.

Thank you for your attention.

Medicine Alone is Not the Solution - Strategies and Definition of the Position of Women's Health Policy

Ulrike Hauffe - State Representative for the Realisation of Equal Rights for Women, Bremen

Several weeks ago, I opened my talk on the "Effects of Research Promotion on Medical Actions and the Health Situation of Women" by stating that women suffer from disorders that have been defined by researchers, male and female doctors, and the pharmaceutical industry as being disorders typical to women. As I was preparing today's talk, I noticed how similar the content of this statement was to that of the slogan "The Personal is Political", which accentuated the (feminist) political departure at the end of the 1960s.

- A Look at the Past

In feminist discussions that evolved towards the end of the 1960s, women analysed that their living conditions needed to be looked at depending on social standards, and they formulated their criticism using clear and concrete examples from the health system. Their new targets included women's needs for self-confidence, searching for individual, women-oriented mechanisms for overcoming mental and physical pain, and recovering lost physical competence. Women of all ages discussed their experiences regarding limitations, uncertainties, and situations in which their minds were made up for them by socially-dictated precepts and bans, such as insufficient opportunities to use contraception, a ban on abortion, standardised prenatal care and birth.

The feminist demand for self-responsible life planning of the most female abilities - sexuality, pregnancy, and birth - was one of the strongest driving forces behind the women's liberation movement. Chanting "Mein Bauch gehört mir" (My belly belongs to me), daughters, mothers, and grandmothers took to the streets for women's right to legal and safe abortion.

Not only did feminists discuss new standards of thought and judgement - they also changed their behaviour and ways of life, and assessed the effects on their inner well being. Regina Stolzenberg, one of the protagonists of the self-help movement, described this process, quite rightly, as a "cultural revolution".¹ The more drastic many women felt the powerful role of medical standardisation to be, the more clearly they attempted to develop alternative models. The establishment of women's health centres is due to this motivation, as are many other positive changes in procedures, particularly in obstetrics.

At this time, the central focus of the women's health movement was not only on the question of self-responsibility and self-determination, especially embodied in the debate over § 218 (German abortion law), but also on the critique towards medicine.

We are now living in the year 2000. Many activists from the earlier women's health movement are now menopausal, have gone through their menopause, or at least will shortly experience it. Much has changed: with the help of the pill, (also unmarried) women take it for granted that they are able to decide whether or not they wish to become pregnant, and if so, at what stage in their lives. Involvement in women's health politics has managed to establish a considerably improved abortion service. Women can inform themselves about prenatal care, and they can choose who should look after them during prenatal care and at birth, using their preferred method - assuming they have the

¹ Stolzenberg, Regina: 1998; Die Sehnsucht nach Ganzheit und Gleichheit – Einige Fragen und Antworten zur Standortbestimmung der Frauengesundheitsbewegung. In: Beiträge zur feministischen Theorie und Praxis 49/50

necessary information and resources available, and are interested in structuring such aspects themselves.

Moreover, women are now able to ignore the ticking of their biological clocks, and, even at an older age, can become pregnant following fertility treatment. They can (although not yet in Germany), sell their ova or their childbearing ability.

Which goals have we reached? When I look back and observe the numerous changes that were triggered by the women's movement, I have a feeling of great pride, since I can still clearly remember the energy we put into the movement. Nevertheless, there are some examples that irritate me, and several fields of medical care that are still a long way away from fulfilling the needs of women.

Below are some impressions regarding women's health policy:

- The Example of Pill:

In August of this year, the journalist Eva Schindele paid tribute in a WDR radio programme to the discovery of the pill forty years ago. The pill was and still remains the major method of contraception, which also contributed significantly to the sexual liberation of women - even if the pill was misunderstood by some men to be an easy protection from unwanted fatherhood. Initially, it was difficult to obtain the pill, and it was embarrassing for women, especially those who were unmarried, to request the pill from their doctors. But then the pill became a must for the modern woman. Currently 58% of women between the ages of 20 and 44 are now on the pill.²

However, it should not be forgotten that the pill is a drug. Not only must it be prescribed by a doctor; women who are on the pill must also be examined regularly by their gynaecologists. The pill transformed contraception into a medical topic, and turned healthy women into patients. This is a new problem that we are facing today. Incidentally, the number of gynaecologists has quadrupled since the pill was introduced.³

- Health Research

Through the setting of research priorities, certain fields of research have been recognised and considered important. Moreover, it has been stipulated in which areas research is to be undertaken in the future, for what purpose surgical techniques are fine-tuned, and medicinal treatment measures are being developed. For instance, the frequent removal of the uterus was only made possible by the improvement of surgical techniques. Correspondingly, up to 1993, gynaecological specialists needed to prove that they had carried out at least 40 hysterectomies before they could achieve recognition. By 1994, this had led to the situation in Germany in which every second woman over the age of 50 no longer had a uterus.⁴ This means that the illnesses women suffer from are those from which researchers and doctors believe them to be suffering!

The emphasis - or neglect - of specific symptoms or symptom contexts influences and guides the actions and diagnoses of doctors. Some clinical pictures receive greater specialist attention and a higher social priority than others do, while others may be trivialised. The types of illnesses that attract poorly financed research interest are also rarely discussed in specialist journals and the light entertainment media, and are therefore less prevalent in social awareness. They appear as unimportant, peripheral illnesses that are to be neglected. Perhaps one of the many explanations for this is that too few women

² Schindele, Eva. 2000 WDR-Zeitzeichen; Zur Kulturgeschichte der Pille

³ ebenda

⁴ Ehret-Wagener, Barbara. Ed.; 1994; Gebärmutter – das überflüssige Organ

work in the fields of medical care and research. Although 46.5% of medical students in Germany are female, women represent only a third of all doctors employed in clinics. Only around half of the employed female doctors have specialist training. In 1995, the percentage of women among those who qualified to teach at university level was just 9.9%.⁵ Other occupational groups, which have their own viewpoint on women in medical situations, are degraded to "assistant medical occupations", which, due to precise and decisive organisational structures, only possess a limited definition of power.

Due to the acknowledged low number of women participants in the health sciences, the State of Bremen submitted an application in 1997 to the Conference of Equal Rights and Women's Ministers of the Federal States (GFMK) for aspects relevant to women to become embedded in rehabilitation research. The application was successful: a working group entitled 'Gender-specific Research in Rehabilitation' was founded to establish issues in this field that pertained to women.

In health research, differentiations between men and women are made too rarely and imprecisely. Questions about the sociological, economic, political, or ecogenetic bases of human health or disease are too infrequently dealt with. In this sense, health research that predominantly looks at the symptom level fails to prevent or even understand the matter at hand. It labours horizontally at failed manifestations of individual or collective life-styles, but does nothing vertically to encourage improved life-styles that are more conducive to good health.

As early as 1991, the Third International WHO conference on health promotion, which took place in Sundsvall, Sweden, summed up as follows in its concluding document: Health "... is well-being on a physical, mental, social, ecological, and spiritual level. Well-being and malaise, to the extremes of health and illness, are closely interlinked to the sphere in which we act. If this world is characterised by numerous possibilities of self-realisation, participation, and disposal of one's own circumstances, these are factors that are conducive to health."⁶

The WHO's definition does not reduce the treatment of illnesses to medical disciplines. Instead, it points out places and frameworks of individual and social fields of life and action that can either be conducive or harmful to health.

For research into health and illnesses, this means that the questions raised need to be re-examined, and theory and practice must be derived more closely from people's life perspectives and living conditions. Furthermore, a more interdisciplinary approach should be selected, since no one relevant science possesses an isolated autonomy of explanation.

⁵ Bremische Zentralstelle für die Verwirklichung der Gleichberechtigung der Frau; 1997; Über Hürden und Hindernisse in der ärztlichen Weiterbildung; conference proceedings

⁶ World Health Organisation (WHO); 1991; 3rd International Conference on Health Promotion; Sundsvall; Sweden

- Fertility Research and Treatment

Using the example of research into fertility and its treatment, I would like to demonstrate clearly how perceptions of health and illness are disseminated "from top to bottom", and how, by not observing the circumstances, a pathologising reinforcement of health disorders with far-reaching consequences can arise.

In the past, couples in Germany were diagnosed as suffering from a fertility disorder if they had been having regular sexual intercourse for over one year.⁷ Today, women (in actual fact, couples) are already considered infertile and in need of treatment after half a year of involuntary childlessness. Migrant women are frequently declared infertile even before a six-month period has elapsed. Women are rendered "ill" at an early stage, which, in the consciousness of the treating doctor and the treated women/couples, justifies their participation in extensive diagnostic and concentrated medical treatment settings.

These data are naturally included in the statistics, reinforcing the impression given to both doctors and the general public that involuntary childlessness is a rampant epidemic. We are all aware of how significantly this development has influenced the "reproduction market" - officially for the benefit of the affected woman/couple.

Fertility treatment purports to be for the benefit of potential parents, assisting them in having a child, since they purport to have a right to their own child - and a healthy one at that! It becomes obvious how unproductive such a narrow medical point of view is.

- Is reproductive medicine a form of self-determination for women?

Following an invitation from the Federal Minister of Health, I took part in the panel discussion in May this year on the central question: "How do the picture of parenthood and the role of women in society change due to the methods used in medically assisted reproduction, and which tasks are appointed to those advising those affected?" in the symposium entitled "Reproductive Medicine in Germany". In my contribution, I pointed out the remarkable alliance between reproductive medicine and its persistent use of the term "self-determination of women". It seems to be opportune to utilise modern-day biographies to justify one's own medical and research actions.

Women are having children increasingly later in life, and, since they are not as likely to become pregnant as quickly due to this changed life-planning, it is convenient that reproductive medicine offers methods that react precisely to this changed life-planning by women using the formula "Supporting the Self-determination of Women". The term "self-determination of women" is used here in the sense of a self-determined utilisation of medical developments by women. Female planning autonomy is therefore implied in the sense: women plan, and make use of fertility treatment within their self-chosen biography settings, thereby appearing to be autonomous in their planning. The term "self-determination of women" implies that the range of medical techniques, e.g. to assist women in becoming pregnant, is used by women as an expression of their emancipation.

The question as to why women change their life-plans is not part of these debates. It is hardly acknowledged in society that women change their life-planning and fertility biographies because they, just like men, want to be gainfully employed, and no longer

⁷ Kentenich, Heribert; 2000; Reproduktionsmedizin 2000: Klinischer Standard – Gefahren – Ausblick; Talk at the Conference: Frauen und Gesundheit; Schwangerenvorsorge und Reproduktionsmedizin als frauen-gesundheitspolitische Herausforderung in Rothenburg o. d. Tauber, ed.: Bremische Zentralstelle für die Verwirklichung der Gleichberechtigung der Frau

want to be denied the right to their own existential support. However, motherhood and employment, or even simultaneous career planning, are not socially accepted in Germany. What is the use of entitlement to a place in a kindergarten or crèche if it is located a great distance from their homes or places of work, or if it is only open for such a short time that employment is rendered impossible?⁸ How compatible are the holding of management positions and the bringing up of children in Germany?

This means that women decide to have children later, at a biologically less favourable time. This is accompanied by the reduction of their fertility, thus making them reliant on methods of reproductive medicine. This example highlights the schizophrenia of a social development: with their bodies, women repair a social care scandal; the social dimension of a "health disturbance" that is treated with medical means and methods is demonstrated clearly.⁹

A group of women founded the 'Women's Forum on Reproductive Medicine - Reprocult' with regard to these topics. This group establishes public transparency in these developmental contexts, and is currently setting into motion a national critical debate on reproductive medicine. Due to the interdisciplinarity of its participants, the group manages to portray the various different aspects of the meaning of reproductive medical developments with regard to the public's view of "women".

The examples of reproductive medicine and prenatal diagnostics clearly demonstrate the medicalisation of socio-political issues. Since society ostracises people with disabilities, it propagates, as a responsible act, the avoidance of diseased babies by prenatal diagnostic examinations, and, if results are positive, possibly abortion.

- Women as Self-determined Consumers of the Health System

Dedication within the women's health movement has led to the nation-wide establishment of an improved provision of health-related services. This particularly applies to the field of gynaecology, which is often used by women (healthy women, not necessarily patients) to plan their lives. An increasing number of women are becoming self-confident consumers in the pharmaceutical and medical market place. They request support in controlling physical processes, for reasons of self-determination, wish fulfilment, or the presumed avoidance of risks. Regina Stolzenberg states the following about this interplay between supply and demand: women are protagonists and at the same time victims of technological development in medicine, which produces needs, but also reacts to needs. Without women "...the high level of social acceptance of technologies such as in vitro fertilisation, the pill, and hormonal treatment during the menopause, would not be possible."¹⁰ There would not be such an unbroken, instrumental way of dealing with the female body if it were not accepted, or even requested by women. It would be unrealistic of us to argue that social driving forces, male dominance, and profit-oriented thinking alone were responsible for these developments.¹¹

However, what should be the contents and aims of discussions with women who have a more instrumental perception of their bodies and who naturally and self-assuredly make use of the services offered to them, e.g. reproductive technology? How can we

⁸ unpublished documentation: Bundesministerium für Gesundheit; 2000; Symposium Fortpflanzungsmedizin in Deutschland

⁹ ebenda

¹⁰ Stolzenberg; ebenda

¹¹ ebenda

communicate with women who plead for their unlimited right to medical manipulation? Who stipulates what women-supportive and women-oriented health care is? Does the women's movement in its entirety have ethical paradigms that can and want to limit what in the meantime has become medically feasible? Does an "informed decision" and, as a consequence, an equally informed "act" legitimise every treatment? As early as the end of the 1980s, writers such as Anna Dorothea Brockmann, professor at the University of Bremen, pointed out the inconsistency in the concept of self-determination. Discussions about the link between self-determination and self-responsibility need to be developed further.¹²

- What does this mean for the cohesion of the women's health movement?

Do we accept women who make use of services in the medical and pharmaceutical industry as emancipated? Do we sink into incapacitating insinuations if we want to erect hurdles and bans with the argument that these women did not know what they were doing? The traditional topics of the women's health movement: critique of medicalisation, development of women-oriented health care, self-determination, self competence, wholeness ... what do we view as ideologically correct in today's world, in which it is possible to determine whether to utilise modern medicine or not? In my opinion, we have no sufficiently good answers yet to these questions.

- Medicine is not Everything

Using several examples, I have shown in my talk that women-oriented health care is dependent on how a society defines the life framework of women, and also how women actively utilise and help create socially-stipulated structures. Health therefore requires more than just the provision of sufficient medical care. Our health is maintained and determined by all the social, political, and ecological areas of our lives: by our family and social ties, our participation in paid employment and by a women-oriented social and health care system created with the help of women.

- Women's Health Demands Women's Health POLITICS

Although the recognition that "society determines health" is an accurate and important fundamental statement, it is imperative in practice for women to participate in socio-political processes of recognition and decision-making processes. It would be illogical, after critical and correct analysis of social influences on the life of women, to continue to leave to others the solving and reorganising of these connections, or to search for one's own individual solution. If the strengthening of inner certainty and physical potency is to remain on the level of individual development, and no concrete connections to outer factors of influence are to be established, we only manage to create personal space in which to relax. In the end, however, this does not lead to a change in the conditions causing the situation, but contributes to their stabilisation.

An ineffective social disassociation from the promises made by the pharmaceutical industry, e.g. against the latest development in prenatal diagnostics and reproductive medicine, or against a suggested guarantee of health by hormone replacement therapies, does not represent an alternative in women's health policy. And the direct path from discontent to individual satisfaction, e.g. by alternative healing treatment or alternative medicine, leads us into a depoliticising dead end and leaves the historical path of the women's health movement. Definite, systematic participation in political information

¹² Brockmann, Anna Dorothea;1998, Gehört mein Bauch mir? Die Herausforderung des Selbstbestimmungsbegriffs durch die neuen Reproduktionstechnologien, manuscript

processes and decision-making processes in health policy, in the broadest sense, is imperative. The women's health movement requires political weight in order to demand this and to make the connections and effects of health policy measures transparent and comprehensible:

- The "Supportive Environments for Health" Approach of the WHO

This topic was repeatedly discussed at international women's (health) conferences in Cairo, Beijing, and Vienna, and was defined as a desirable objective.

The political approach of gender mainstreaming, which can be of assistance to us in the question of the further development of women's health politics, was also generated there. This concept involves the structural anchoring of equal opportunities as a prerequisite for health in all areas of work and life. The term 'gender mainstreaming', which was coined in 1995 at the fourth women's world conference in Beijing, means that politics should include the perspectives of the gender relationship and should be used to promote sexual equality in all political fields and decision-making processes.¹³

Since the ratification of the Treaty of Amsterdam in 1996, the European Union obliges its member states to act according to this principle. However, examples of its actual implementation have yet to be seen.

- The women's health movement does have political clout!

In Germany, the women's health movement is a workable network, which critically comments on processes in the health system and provides impetus for alternative decisions of thinking and acting. We should extend and expand existing contacts and networks, and build more coalitions for definite purposes, as shown in the following example:

In 1997, a joint conference on "The Hospital as a Working Place" was held by the "Bremen General Medical Council", the "Local Hospitals in the State of Bremen", and the "Bremen Central Office for the Realisation of Equal Rights for Women". The discussions and negotiations between the different positions of interest led, among other things, to an agreement that further medical training at hospitals in Bremen has to be implemented with more transparency (due to the discrimination of women, who, because of existing balances of power, require longer periods of training). There was also a consensus that working and acquiring specialist qualifications needed to become more compatible with bringing up children for both parents. (14) Even though this is just a minor example, it does, however, enable us to look at a field of life that is frequently omitted from the debate on women's health policy: women's workplaces. Many workplaces reveal structural discrimination against women with regard to health. It is hardly surprising that EU committees are currently dealing with the subject "Sexual Discrimination of Woman in Gainful Employment".¹⁴

- The women's health movement has achieved a great deal through its active and goal-oriented participation in social events. This is due to:
 - the public debate on taboo subjects,
 - the provision of alternative, women-oriented health care,
 - the influence made on legislation and the use of § 218,
 - expert interference at all political levels - in work with the professions and professional associations, e.g. in training guidelines,

¹³ cf. Friedrich Ebert Stiftung; 1996, Was ist Gender Mainstreaming

¹⁴ Bremische Zentralstelle für die Verwirklichung der Gleichberechtigung der Frau; 1997; Über Hürden und Hindernisse in der ärztliche Weiterbildung; documentation from a conference

- participation in women's studies and teaching at universities,
- and conspicuously critical statements on reproductive medicine. The demands of women and the issue of gender are increasingly taken into consideration as criteria.
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In the meantime

- reports on women's health have been written at national and state levels.
- the Bündnis 90/ die Grünen and the SPD have submitted a parliamentary question on "Women-specific Health Care".
- the Federal Ministry of Health organised a symposium on "Reproductive Medicine in Germany", during which representatives of medical science and practice, research, ethics, law, social scientists, and the spectrum of critical voices came together and discussed the issues.
- at the request of the parliamentary parties of the SPD, CDU/CSU, Bündnis 90/ die Grünen, and the FDP, the German Bundestag has ordered the establishment of the enquete commission "Law and Ethics of Modern Medicine".
- an increasing number of female researchers are involved in women's research.

The integration of the topic "Violence Against Women" has also come to fruition, long after the subject had already assumed an important role in Great Britain. While the city of Glasgow, for example, can demonstrate an action programme against violence towards women, which is integrated into its local health concept, the process experienced problems when it was introduced - by women - in Germany. In the meantime, there are diverse local concepts and a federal prevention plan. Also the German Society for Obstetrics and Gynaecology (DGGG) dealt for the first time with the centrally positioned subject of "Violence towards women" at its academic congress in June 2000.

The fact that the DGGG has become involved in the subject of violence could have been viewed as progress, if they had not repeatedly claimed that at last somebody was dealing with this socially explosive topic. In fact, they demonstrated annoying ignorance about the long history of women's (health) centres that assist battered women.

In Bremen, we have tried to combat the deficits of doctors, and the ignorance of funding agencies regarding the universal only symptomatic treatment of female victims of violence, by putting forward a targeted training curriculum for doctors. Such training should be obligatory in the training regulations.¹⁵

All this would not have occurred if women had not followed women's health policy goals with solidity and intelligence, with perseverance, and precisely thought out, pragmatic ideas. The public health service acts (ÖGDG) of some States also show signs of women's influence.

- Using the example of the Bremen Forum for Women's Health, I would like to demonstrate the special importance and working methods of a regional, in this case local, network of women's health interests. Forums and round tables for women's health have already been recommended as good practice by the German Convention of Municipal Authorities. They have already been implemented in some regions and many towns and cities of German, or are currently being developed. The

¹⁵ Bremische Zentralstelle für die Verwirklichung der Gleichberechtigung der Frau, 1998; Sexuelle Gewalt – Ursache für spezifische körperliche Beschwerden von Frauen und Mädchen

Bremen Forum for Women's Health, which was founded in 1994, is a plenum consisting of representatives of women's projects, advisory offices, educational institutions, midwife associations, clinics, companies, employee associations, and authorities - all from the fields of health, education, science, and research. Women experts take part as professionals in their respective fields of work, but also as women who are personally affected, who consume, are treated, and are part of a "target group".

Interdisciplinary aspects of women's health are discussed on this expert committee. Moreover, women-friendly alternatives in health provision and in advising politicians are developed and passed on. In such discussions, topics are taken up that, in the opinion of women, have not yet enjoyed much attention in health policy discussions, but which are of critical importance to the provision of women's health. These also include factors that influence the health of women, such as discrimination in the workplace, poverty, as well as sexualised language and advertising, psychological violence, and the consequences of migration.¹⁶

The Bremen Forum for Women's Health represents just one sector of the political work within the women's health movement. Its organisational structure is just one example of organised participation, an important asset for future policy.

Other active sections of the women's health movement include:

- women's health centres,
- activists concerning pregnancy and birth, such as midwives and obstetricians,
- Pro Familia institutes and advisory centres for family planning and abortion,
- the working group "Women's Health in Medicine, Psychotherapy and Society" (AKF),
- the National Network of Women's Health,
- Reprocult - the women's forum for reproductive medicine,
- a growing number of round tables and forums throughout Germany,
- women's representatives and regional authority co-ordination offices for women and health,
- educational institutions,
- staff associations,
- and many others.

I believe that it is important in the future not to limit oneself only to searching for alliance partners in a narrowly defined field of health care. Numerous political developments and decisions have both direct and indirect health-related consequences: health policy is a cross-sectional task. It is relevant to education policy (for example, healthy schools), to domestic policy (women refugees who have suffered genital mutilation, war refugees from Kosovo), to labour policy (not only in the medical professions), etc., as well as to town planning policy. Many "healthy city" projects have already demonstrated the significance of health policy in town planning.

¹⁶ Bremische Zentralstelle für die Verwirklichung der Gleichberechtigung der Frau; 1999; Umsetzungsstrategien für eine Gesundheitspolitik für Frauen; Essay

- Bremen Beginenhof Model

I would like to point to the Bremen Beginenhof model as an example of a completely autonomous and pragmatic town-planning project. The Beginenhof model is a housing, business, and future-oriented project for women of all ages who wish to improve the quality of their daily life, who dare to undertake innovative initiatives, and who want to open up future areas to women. According to the principle of affinity, a process of mutual support is to be initiated, which makes use of the many potentials women have for one another. The Beginenhof model, which is an Agenda 21 and a Bremen-based EXPO project, is a true-to-life example of human ecological living, which seeks to realise exactly those principles named by the WHO as the health-promoting factors: well-being from a physical, mental, social, ecological, and spiritual point of view in a community that offers possibilities of self-realisation. The vision of younger and older generations living together in harmony is to be realised, loneliness is to be avoided, and a women-friendly town culture is to be realised.¹⁷

When I look back at the results of the women's health movement in recent years, I discover that we have set realistic and, in many areas of health care, women-friendly standards. Also, a vital discussion on possibilities, limitations, and ethical repercussions of medicine is taking place. However, there have never been and there never will be simple solutions. The problem areas have now changed - but the number of problems remains the same. Interdisciplinarity in analysis, comprehension, and in the development of competence in health care and in practice is necessary for all structural changes to the health system. No one specialist discipline alone can state its explanation and treatment claim. Nevertheless, interdisciplinarity cannot be prescribed. It is a process of esteem that needs to be developed, a process of finding a common language, etc. Women have long taken this path in many places and in many different ways.

¹⁷ Bremer Beginenhof Modell; Langenstrasse 52-54; 28195 Bremen

The European Women's Health Network - EWHNET

Katja Eichler

The European Women's Health Network (EWHNET) is a project in the Fourth Medium Term Community Action Programme on Equal Opportunities for Women and Men (1999-2001) and is financially supported by the German Federal Ministry for Family Affairs, Seniors, Women and Youth (BMFSFJ). The EWHNET was founded in 1997 and since 1999 it has been co-ordinated by the Landesvereinigung für Gesundheit Niedersachsen (Association for Health Promotion in Lower Saxony) in Hannover. The network aims at promoting equality in the health system by increasing the visibility of women's health needs. It works to give public recognition to women-friendly approaches in health care and health promotion. A central component of the network's activities is the documentation and dissemination of models of good practice.

Organisation

EWHNET is characterised by interdisciplinarity and multiprofessionality; its membership includes medical doctors, psychologists, midwives, nurses and social scientists. Member organisations include women's health centres, research institutes, non-governmental organisations and representatives of public health institutions/facilities. Women practising in the field of women's health and the decision-makers of different institutions and political parties are addressees of the network. As of September 2000, the network consisted of representatives of organisations from ten European countries: Denmark, Germany, Finland, Greece, Great Britain, Ireland, Italy, Netherlands, Austria and Sweden.

Why a European network for women's health?

The starting point for the foundation of a women's health network were the results of women's health research. Women and men differ in their health status and behaviour as, for example, in regard to the incidence, prevalence and types of diseases and symptoms, communication styles (e.g. in communicating with the doctor), coping strategies in regard to stress and the medical care they receive. The health system is characterised by gender bias. The consequence is that it is partly orientated to the health needs of men and that gender-related differences are often ignored or stereotyped. On the other hand, in some fields there is unnecessary treatment. As a consequence the health needs of women are not adequately considered. For the representatives of EWHNET, women's health is not a purely medical concern but also a socio-political issue that must be viewed in the context of political structures and socio-economic factors.

The perception of health/ill-health as well as the thematic foci vary according to different social, historical and cultural circumstances. The aim of EWHNET is to understand and show the specific situation in each of the countries and to achieve a communication process across borders, which makes an exchange of good practice and successful strategies possible. This reveals possibilities for making the health needs of women visible Europe-wide and to promote their consideration.

Fields of Activity and Dimensions of Women's Health

The work of EWHNET is based on a social model of health following the Ottawa-Charter of the WHO (1986). Socio-economic factors, life-style and living conditions are considered central determinants of women's health. This includes, for example, inequality in regard to economic and professional chances, stress from multiple roles, lack of social acknowledgement as well as the grade of self-determination in regard to health issues. EWHNET promotes a social model of health as a guideline on regional and local levels and a salutogenetic model - the question of how health can be maintained instead of how disease can be avoided.

The Ottawa-Charter (WHO, 1986) defines five levels of activity for health promotion. In regard to women's health this means:

"Build Healthy Public Policy": implying that gender-specific approaches have to be brought to the focus of political decision-makers in all fields.

"Develop personal skills" including

- developing self-esteem and self-determination in regard to health issues
- empowering women to make personal decisions on health issues based on informed consent
- indicating the provision of adequate knowledge
- promoting a resource-orientated approach, which may initiate empowerment-processes for women and the demedicalisation of women.

"Strengthen community action" meaning

- the promotion of women's networks in communities and
- the promotion of self-determination of women in neighbourhoods in order to achieve autonomy and self-control in regard to health issues.

"Reorient health services", transferred on women's health, means

- to develop gender-sensitivity in the fields of health promotion and care, rehabilitation and health planning.

"Create supportive environments" embraces

- the creation of safe and comfortable working and living conditions for women
- taking into account the consequences for women of measures in urban and ecological planning as well as in leisure time organisation.

Activities

Models of good practice which contribute to women's and girls' health are identified and imparted by the EWHNET partners. In regard to this, the reports, which are produced by the network partners of the represented countries, play a central role. They contain information on the national health systems, on the development of the women's health movement, as well as in-depth-contributions on relevant topics. EWHNET initiates working groups with women working intensively on special topics and detailed transnational guidelines. Currently working groups on the topics of health promotion for girls at school, women-friendly psychotherapy, and women, work and health; are active. A further central aim of the network is to improve the dialogue between representatives of northern and southern European countries. In this context a "Dialogue-Workshop" has

already taken place. The representatives of EWHNET foster contacts to organisations that undertake lobbying activities on a European level and in this way bring an influence to bear on decision-making processes in political institutions. For the coming project year a number of new activities is planned, including among other things the development of a trainee-exchange-programme that aims at enabling women who are active in the field of women's health to directly experience models of good practice and to test their applicability in their own work context.

The representatives of EWHNET regularly come together in transnational meetings for the co-ordination of activities.

Women and Health in Glasgow

Sue Laughlin - Women's Health Co-ordinator, Greater Glasgow Health Board

Alison Miller - Counselling & Groupwork, Centre for Women's Health

This presentation aims to summarise the development of work in one city, Glasgow, where a strategy for women's health has been established. It will highlight the essential relationship between this strategy and the practical work that has followed as a consequence of the strategic work by examining the work of the Centre for Women's Health in general and how it has worked specifically on the issue of gender-based violence. The presentation will also consider the factors which make the work potentially replicable elsewhere.

In 1983, a group of women working within the health authority, the local authority and voluntary organisations (NGOs) came together with community activists to organise a health event for women which explored a number of issues important in women's lives and the likely implications for their health - employment and unemployment, women's social role, food and exercise, family life. The event attracted 6000 women from a broad geographical area, demonstrating the demand by women to meet and consider their health in the broadest context. It was followed up by numerous smaller events in local communities and started a process of dialogue between women professionals and women users of services in the city.

Subsequently, different groups of women coalesced around a campaign to extend the meaning of women's health and to improve the nature of health provision for women. The campaign lasted for a number of years and despite the usual difficulties of campaigning, there were two enduring outcomes. Firstly, it helped to redefine the traditional model of women's health. Secondly, a Centre for Women's Health was established in 1993, funded by the health authority and the local Council in recognition of its relevance to both health and local government services.

At the same time as the activity to address women's health concerns, Glasgow embarked on its involvement with the WHO Healthy City movement. The work to raise the profile of women's health, operating mostly informally, was then able to gain more formal recognition by becoming part of the Glasgow Healthy Cities Project. This acknowledgement facilitated a multi-agency group to bring forward a Women's Health Policy for Glasgow. Launched in 1992, after a comprehensive consultation, the Policy was adopted by the Healthy City Project partners which included the health authority and the City Council. A second phase of the Policy was relaunched in 1996 to address gaps in the original document.

The Policy is based on three underlying assumptions about the key determinants of poor health in women, namely, women's complex reproductive system, sex and gender differences in general health problems and the impact of the experience of gender inequality in society. The emphasis of the Policy has been to introduce organisational change rather than focusing on women's health behaviour, as highlighted by the four objectives of the 1996 version of the Policy:

- to increase awareness and understanding of the factors which affect the health and well-being of all women in Glasgow

- to shape general policy development, planning and service delivery to improve the health and well being of women
- to ensure structures within organisations which take account of the factors which affect the health and well-being of women
- to ensure that the key issues identified by women - which included poverty, the physical and social environment, mental health, women as carers, the needs of black and ethnic minority women, disabled women and lesbians - are addressed as priorities

Implementation of the policy has varied across the partners of the Healthy City Project according to the extent to which there is formal recognition of health as being part of their core business. Not surprisingly, it has been easier to carry forward within the health service especially in view of many recent changes in local government in Scotland. Although developments within the health service should be viewed as positive, this has arguably distorted both the processes of change and its progress.

Overall, progress on the policy falls into six main categories: the establishment of organisational structures by the Healthy City partners with responsibility for facilitating implementation of the Policy; making some services (particularly pre-existing community health services for women and sport and leisure facilities) more women-sensitive; the production and dissemination of information and resources for women and about women's health; making and consolidating links with communities and groups of women; the establishment and funding of a model project, the Centre for Women's Health; and comprehensive activity aimed at tackling violence against women. All of these areas of progress do however remain under constant threat and require considerable effort to maintain at an effective level of activity.

The nature of both the Policy and the way of working in Glasgow have been adopted by the World Health Organisation as a model for Europe although the challenge is to work out how to introduce this approach across Europe.

- **Investing in Women's Health**

Investing in women will not only have a positive effect for women but for the population as a whole, through a reduction in inequality. There is a need to make women's health a priority because of the effects of disadvantage and discrimination that women experience.

- **Social Model of Health**

This highlights the need to take a view of women's health which recognises its social, economic and environmental determinants. It seeks to emphasise the significance of women's poverty on health. This view of health recognises the biological factors which affect women, but places them in a broader framework.

A social model of health also helps to show that women are not all the same and highlights inequalities which exist between different groups. The Glasgow model therefore emphasises the need to examine the specific needs of black and ethnic minority women, disabled women and lesbians, and develop appropriate responses.

- Consultation and Participation

Women have limited access to decision-making and may have limited opportunities to define their health needs. There is a need therefore to develop and implement processes which allow women to actively determine the agenda for promoting their health.

- Interagency and Organisational Development

Liaison and co-operation with a range of organisations willing to take the lead in implementing policy is very useful. This is a prerequisite for the effective planning and delivery of all services which have an impact on health.

- Strategic Framework

It follows from the above that a strategic framework with the following elements is required:

- women's community development to help articulate health concerns
- a forum for women's health which brings together statutory organisations, NGOs and community groups to identify priorities
- women's health policy development and implementation
- organisational structures and systems which raise awareness and facilitate data collection by gender, gender monitoring and gender sensitive planning
- a centre for women's health to try-out new methods of responding effectively to women's unmet health needs
- research and development of indicators of women's well-being.

This work may appear very abstract but we argue that without this challenge to the existing male dominated approach to policy making and the traditional approaches to health and without the structures to make lasting change we will never make a significant difference to the health of women. The next part of our presentation will focus on one of the practical outcomes of the Women's Health Policy.

The Centre for Women's Health forms one strand of the strategic work of the Women's Health Policy outlined by Sue.

I want to give you a very broad outline of the work of the Centre for Women's Health and then to focus on a specific issue, domestic violence, to illustrate how the work we do directly with women links to the strategic work Sue and others are engaged in.

The Centre for Women's Health was opened in 1994 in a building in the centre of Glasgow. Its aims are:

- To provide a health promotion service run by women which responds to the unmet needs of all women.
- To provide a training centre for statutory and lay workers in order to increase their understanding and practice of women's health.
- To assess the feasibility of existing services encompassing the model of interagency practice in the provision of women's health services.

The services we provide directly to women are:

- 'Listening Ear', i.e. one off counselling support to women who drop in to or phone the Centre
- Ongoing one to one counselling

- Support Groups
- A library of books relating to a wide definition of women's health
- A database of organisations providing support and information for women
- A creche for children

Because we are aware that women are not a homogeneous group, as well as trying to address the needs of women in general, we also target specific groups which tend to be marginalised and poorly served by mainstream services. These groups are:

- Black and ethnic minority women
- Women living in poverty
- Lesbians
- Disabled women

We particularly address in our services issues which affect women because they are women:

- Low Self Esteem
- Eating Disorders
- Child Sexual Abuse
- Domestic Violence etc.

Our approach to improving women's health then happens on three levels:

- The strategic level:
influencing policy and decisions at organisational level
- Working with workers:
through training and consultation, supporting workers to offer a better service to women
- Working directly with women:
Consulting women about their needs and providing services that attempt to address those needs

I think this can best be illustrated by taking one issue, domestic violence and showing how the work at the three different levels interact with each other to create a more integrated approach.

- The Strategic Level

The Women's Health Policy highlighted responding to women experiencing domestic violence as one of its priorities. Greater Glasgow Health Board (GGHB) and other statutory and voluntary organisations agreed to the priorities identified in the Women's Health Policy. A Women's Health Policy Working Group was established, which in turn set up a sub group on domestic abuse. When the Health Board set up Health Gain Commissioning Teams (HGCT) to address the needs of particular areas, the Women's Health Policy Working Group (WHPWG) Sub Group on Domestic Abuse lobbied for a HGCT on the issue of domestic violence, the only issue based HGCT.

The WHPWG Sub Group on Domestic Abuse formed the core of the new HGCT on the Treatment of Abused Women. Having domestic violence accepted and acknowledged as a public health issue instead of simply the personal and private experience of some women had considerable implications for its potential to be addressed within health settings.

Research was conducted in particular health settings, which highlighted various needs, both in staff and women affected by domestic violence.

- Work with Domestic Violence

Domestic Violence (DV) provides a good example of the approach we have taken to women's health in Glasgow. Up until fairly recently, all the work around DV in Glasgow and elsewhere has been done by Voluntary/Women's Organisations, both offering a service to women and campaigning for change in society. These organisations have certain strengths:

- strong ideological/political analysis
- independent
- commitment to the issue
- driven by direct experience of members
- build up experience and expertise in dealing with the issue
- solidarity/identification with the women they offer a service to
- change public perceptions
- put domestic violence on the political agenda

But there are limitations to the work such an organisation can achieve on its own:

- isolated/marginalised
- relatively powerless
- lack of sympathetic support in national/local government
- lack of funding
- confirm public prejudices

But what of the responsibility to women who have experienced domestic violence in a statutory organisation such as the Health Board?:

While it is common knowledge in women's organisations that women's health, both physical and mental, is adversely affected by violence done against them, it is very difficult to have that view accepted or acknowledged within the statutory services.

Evidence from America suggests that women who have been abused are more likely than non-victims to have poor health. The health service is often the first formal agency that women turn to for help. Despite this, many abused women pass through the present system undetected and there is no reliable information on how often services are used or their effectiveness.

Some of the weaknesses of the health service then are:

- male dominated culture
- medical model, i.e. treat individual injuries/ignore the causes
- lack of recognition of domestic violence when women present with injuries or mental health problems resulting from it
- no or very little gender breakdown of statistics
- unwillingness to learn from non medical sources like women's/voluntary organisations

So how do we change that? How can we change the age old culture of the health service? How do we integrate into the mainstream the knowledge that is gained on the margins? With great difficulty!

But in Glasgow we have begun to look for ways in which we can build a strategy that will address the issue of domestic violence and other issues that affect women's health.

So we work if you recall at three levels:

- strategic
- working with workers
- working with women

These are some of the strategic factors that allowed us to take this work forward:

These strategic and environmental factors allowed for the first time for funding to be identified and released for work with the health effects of domestic violence on women.

Working with workers and providing a service to women: the role of the Centre for Women's Health

Much of this work has been undertaken by my colleague Kate Munro from the Centre for Women's Health along with Siobhan McCartney and more recently Katy Cosgrove from Sue's team, the Women's Health Team in Public Health.

This has involved them in:

- gathering evidence
- involving and consulting women's/voluntary organisations
- creating guidelines
- training staff
- piloting services
- evaluating services

Evidence gathering Audits of Accident and Emergency (A&E) and Family Planning:

- establishing numbers of abused women attending
- finding out current practice in managing/treating abused women
- developing and writing good practice guidelines
- developing and delivering training programmes to explain the good practice guidelines
- monitoring and analysing the effect of good practice guidelines on patient care

In her work, Kate has been involved in offering training in good practice for domestic violence to General Practitioners (GPs), Midwives, Dental Hospital Staff, Family Planning, Well Woman Clinic Staff, A&E staff.

To finish this part of our presentation, I want to look at the newest piece of work to come out of this. In December this year the Health Board will begin a pilot project aimed at providing a service to women who come to an Accident and Emergency Department with injuries sustained through Domestic Violence. The Centre for Women's health has a key role in this.

- Accident and Emergency Pilot

The aim is to provide and test the effectiveness of a support service for abused women on site in an Accident & Emergency department. During the evidence gathering phase, A&E staff said that a big problem for them is having no one there at the time that most women come in with injuries from domestic violence, i.e. in the middle of the night, at the

weekend, when all other support services are closed. Because of the strategic work it has been possible to get funding to offer a service tailored to the needs of abused women in a Health Service setting:

- Training and Induction for A&E staff
- Adequate funding to pay support staff
- Appropriate setting on site in A&E
- Appropriate times 8.00 pm - 8.00 am, Fridays and Saturdays
- Appropriate Service
- Counselling: liaison with A&E staff
- Support: support for A&E staff
- Advocacy: liaison with housing, police etc
- Follow up support: information
- Appropriate staff drawn from women's /voluntary organisations
- Monitoring and evaluation

It is the evaluation of projects like this that then feeds back into the cycle of discussions about where money should be spent within the health service. In this way, Domestic Violence becomes a public health issue and not just the individual misfortune of individual women or simply the concern of groups on the margins.

We believe that the Glasgow approach has much to contribute to the women's health movement but in order for it to do so, it is helpful to consider some of the factors that have contributed to its progress.

Firstly, the work has undeniably been aided by the presence of advocates with sufficient status to have some influence in both the health and local authorities and their persistence in trying to find avenues to raise and promote a women's agenda. Secondly, the struggle for change has combined, for much of the period under consideration, action from within organisations with pressure from women's groups outside, much of it co-ordinated through the Clydeside Women's Health Campaign, exemplifying the role of lobbying and campaigning by the population group concerned. A third factor has been the ideological perspective of women's health which has linked women's oppression with women's health in a different way, than the traditional interest of the women's health movement with women's rights within the medical system and the demedicalisation of women's reproductive health problems.

A fourth consideration is the development of a strategic perspective which focused on multi-agency organisational development rather than seeking behaviour change amongst women or placing the sole emphasis of change in the practice of individual practitioners.

The nature of the demonstration project (Centre for Women's Health) has played a key role in that it has sought to integrate service provision aimed at meeting women's unmet needs with a strategic function which attempts to inform mainstream service delivery to respond more effectively to women's health needs.

The last factor has been the local and national struggle for public recognition of the abuse of women by men. Until recently this struggle has co-existed with the work on women's health more generally but there has been a gradual coming together over recent years as the poor health associated with violence has become more apparent helping to highlight the link between women's health and the experience of gender inequality.

It is however worth noting the general environment in which the work in Glasgow has been operating. Unlike some other countries - Australia and Canada for example - there has been and is still no national policy, either in the UK or in Scotland, for promoting the health of women which recognises the social context of women's health. Undoubtedly, this can be partly attributed to inherent sexism within Government ministries with responsibility for health and associated issues despite sporadic attempts to raise the profile of women's health and the new interest in gender mainstreaming.

The "Women's Health Centre" in Russia

Tatjana Schipulo - "Russia's Women", Moscow

Dear Colleagues and Friends,

First of all, in the name of the Russian participants in this forum, Ms Marina Chabarowa and myself, I would like to thank you all for extending an invitation to us and for your solidarity and support of our work on "Women and Health".

The previous ten years have been extremely complicated for Russia. The transition from a centrally controlled economy to a market economy led to far-reaching political and social changes. One of the main obstacles to becoming a fully operative market economy was the rapid, but insufficiently thought through process of privatisation, leading to the new owners dealing irresponsibly with former state property.

The reforms carried out in Russia led to a rapid increase in unemployment, particularly among women (64 per cent of the officially unemployed are women; whereby regional differences also play a large role: in the Tatar Republic and the Republic of Gorno-Altai, for instance, unemployment among women has reached 70 to 80 per cent).

Women were only rarely involved in the privatisation process; women are now predominantly employed in badly-paid sectors, since typically female professions, such as medicine, teaching, and university teaching, have traditionally, even in times of the former Soviet Union, been badly paid. Men are accepted more quickly into the private sector, whether in private schools or private clinics, etc. women often earn less than men.

Women, whether they are post-graduates or have even earned a PhD, or whether they have only attended primary school, are predominantly employed in small- to medium-sized enterprises. Furthermore, the majority of all employees in this sector work in the black economy.

Major changes are taking place in the economic, social, political, and cultural areas of life. Unfortunately, the high speed of economic reforms is not accompanied by corresponding changes in the social sphere. This affects the absolute majority of the population. The underprivileged classes now find themselves in a precarious situation. These classes include pensioners, most of whom are women, since the life expectancy of women is about ten years longer than that of men (at the beginning of 1999, the life expectancy of women was 73, while men were expected to live to 61; compared with 1995, when women reached the age of 72, and men lived to 58).

The State delays the payment of wages, child benefit, and pensions, at a time when countless state enterprises have been closed down or sold to the private sector in the course of the economic reforms, leading to unforeseen mass unemployment.

In the health service, the following tendency can be ascertained: a private health service is coming into existence alongside the general state system. If Russians have a certain amount of money at their disposal, they can obtain the highest quality medical care and medicine available. At the same time, the best doctors have defected to the private sector. There is a considerable lack of specialists (including dentists, endocrinologists, and urologists) in the public sector. Patients have to wait a considerably long time for

medical care. Many types of medicine, which were and still are only produced abroad, have become too expensive. These include insulin, gynaecological and cardiac drugs, as well as hormones.

The present economic situation means that it is no longer possible for the State to buy up medicine and distribute it free of charge or at a reduced price to those who regularly require it. The supply of medicine that is produced in Russia is equally dependent on world-market prices, since most ingredients required come from abroad.

The total cost of the health service in Russia amounts to between two and three per cent of the gross national product. The World Health Organisation recommends that between six and nine per cent be spent on health. The consequence was a reduction in the share of public spending on medicine. Moreover, forecasts for the years 2000/2001 predict a reduction of the pharmaceutical market in comparison with 1997. Less and less medicine is being imported into Russia, including contraceptives and hormone preparations. This makes the position of population groups consisting mainly of women: (pensioners, the disabled, and parents with many or disabled children) particularly more difficult.

It is possible to imagine a pyramid, the top of which consists of a small group of people who are in a position to provide decent medical care for themselves and their nearest of kin. The middle section of the pyramid comprises mainly the intelligentsia, who are very aware of health issues. Members of the intelligentsia take care of their health, and that of their children and dependants by not limiting themselves to the public health sector, but also occasionally turning to the private sector, for which services must be paid out of their own purses. The third group, situated at the base of the pyramid, consists of those people with the lowest income: pensioners, recipients of state benefits, the unemployed, and refugees.

As a consequence, the state of health service is becoming increasingly complicated. We are experiencing the reoccurrence of diseases that were presumed eradicated in the 1920s in Russia. These usually have a social component: tuberculosis, sexually transmitted diseases, alcohol and food poisoning, caused by the low quality of goods. Maternal mortality is extremely high (44 deaths per 100,000 in 1998), as is the occurrence of severe illnesses among pregnant women (anaemia, circulatory disturbances, late toxicosis, thyroid disorders).

Conditions for women in the health service are catastrophic. Abortion remains the main form of contraception. Two abortions are carried out per birth. Mother and child mortality is very high, and the number of alcoholics and drug addicts, as well as AIDS patients, is continually rising.

Women's organisations must therefore make the issue of women's health their top political priority. Around 300 family planning clinics have been established in Russia in extremely difficult circumstances. Their main objective is to put taboo issues, which until now women have dealt with on their own, into the political arena, enabling work in this area to be focused on prevention and education, rather than on consequences.

The founding and activity of these centres come up against numerous obstacles: criticism by the Orthodox Church, communist, and nationalist organisations, and the activity of the American organisation "Pro Life", for example, in the press.

Moreover, there is a rapid deterioration of the demographic situation in Russia. The population has decreased by 2.6 million in 1993, to 145.7 million inhabitants at present. There is a tendency to attribute this fact to the activity of family planning clinics, and to insinuate that they are aiming to drive the nation into extinction. Unfortunately, the media also tends to find a culprit for every evil, and these are often those who were involved in establishing family planning clinics in Russia. Just one example of this is Ms Ekaterina Lochowa, member of the Russian state Duma, and director of the democratic organisation movement "Russia's Women", who has been attacked for her activities.

Many organisations, which are members of the Movement "Russia's Women", are involved in this area. There are a number of organisations, run by doctors and gynaecologists, which explain the necessity of educational work in all sectors of the population, in particular for the young.

The director of one of these member organisations of the "Movement Russia's Women" is Ms Marina Chabarowa, a doctor who has already participated in several women's seminars in Germany. This gynaecologist has brought attention to herself through her work with schoolchildren. During work at the family planning clinic in the City of Tambov, it became obvious that both parents and teachers need to be integrated into the process. In fact, a general consultation with a certain doctor became an educational opportunity (50 to 60 patients per consultation!). It soon became apparent that such talks at school needed to be separated according to gender, and that it was better to have such conversations outside the school and the doctor's practice - which led to the search for a suitable location.

Due to the knowledge of organisations that are dedicated to women's and girl's issues in Germany, the desire arose to combine social and professional activities outside the state, i.e. a very regulated, system of medical care. Meetings with activists in the City of Tambov indicated that there is an interest in the issue of women's health in all age groups. It also became clear that information on the health of women over the age of 50 regarding healthy nutrition, the fight against osteoporosis, prevention of breast cancer, and modern hormone contraception, is fully inadequate.

Following regular meetings and talks with specialists, including German participants such as Claudia Czerwinski, an idea gradually came into being to found a women's centre within the framework of a private gynaecological practice. We believed that it was an opportunity to carry out public relations work on the subject of "Women and Health", which in no way excludes the work of self-help groups run by various social organisations. The founding of the centre, and the acquisition of a room would not have been possible without contacts to local organs of power.

In our opinion, the subject "Women and Health" is one of the most significant issues for the women's movement. We require social centres for "normal" women and girls, and not only fitness centres for the rich. This is why the experiences of European women's health centres are of great interest to us, especially the aspect of working with all age groups - from young girls to elderly women.

Educational work in the area of sanitary conditions and hygiene stopped around ten years ago in Russia. The issues that need to be discussed and elaborated on are therefore manifold. The following factors have also contributed to this:

1. behavioural stereotypes have fundamentally changed (earlier contacts with the opposite sex, late marriage, the increase of couples "living in sin", the high divorce rate);
2. high incidences of migration among the population;
3. increase of drug and alcohol addiction, AIDS, tuberculosis, and sexually transmitted diseases;
4. deterioration of the economic situation of the majority of the population and, as a result, a deterioration of nutrition;
5. the range of new types of food and medicine available.

The centre in Tambov hopes to take up youth work within its family planning programme. It is becoming an important factor in the development of sexuality, which, in our opinion, is one of the most significant requirements for reproductive health and sexual equality for women. Ms. Gro Brundland, former Prime Minister of Norway, constantly reiterates that every American dollar invested in family planning saves society 200 dollars in medical and welfare assistance.

The main attention of the "Women and Health" centre is dedicated to the youth (girls, schoolgirls, and female students), as well as elderly women, who are socially and politically active. Many of these women are doctors, teachers, or lawyers; at the same time they act as multipliers who publicly make others aware of the problems.

It is important for us to remain in contact with women's organisations abroad. We would like to be informed beforehand about priorities set in the area of women's health for the years 2001 to 2002, so that we can report about them to women's organisations, or at least (over 60) regional branches of the "Movement Russia's Women".

In the long term, we would like to run a summer school entitled "Women's Health", and other seminars, in Tambov.

Currently, our largest problem is publishing reasonably priced material, adapted to Russian conditions of living, on the subject of women's health. Financial assistance is required for high-quality translations of the cassettes, films, and literature that are used by women's centres in Western Europe. We appreciate any practical advice and concrete assistance that our colleagues from other countries are able to grant us.

Combined with our thanks for the hospitality we have experienced, we hold the hope that our contacts will contribute to understanding between our people in future, since contacts made by women are equally important as contacts made by the politicians/men of our country.

Promoting Women's Health in two Settings: Aletta, Netherlands Centre of Women's Health Care and the NSPH Unit Gender & Health

Lea den Broeder

I'm very pleased to be invited here to tell you something about Dutch experiences in women's health.

When I talk about the women's health movement in the Netherlands, first of all we must realise that there are a number of approaches towards women's health, each with a different perspective on the health issue. At the universities we have women's studies in medical science and research. There is the patient perspective approach: a self help movement which developed outside the regular medical mainstream. People involved in policy making have developed ideas and aims concerning women's health. Last but not least there are groups and organisations who work in implementation. They are the bridge-builders between the other three fields and the regular field of health and health policy.

It is this last category I want to talk about today.

I will focus on two examples; firstly, the Netherlands Centre for Women's Health Care Aletta, which existed from 1980 up to 1999, and secondly the Unit Gender & Health of the Netherlands School of Public Health, started up in 2000. Apart from many other differences between the two, it is important that Aletta was an autonomous organisation centred around the topic women's health, while the Unit is part of a regular organisation. However, in both cases questions about autonomy and mainstreaming come up, as we will see.

Let me take you back in time to the year 1980. A group of women in the municipality of Utrecht, Netherlands, set up a women's health group. They did so because they felt that regular health care did not meet women's needs and wishes. The women criticised the authoritarian way women were treated by doctors and other professionals, the medicalisation of women's lives, and the fact that women's experiences were not taken seriously by health professionals.

Two aims were central for Aletta in this early period:

- Realising an alternative women's health service that matched their needs for empowerment, knowledge, and sharing of experiences.
- Working out a critical glance at health care in general from a feminist perspective.

In these early days the self help approach was very important. Women's groups like Aletta were practising self-examination of the breasts or vaginal self-examination, and thus gained knowledge, but also self-confidence and the capability to speak up for themselves. As such Aletta started as a grassroots organisation, run completely by volunteers.

Aletta's initiative grew fast. More groups were set up, health information for women was provided on a larger scale. Group counselling and individual counselling was carried out in the centre. The 'good practices' developed by Aletta became more and more sophisticated. Aletta's staff and organisation became professionalised. At this stage it was felt that criticising the medical establishment was not sufficient. Criteria for woman friendly health care were formulated and needed to be communicated to the medical field.

This meant that there was a shift from mainly providing services to women towards the policy level. It is mirrored in Aletta's change of name: whereas the organisation was initially called Women's Health Centre, later on it carried the name: Netherlands Centre of Women's Health.

At the centre different activities were carried out. To mention some:

- Developments in the health care field were followed critically and commented upon in different ways: through the press, debates, and by taking part in committees and networks. A good example of this last way of keeping a critical eye on health care was the membership of a staff member in the Dutch Society for Medical Technology Assessment. The centre's staff were often invited for interviews or consultations concerning women's health. Expertise was present concerning many topics such as eating disorders, pregnancy, lesbian motherhood, vaginal discharge, menopause, osteoporosis, coronary heart disease, breast cancer screening, and HIV/STD prevention.
- Health information and counselling for women was provided, both individually and in groups. Files were prepared about many women's health subjects for women patients/consumers to read. There was a telephone line for women with health questions. Informative brochures for women were published.
- In 1984 Aletta set up its own general medical practice. This required courage, for in the Dutch situation it is uncommon that general medical practices are founded without the consent of surrounding practices. Still, the indignation of the other Utrecht general practices was short-lived, and Aletta's practice was well integrated in the municipality, taking part in all activities, and in night and week-end calls.
- Innovative projects were carried out such as developing criteria lists and auditing methods concerning gender sensitivity in care. An example is a project aimed at integrating gender specific health care views in health extension. Research was carried out, interdisciplinary expert meetings and round table discussions were organised, resulting in an informative book describing how gender aspects can be addressed in health extension services and activities.
- Training of professionals such as medical doctors, physiotherapists, nurses, home carer providers and others was a substantial part of the work at the centre. The training activities were highly valued. For example, a project concerning integrating gender specific health care into the curriculum for gynaecologists resulted in an obligatory combined module Psychosomatics, Gender Specific Health Care and Sexology in the gynaecological curriculum.

Aletta was a successful organisation in many respects: the Ministry of Health recognised Aletta as a centre of expertise regarding women's health which gave the organisation a certain status in the health field. Projects were granted subsidies. Project partners evaluated the know-how and skills of the Aletta staff positively and were enthusiastic about the co-operation. In a number of fields women's health views were implemented.

Which factors can be identified that accounted for this success?

- A very important factor was the professionalism of the staff members. Aletta's staff consisted of highly qualified women from the nursing and medical professions, social sciences, and psychology. They were supported by an equally professional office staff. There was a house style in publications, there were fact sheets with short descriptions of each project, and PR materials were developed. The office staff used to make sure that no Aletta staff member would ever go to a meeting without taking some relevant material with her.

- Furthermore, the multidisciplinary nature of the staff guaranteed a broad working field and correspondingly a large network. Especially the presence of medical doctors in Aletta's staff made the entrance into the regular medical field easier. These women knew the 'language' of their colleagues in the regular field. They passed on their knowledge to the other staff members, which enabled them to communicate effectively with physicians.
- Communication with the regular health field worked out well because co-operation with regular health organisations was sought, instead of mere confrontation. For instance, in developing the criteria for gender sensitive gynaecological care mentioned before, gynaecologists, nurses, and social workers from hospitals were involved. A sense of partnership was promoted by taking the opinions, questions, and problems of these regular health workers as a starting point.
- Success on the policy level was promoted by building up alliances with 'influential persons' who supported Aletta's aims. Some well known and highly respected doctors have done important lobbying work for Aletta.
- Last but not least: Aletta was an autonomous organisation, an 'outsider' in the field of health care. This position provided the independence, the space one needs to formulate critical views and develop new approaches towards women's health.

On the other hand, autonomy is relative when an organisation has to rely on government financing. Aletta was for a large part dependent on an annual subsidy by the Ministry of Health. Indeed Aletta's successes led to the Ministry's decision in the mid-nineties that Aletta should cater for itself and start working in a market-conformed way; this was based on the observation that Aletta was a successful and valued organisation, overlooking the fact that Aletta's co-operation projects with regular health organisations had been, for these organisations, free of charge, or at least relatively cheap, for a long time. Although Aletta was given time to implement organisational changes to adapt to the new situation, this shift could not be made easily, and the pressure on the organisation was one of the main factors leading to the closing down of the centre.

Another problem was that structural commitment to gender sensitive health care within regular organisations is hard to accomplish from the outside. An important strategy was to find key persons within those organisations who could function as a counterpart. However, when such a key person left the organisation, the commitment would also diminish.

Thirdly, one of the strengths of Aletta was the concentration of a lot of knowledge and expertise in one place. But it was also a risk factor. The closing down of the organisation in 1998 meant a tremendous loss of human capital.

And last, being autonomous led to a certain level of self-reference within the organisation and isolation from the outside world. This made it difficult to go along with developments in the field of health and to act effectively.

I have just shown you some advantages and disadvantages related to autonomy as a women's health care centre.

The Unit Gender & Health at the Netherlands School of Public Health is not autonomous but is part of a regular organisation in the health field. Some information about the School is to be seen on this overhead sheet: it is an organisation in which 4 universities participate. The school offers postgraduate courses in social medicine and public health. Besides this, it develops and carries out supportive programmes in the field of public health.

Now, what are the differences between the two settings?

- The first difference was the very start of the unit. The unit was set up after the closing down of Aletta. My colleague Leonore Nicolai and I had just started up a project concerning the integration of gender specificity in the training for occupational health physicians and were looking for an organisation to carry on with this project. The Netherlands School of Public Health was interested, being one of the main training centres in occupational health. And as the project was being carried out, a number of persons within the organisation felt that gender should be mainstreamed into more programmes and activities of the school. Most of these persons had some knowledge about, or experience in, women's health or gender specific health care.
- In the same period the Minister of Health brought out a policy letter stating that all health care fields as well as all medical training programmes needed to take gender and ethnicity into account. So there were, at one time, a number of favourable circumstances for setting up a Gender Unit: an exemplary project being carried out, a positive attitude under at least a part of the staff (including - very importantly - the director of the school), and supportive government policy.
- So, it was not the women's health movement itself that took an initiative, but there was a demand from within a regular health organisation itself. Essentially this is what mainstreaming is about: applying gender sensitivity to regular work fields. As such it is also what Aletta was striving for. A success for the women's health movement!
- Mainstreaming, however, is also a process that takes at least years, if not decades. One important matter within the unit is the discussion on how to evolve from being something 'extra' added to the school into an organic part of every process in the organisation. At this stage we are therefore busy developing a gender sensitivity matrix for all levels of work within the organisation: Management, staff, students, contents and form of programmes and activities, facilities, etcetera.. For each level criteria will be formulated. We will then assess the situation and think of actions or changes that might be necessary. The third step will be implementation of these activities/changes. The whole process has to be carried out together with the people concerned - we have to find ways of communicating and working together with people who sometimes might have a completely different frame of reference, or who do not support a gender approach in their particular work area.

In our activities aimed at the field of public health outside the school, our position is much better than before. Our experience is that feminist organisations are often stigmatised as not to be taken too seriously. In fact it took a lot of time and work for Aletta to overcome this problem. The Netherlands School of Public Health is a well-respected organisation and this gives the unit a certain status, which is supportive for our work.

But what about autonomy?

As far as the contents of the work are concerned, there is some autonomy. Since the gender approach is rather new within the school, the unit staff members have quite some room to frame their work according to what they think is important. However, we have to define the work in such a way that it links up with the regular programmes and activities of the school.

At the same time, the unit must submit to structures and hierarchies that exist within the organisation as a whole. Decisions about budgets and staffing are made by the

management. These decisions are not only based on commitment towards a gender approach; there are other interests, such as financial resources and other priorities. Especially in the first time after starting up the new unit the pressure is high here. There is a constant necessity to prove that a gender approach improves the quality of the school's programmes, and that the outside world is interested in the 'products' of the unit (and is prepared to pay for them). This is a rather insecure base for developing the unit.

There is one other aspect linked to autonomy:

In an autonomous women's health organisation the sense of working together to attain certain goals is very strong. There are plenty of possibilities to discuss strategies, celebrate successes, and find solutions for problems or difficulties. Working in a regular organisation you very often get the feeling of being a token woman, being cut off from the women's health movement. I think networking with women in autonomous organisations, or in mainstreaming positions, is a necessary condition to be able to function successfully in the regular setting.

I think this is one of the reasons why this conference is so important: it provides the opportunity to strengthen the women's health movement as well as to support individual women carrying out their work in different settings.

I have shown you two different settings in which work in women's health has been carried out. How do they change women's lives and health?

It is very clear to see how Aletta's work did, since a lot of services were provided straight to women themselves. Aletta also influenced women's lives and health in a more indirect way by the activities in policy development and the training of health professionals. The work of the unit only concerns this second approach. However, since the Netherlands School of Public Health covers such a broad working field I think that a new gender sensitive approach by the school will definitely have a positive impact on women's health. At this stage, we are not yet there. A lot of work has to be done. I have tried to give an overview of the matters and problems we (have to) deal with, and look forward to reactions.

National Women's Council of Ireland

Audry Deane

Irish Health Care System

Everyone in Ireland is entitled to free hospital care under the public system. Procedures and operations are organised on a waiting list system. The current status of hospital waiting lists is a grave cause for concern so much so that 1.6 million Irish people are bypassing the public system and taking out private health insurance which is tax deductible. This two tier system is grossly inequitable with those who can afford private care accessing treatment as soon as required unlike public patients who wait sometimes for years for life saving procedures.

Despite the new found economic success currently enjoyed in Ireland the country still ranks near the bottom in Europe for Government spending on health. Gross Domestic Product expenditure on health has dropped from 7.3% to 5.5%. The anomaly within the Irish two tier system that increases inequity has been noted by the WHO when it castigated Ireland for effectively subsidising consultants by allowing them to practise privately in hospitals in parallel with their public system work.

Assistance towards the cost of General Practitioner visits, prescriptions etc is administered via the General Medical Scheme (GMS). Eligibility for this scheme is income related with many people experiencing relative poverty excluded due to the low eligibility limits.

Studies have shown that the population not covered by the GMS system i.e. those above the income eligibility levels experience better health than those forced by their income inadequacy to avail of the public system.

Women's Health Policy in Ireland - A Short Overview

In April 1997, following an extensive consultation process, carried out in association with the National Women's Council in each Health Board¹⁸ region, the Department of Health & Children published the Plan for Women's Health. The four main objectives of the plan were:

- Maximise the health and social gain of Irish women,
- Create a woman-friendly health service,
- Increase consultation and representation of women in the health services and
- Enhance the contribution of the health services to promoting women's health in the developing world .

Linked to the above objectives were the principle of health gain - improvement in life expectancy and quality of life - and social gain - the wider social, cultural and economic factors linked to health which can be improved through changes in how health services are delivered.

In order to begin to deliver more women friendly services at regional level each Health Board set up a Women's Health Advisory Committee to devise, agree and implement a regional women's health plan. These committees are made up of senior Health Board

¹⁸ Health Boards are the regional health authorities, there are 8 in Ireland. They provide most health services except those delivered in hospitals.

staff with at least two representatives from the National Women's Council of Ireland (NWCI) who are based in the catchment area of the Health Boards.

What is the National Women's Council of Ireland

The NWCI is the national representative body for women's groups in the Republic of Ireland. It is an NGO funded by the Department of Justice, Equality and Law Reform. It seeks to improve the position of women in Ireland by lobbying, campaigning, raising awareness and negotiating as a Social Partner on issues such as childcare, women's poverty, women's health, and violence against women and equality in employment and education. The NWCI is governed by an Executive Board, elected by the member organisations (approx 155). Policy is the largest team within the paid staff, followed by communications, administration and specific projects of which the Women's Health Project is but one.

The NWCI seeks to engage its membership in its decision making process by offering special interest forums; Social Affairs, Work and Education which each organisation can nominate its members to participate in. There is no regional structure, due to funding and poor public transport. Meetings and seminars are held in Dublin with regional events whenever possible.

History of the NWCI Women's Health Project

The consultation process which preceded the launch of the Plan for Women's Health was the first of its type between the Department of Health and a non statutory body. For the first time women were asked what they wanted from their health services. Their replies, if not homogenous due to local variations in service delivery, echoed their desire for

- more and better access to information on health issues;
- a change of dynamic in the doctor patient relationship;
- support and development of women's health service models, i.e. women's health clinics, family planning clinics etc..

The process engendered high expectations that the consultative model used would lead to a more open and participative approach to the design and delivery of women's health services. In order to maintain the momentum and energy already expended by NWCI members during the consultation process the National Women's Council began a three year Women's Health Project partly funded by the Department of Health in June 1997. The aim of this project is to provide a support structure for the National Women's Council of Ireland women representatives participating in the eight regional Women's Health Advisory Committees and the National Committees (both Breast and Cervical Screening Advisory Groups and the Women's Health Council which is the body which formulates women's health policy in Ireland.

The energy and motivation for this project is grounded very much in the commitment, expertise and enthusiasm of the National Women's Council's health representatives who work tirelessly at regional and national level to ensure that the authentic and representative voice of women is heard. Through these health representatives the NWCI has a sound knowledge of the status of the regional Women's Health Plans and of the national committees.

The Women's Health Project is now three years old. In this period the National Women's Council of Ireland has focused on

- Lobbying to ensure that sufficient funding to carry out the actions agreed on the regional Women's Health Advisory Committees is secured
- Ongoing support and advice to NWCI health representatives both in their work on the committees and in their role of communicating about the project to local groups.
- Ensuring that women's health issues are prioritised and specific initiatives negotiated and implemented within the Social Partnership model.

Note on Social Partnership

In order to understand the NWCI's relationship with Government it is important to understand the economic and political framework in Ireland. Social Partnership is the negotiation model whereby the Irish Government, trade unions, farmers, employers and the community and voluntary sector negotiate national agreements governing pay levels and social policy issues.

The national wage agreements usually have a life span of some years and there is always a period of intense negotiations (lastly some months) before agreement is reached between all parties. There is a very strong emphasis on social exclusion, income adequacy and equality.

Where is the NWCI Positioned?

As an NGO the NWCI is situated very much on the user's side of the White model¹⁹. We represent the voice of Irish women as end users of health services. Because of our role within the Social Partnership arena of policy formulation we have an important voice with regards to women's health in Ireland. A high percentage of the NWCI's resources are directed towards its role within Social Partnership - it is represented on various high level Governmental Committees which are formed to drive specific initiatives such as equality, domestic violence, poverty proofing, National Anti Poverty Strategy etc.

Impact of the Project

The NWCI's Women's Health Project aims to ensure that specific regional and local women's health issues are fed into the regional plan for women's health via the NWCI health representatives. These NWCI representatives come from local women's groups (who are members of the NWCI) who work within a community development ethos.

Funding for the NWCI Women's Health Project

The project is funded directly by the Department of Health & Children. The current three year contract with the Department of Health & Children will expire in December 2000. The NWCI is currently conducting an evaluation of the project so that it can submit a request for future funding from the Department to continue its partnership.

Successes and Failures of the NWCI Women's Health Project to Date

A lack of clarity with regard to accountability, communication, responsibilities and a lack of a monitoring/evaluation mechanism have dogged the Plan for Women's Health since it was launched. The NWCI's project is also affected by these problems as its representatives and co-ordinator strive to create a partnership relationship with statutory

¹⁹ A model, developed by White, to analyse health care systems. It was sent to all lecturers in preparation of their talk as an orientation pattern.

Health Boards who often exhibit a lack of understanding of consultation, empowerment and community development.

Mistakes Made

Not enough clarity was established in the set up phase of the committees' existence. This resulted in a vagueness which persisted until quite recently as to the exact remit of the committees, the respective role of all players (Department of Health, NWCI, Health Boards and the Women's Health Council). Lack of clarity re accountability, structures, monitoring mechanisms was not tackled in a systematic way with the Department of Health, instead at times frustrating dialogues with individual Health Board Women's Health Advisory Committees took up the NWCI's energy and resources.

I will elaborate on what others can learn from our mistakes in my presentation. Success is measured in real improvement in regional health services stemming from the work of the committees.

"ProMama": A "Model of Good Practice" from Finland

Gisela Gästrin

I am going to discuss programs for breast health and the early detection of breast cancer from an interdisciplinary and holistic point of view. This view includes the question of equal rights among women in all societies and all age groups, when it comes to their access to professional caregiving. The target of interest - the breast itself - concerns every woman. The items to be analysed have personal, cultural, ethical, medical, social, organisational, political and financial dimensions. In this oral presentation I will proceed from background research via practical models to visions for the future.

Epidemiological Research

Ninety per cent of women will never have breast cancer. However, it is the most common female cancer in industrialised and developing countries. Epidemiological statistics show similar breast cancer incidence figures in most countries. In Finland circa 25 % of the annual cases are diagnosed in women 25-49 years of age, 25% in ages 49-59 (Finnish mammography screening-ages) and 50 % in women over 60.

Clinical Research

Women themselves through accidental observation of changes from normal discover the majority of breast cancer cases. This is often followed by delay of the self-referral to a physician. These women represent late cases with a poor prognosis. The situation causes anxiety in other women, who in their turn will delay, when it comes to self-observation or self-referral. On the other hand, those women who present breast tumours that are less than 2 cm in diameter and with cancer local in the breast only can be definitely cured. This fact is aimed at causing optimism and awareness in women and professionals.

Three Screening Programmes for Early Detection

The WHO already investigated in the early 1960 the breast cancer situation in the world population. A WHO-Memorandum from 1984 describes three "screening tests" for the discovery of changes in the breasts. These tests are:

- a) technical investigation with screening-mammography technique,
- b) breast physical examination carried out by a physician and
- c) breast self-examination (BSE) carried out by the woman according to exact instructions.

In all these screening models the diagnosis of the "screening-positives" has to be done with clinical mammographic-, ultrasound-, microscopic- and other investigations. The WHO recommends research to be carried out on the influence of a screening program on breast cancer mortality, before implementation in public health policy.

The required research has shown that

- a) screening with mammography reduces mortality from breast cancer in the age-groups between 50 and 70 (Strax, Tabar),
- b) in screening with breast physical examination the result is equal with that of mammography (Mittra) and
- c) in screening with BSE in the Finnish Mama Program study, the reduction concerned all age groups between 25 and 85 (Gästrin).

Practical implementation has shown that strategy a) is expensive, b) is inexpensive and c) is inexpensive to adopt.

Breast Self-examination Approaches

Different approaches in BSE-programs have been used with different outcome.

The conventional BSE-approach: temporary information

Public education with mass communication one-way using brochures, films, lectures etc., is aimed at

- a) teaching the BSE-technique and cancer symptoms and
- b) motivating women to see a physician if breast cancer symptoms appear.

This impersonal temporary message increases knowledge, but it does not fulfil expectations when it comes to influencing attitudes and health habits. Having been informed, the women are left alone with their anxieties, uncertainties and incompetence to learn to know the own breasts and to draw the right conclusions. This concerns especially women in the middle ages with age-related changes and those with large breasts. Some women think that the strategy is a "model of monthly search and destroy mission". Others see their breasts as "ticking bombs". The author, being specialised in diagnostics and oncology, has met several women of this category in hospitals in their role of "late coming patients". Their sad situation made me develop an innovative approach for the use of BSE.

The innovative approach: comprehensive, continuous program

In this approach the aim is to motivate women

- a) to accept oral two-way-communication with a health professional / key-person,
- b) to accept the message and the specially designed working material (with facts for women at different ages, correct BSE-technique, continuous personal support and for follow-up) and
- c) to accept a physician's consultation strategy that is arranged for those women, who will discover changes during the ongoing programme.

For the practical implementation of the model, women have to be met in their everyday environments, as, for example, workplaces, women's groups, doctors' offices, health centres and so on. For self-referral to physician's consultations in the case of breast changes, arrangements have to be made on a national or local level with radiologists, surgeons, etc. who will handle the diagnostic procedures.

The Mama Programme Screening Trial in Finland

The innovative approach for the use of BSE as a screening test was practically tested in women representing two women's organisations of "Marthas" in Finland. The name "Mama" was derived from the first letters of the names of these organisations. The message was written in a special manual and orally communicated to the women by health professionals and supporting key-persons.

For continuous motivation and activation a personal "Mama-card" with a calendar was developed

- a) for reminders and follow-up and
- b) for self-registration of the BSE-activity. For self-referring women, clinical mammography consultation was arranged.

The Mama Programme Screening Research

The WHO-recommended research in the Mama study was about BSE serving as a screening test and about the Mama strategy serving as a screening programme.

Effect of BSE as a screening test (project 1973-75):

- Women performing monthly BSE rose from 2 to 55 %,
- Symptoms and self-referral in 2 % of the BSE-performers,
- One out of eight of the self-referrers was a new breast cancer case,
- The caregiving in the program gave women a sense of security,
- Effectiveness of the Mama Strategy as a screening programme (30,000 women, follow-up 15 years, Doctoral Thesis Gisela Gästrin 1994) and
- Mortality from breast cancer was 29 % less than expected in women aged 25 - 85 years.

Implementation: Networks for the Mama Programme's Informative Part

Women in all Finland 25 - 85 years of age are welcome to the voluntary Mama Programme's informative part

- to be given individual counselling by health professionals through networks of Public Health Care systems (Information about the strategies communicated to health professionals in annals; key-persons are trained by the author).
- to be given group counselling by health professionals / key-persons through women's organisations and other groups (information about the strategies communicated to women's organisations leaders; key-persons are trained by health professionals and in courses organised by ProMama Association)

Implementation: Networks for the Mama Programme's Clinical Part

Women with self-discovered symptoms refer themselves to

- Public Health Care "Health Centres", open for every inhabitant on their own initiative
- Private physicians and Mammography clinics
- Women are referred to regional Oncology Clinics for treatment.

Material to be Used in the Mama Programme

- Manual for the key-person
- Mama-Card for the individual woman
- Pamphlet on Clinical Breast Examination for the physicians in Health Centres and private offices.

Breast Cancer Incidence and Mortality in Finland, 40 Years

In Finland, for BSE-instruction, one-way communication was the only source of information during the period 1960 - 70. The proportion of women who died from breast cancer was about 50 %. Women were passive with BSE. Since the introduction of the Mama Programme in 1973, there are more new breast cancer cases registered than expected, with an increasing trend. Mortality from breast cancer has been reduced to 25%. The official, nation-wide mammography screening for women 50 - 59 was introduced in 1987 and contributes to the positive trend. In oncology clinics there are an increasing number of breast cancer patients with small tumours. This development may be a result of increased knowledge, awareness and self-care in the female population.

The MAMA Programme Ready for Widespread Use

After implementation of the Mama Program in the Finnish Public Health Care system, trials and projects of different kinds have been carried out in Russia, Canada, Estonia and Sweden. It is obvious that the strategy can be used in different cultures and different health care systems and that the way of motivation and support of individual women can be adopted world-wide. The method is simple and inexpensive.

From Data to Deeds: The Vienna Women's Health Programme

Susanne Schmölzer

Vienna is one of the European cities that implements health promotion programmes specially designed for women. The development of the Vienna Women's Health Programme involved approx. 100 experts from a variety of professions. The programme was unanimously adopted by the City Council in November 1998. The Vienna Women's Health Programme is an open programme whose areas of action are defined but whose implementation needs to be agreed upon by an advisory council. This approach permits quick responses to current requirements and safeguards that no target group will be "forgotten". The involvement of an international advisory board is to provide access to a body of international experience.

It is the overall objective of the Vienna Women's Health Programme to improve the quality of all medical, psychological and social services for women in Vienna.

The Vienna Women's Health Programme evolved over several phases. The basis was laid by the first Vienna Women's Health Report (Wimmer-Puchinger, 1996). This report addressed areas of action identified as particularly relevant for women both from the perspective of research and with respect to measures and interventions.

Workshops with a wide range of women's health experts and representatives of self-help organisations worked to discuss the areas of action and develop concrete proposals for specific topics.

As the next step, an expert commission chaired by the two Executive City Councillors (Dr. Sepp Rieder, Executive City Councillor for Public Health and Hospitals, and Mag. Renate Brauner, Executive City Councillor for Integration, Women's Issues, Consumer Protection and Personnel) was established in July 1997. In addition to health policy representatives of all political parties, this commission included 30 experts from the most diverse fields of medicine as well as psychotherapists, psychologists, medical sociologists and representatives of the Association of Midwives, the Patients' Advocacy Office, the Vienna Hospital Association, Vienna's women's shelters, senior staff members of the Municipal Departments of Vienna and self-help groups.

Working groups discussed and analysed 12 areas of action with respect to their objectives and possible measures. The formerly "gender-neutral concept" of health and illness was thus "fine-tuned" to meet the needs of women, thus acting as a co-operation partner of all institutions concerned as well as representing a women-oriented programme in the respective communities.

The 12 areas of action of the Vienna Women's Health Programme are:

1. Cancer prevention, counselling and follow-up care, in particular for breast cancer patients
2. Care for pregnant women and women suffering from post-partum depression
3. Mental health
4. Drug and alcohol abuse prevention
5. Health promotion for elderly women
6. Violence against women
7. Legal aspects concerning women in the health care sector

8. Psychosocial care for women and care standards in the health care sector
9. Integration of migrants into the health care sector
10. Health of women in the work environment
11. Women in health care professions
12. Health situation of mothers

The measures are carried out in the field of health promotion and preventive care, in inpatient and outpatient therapy as well as in follow-up care and rehabilitation. The close interactions between scientists, self-help organisations, relevant decision-makers in the municipal administration and politicians in Vienna's municipal government have created important interfaces for practical implementation. An advisory council appointed by the Mayor of Vienna is to ensure programme continuity.

- Implementation of the Vienna Women's Health Programme

The implementation of the Vienna Women's Health Programme began in 1999 with four pilot projects:

The establishment of the Women's Health Centre F.E.M. South was the outcome of an analysis of citizens' needs in the 10th municipal district of Vienna (Wimmer-Puchinger et al., 1998): among other things, it is a task of the Women's Health Centre to break down barriers impeding access to the health care system and to encourage socially disadvantaged women and migrants to take initiative in order to improve their situations. Since a great number of migrants live in the immediate vicinity of the Women's Health Centre, F.E.M. South also offers its information and counselling services in the Serbian, Croatian, Bosnian and Turkish languages. Since May 1999, a total of 9,664 women, of which 2,301 were migrants, have received care and counselling.

The eating disorder campaign "Ich liebe mich, ich hasse mich" (I love myself, I hate myself) on the one hand directly addresses women and girls affected by such disorders as well as their relatives by offering a wide range of services. On the other hand, training classes that promote the early identification of symptoms and encourage interventions are carried out for health care professionals and teachers. The health-endangering effects of our society's ideal - the super-slim body - are highlighted, and the population is informed about eating disorders and their consequences. Since the beginning of the campaign, the eating disorder hotline has recorded roughly 4,000 calls (50% by persons affected, 50% by relatives). 6,000 school-age girls participated in information classes, and 500 relatives were given counselling. The rate of participation in therapeutic measures increased by approx. 50%.

The Vienna breast cancer prevention programme addresses women aged 50 - 70 and aims both at safeguarding the quality of the prevention programme and at improving the level of psychosocial care. The programme was developed jointly with Vienna Cancer Aid and self-help organisations for breast cancer patients and is supported by the City of Vienna, social insurance institutions and the Vienna Medical Association.

The project for the prevention of post-partum depression was implemented in three tertiary-referral hospitals. A close-knit system of care by psychologists, social workers and midwives - especially for socially disadvantaged women - aims to reduce the number of cases of post-partum depression. The project was conceived for a two-year period and will also be evaluated.

Further Initiatives

Further initiatives include basic and advanced training classes focusing on violence against women, which will be held at all relevant hospitals; a directory of all physicians licensed to practise in Vienna to be published in 15 languages to help non-German-speaking patients; an information campaign on hepatitis B for migrants; and a project to facilitate access to information for all women in Vienna, e.g. by means of an open-house Health Day at Vienna City Hall.

AKF and IZFG as Innovative Approaches to Women's Health in Germany

Regina Stolzenberg

It is difficult to understand the development of the German women's health movement in general and the AKF specifically without a basic knowledge and analysis of the German health care system, which can be described as follows:

Our health care system is based on a combination of public and private responsibility, of social and market principles; i. e. it is mainly organised on the basis of free enterprise with governmental regulations as well. The legislative level of responsibility is with the federal ministry, while the implementation and organisation of health care comes under the control of the state governments. Health insurance is compulsory and guarantees health care for everyone.

When you look more closely, though, it turns out to be a very complicated construction, difficult to comprehend even by its participants, one in which very different interests are competing with each other.

Under the current system, budgets and services, orientated toward models of social partnership and self-administration, are negotiated between health insurance (respectively, social and accident insurance) as representatives of the insured people and the providers of services on a regional and national level, while the government provides judicial guidelines. Among the providers of outpatient care, the role of the "Kassenärztliche Vereinigung", an association representing doctors in private practice, must be acknowledged above all. Because of their strong professional lobbying ability and their traditionally unbroken dominance within the health care system, there is, in fact, a huge power imbalance between users and providers, and between the different medical professions. Hierarchical, rigid and bureaucratic structures have prevented reform and innovation for a long time. Although broad parts of the system function according to the market principles of offer and demand (for instance, the free choice of doctors), this has, in many respects, not led to high quality treatment but rather to a maximum instead of an optimum of care. The large availability of medical services because of high physician density and a lack of consumer orientation has only contributed to a general tendency toward over-treatment especially of women, i. e. treatment of healthy people (for example: hormones for menopause), while at the same time there are deficits in the treatment of seriously ill or disadvantaged people. This means we suffer from abundance rather than from a deficiency. Under these circumstances, the strong social component for which Germany is seen as a model world-wide is currently endangered. Political intervention by means of so-called Health Reform Legislation has not been able to solve the problem. Users of the Health Care System as well have not been able to use their power as consumers in a purposeful and effective way.

AKF

The Arbeitskreis Frauengesundheit in Medizin, Psychotherapie und Gesellschaft (AKF, Women's Health Association in Medicine, Psychotherapy and Society), founded in 1993, mainly organises female experts in various professional areas of women's health, such as physicians, psychologists, scientists, counsellors, midwives, nurses and educators, but

also includes women active in the area of self-help. Three goals were connected with its founding:

- To create a network of critical forces from within and outside of the medical system and to promote interdisciplinary co-operation;
- To criticise the misdirection in medical developments, especially the medicalisation of women and the lack of quality diagnosis and treatment;
- To work publicly for health care that meets women's needs in a holistic way, i.e. that considers causes and courses of diseases within the context of women's lives.

With its critique of the medicalisation of women, the AKF joined the political current that had been initiated in the seventies by the women's health centres in Germany.

It has to be seen as a special success and a new quality that AKF members were the first to criticise the medical system in a women-specific way from within, as some of the members are in acknowledged and leading positions. Thus their criticism had a larger public impact than the former critique formulated by the women's health centres, as the monopoly of knowledge and the myth of infallibility within the medical system were much more deeply challenged by a critique rising from within its own ranks.

The centre of the critical discourse concerning medicine have been the annual meetings, which stimulated the public discussion. The positions gained from these meetings have spread and thus contributed to changes in medical practices (fewer hysterectomies and a critical debate around mammography screening) or concepts like the demand for a holistic approach to health. This demonstrates the power and effectiveness of the work, as well as the ambiguity of this kind of success, since the holistic view is likely to become perverted as a promotion idea for products like fitness studios or management courses.

The critical look at medical science has been the main field of action for the AKF up to the present moment. This deals with such questions like hormones in menopause, the medical control of pregnancy, reproductive technologies, and the image of women in medical science in general. One of the important projects of the AKF has been work on a gynaecological textbook. This textbook will be the first in the history of gynaecology in which the field is exclusively described from a female perspective. This will meet an old demand of the women's health movement that in gynaecology women should define what is adequate care for women, and thus finally offer an alternative to a doctrine of thought exclusively created and maintained by men. Additionally, the AKF has influenced political decisions concerning women's health through its expertise in different public organs, from the decision about the micropill to general health care reform.

The internal networking of certain professional groups in working groups has been especially effective, particularly the professional group of gynecologists and the group "Psychotherapy, Psychiatry and Psychosomatic (PPP)". The gynaecologists organised further education in the group, discussed standards of women-adequate medicine and reflected on the conditions of their profession in a critical way. This was the first time that women searching for a good gynaecologist could be referred systematically and successfully. AKF membership thus became a stamp of quality for good gynaecological treatment. Due to the particularly active group PPP, quality standards for a women-adequate psychotherapy could be developed and published, which can be seen as a discussion base and guideline for the profession itself and for health policy.

But the AKF still has much undeveloped potential. Originally founded by single individuals, it now houses many so-called official personages under its roof, i. e. associations and organisations like the Midwives Association, Women's Health Centres, Women Doctors Association and the Müttergenesungswerk (organisation providing recovery for mothers). Thus, the number of the members it represents are several ten thousands. By this quantitative factor as well as a qualitative one, which consists of the - at least in Germany - rare combination of different professions out of the medical, scientific and social sectors within one organisation, the AKF has gained strong political weight. It is up to us now to bring it to bear.

The AKF has built up a large, effective network. What it lacks, in my opinion, are systematic analyses, a definition of tasks and target groups and a clear, politically strategic aim. An overemphasis on grassroots activities and a fear of too much centralism - a mistrust that probably results from the burden of German history and characterises social movements in Germany as a whole - has prevented us in the past from moving in this direction. In spite of this, I think we have to move one step on. I see it as the charge of the future to commit ourselves to common fields of action and tasks, and in this work to show the multidisciplinary approach off to its advantage.

In respect to future areas of action, I see the following priorities:

As for its position within the health care system, the AKF should continue to consider as its main goal the improvement of women's health care. Out of following reasons, though, it should move away from the field of ideological argument within medicine to concentrate on a change of structures:

Our society not only allows itself the luxury of 1) spending resources for over- and mistreatment, 2) providing for the costs resulting from this, but 3) making critical forces spend all their energy to criticise and fight these mistakes.

A change of structures is also important because the culture of decision making in our health care system still is influenced in many areas by undemocratic patterns, from universities through hospitals to health insurance. This situation has no small impact on the decision making process of women. The "emancipated patient" and the "informed consent" are still distant ideals. To carry through patients' rights as democratic rights, and to achieve more democracy and partnership between medical professionals and patients, but also among the different professions as well, would be goals for which the AKF, within its organisational structure itself, has already created a model to be implemented into the health care system. At the same time this means fighting for more women in leading positions.

The strategy of Gender Mainstreaming could play an important role in regard to the quality and content of medicine so that women's interests are taken more into account, and that they are not longer seen as particular interests but move into the centre of attention. This is how we can achieve not only changes in consciousness but also fundamental changes in the structure of our society.

IZFG

The International Centre for Women's Health (IZFG), officially founded in December 1999, already had a long history. Its roots are in the AKF as well as in the region Ostwestfalen-Lippe (OWL). Some of the AKF board members saw the IZFG as a possibility to convert their general goals into practice. (In the meantime, the IZFG

became organisationally independent from the AKF.) At the same time, women in the region were starting a strong initiative for a women's health centre. Thus, the IZFG is a result of top-down as well as bottom-up activities. The structural crisis in the so called "Spa and Rehabilitation Region OWL" caused by the health policy of the government (a drastic reduction of health insurance expenditures for prevention and rehabilitation measures), was a convenient economic starting point for the development of the project. Local financial backers could be convinced to "invest in women's health". The IZFG was founded as a limited company with a charitable status. Its three shareholders (the city and the Staatsbad of Bad Salzuflen and the rehabilitation clinic "Kliniken am Burggraben") promised basic financial support for three years. So the IZFG not only has several mothers but paying fathers as well.

Its goals are:

- to develop OWL as a model region for women's health;
- to promote networking and co-operation on a regional, state, national and international level;
- to develop new models of prevention and care and to integrate them into the regular system.

Various characteristics differentiate the IZFG from "traditional" women's health centres:

1. Its organisational form:

As a limited company, it has structures that are adopted from the private economic sector, including hierarchical management structures - undoubtedly an ambiguous matter containing problems as well as opportunities. On the one hand it means dependencies that require a permanent levelling out of interests, on the other hand there is a more secure financial base and more effective working structures.

2. Its location in a rural area:

All German women's health centres up to now have been situated in big cities. For women in the countryside, there was a huge inadequacy in the provision of information, complementary services and choices. One of the IZFG's future tasks will be to investigate and document this situation, and to remedy this state of affairs.

3. Its stronger orientation toward health than disease:

The use of the salutogenetic (Antonovsky) approach means to put more emphasis on the development of preventive services and to consciously refer to women's resources instead of their deficits.

4. The combination of services with structural goals:

It is our concern to develop women-specific services not as additional or alternative offers, but to implement them into the regular care.

5. The acceptance of responsibility not only for the development of women-specific opportunities, but also for the structural development of the whole region:

The women's health movement was orientated at its start toward taking women's needs seriously and toward putting their well-being into the centre of its focus. Influencing and shaping the environment by political means was often lost from sight. In contrast, the IZFG feels committed to actively contribute to shaping the social, economic and ecological conditions of the region.

The guideline and philosophy of the IZFG is the idea formulated in the concept of Gender Mainstreaming: to take the biological and social differences between the two sexes as a starting point in order to implement measures and demands formed around the interests of women. This is the basis from which we are demanding "another kind of medicine", or "women-specific offers for prevention and rehabilitation".

Beside the organisation of this conference, we have worked on the following projects: Together with the Feminist Women's Health Centre Hagazussa in Köln, the IZFG has become the seat of the "Women and Health Co-ordination Centre for (the State of) North-Rhine-Westfalia (NRW)". The goal of this institution is to bring together the potential of all the organisations already working on a state level on the topic of women and health, as well as those working in health relevant fields like violence. The synergetic impetus and effect coming from this co-operation will benefit its members as much as the general public. Issues relevant to women's health shall be identified and publicised. The Co-ordination Centre will become at the same time a centre of expertise with counselling functions for politicians and professionals. Its task in relation to the health care system is to promote a gender specific approach for all the system's different areas and thus initiate processes of change.

As the first institutionalised service for women in the region, the IZFG opened an "Information and Contact Centre for Women's Health" which offers information workshops and an information hotline twice a week. The broad range of women's requests is being documented in a questionnaire in order to get an overview of women's needs and wishes in the region, and to develop proposals accordingly.

As a further service that has model characteristics, for one year the IZFG has run a "Second Opinion Practice" for women with gynecological problems. Even without advertising, nearly 300 women have already used this service. This demonstrates its great need. The experiences and results of this work will be documented and evaluated in order to prove their necessity to the relevant authorities of the health care system, like those in health insurances and the "Kassenärztliche Vereinigung", in order to transform it into an elemental part of the regular services. (Switzerland already rewards getting a second opinion with a bonus as it apparently helps to save money.)

There is one project that I want to set out in greater detail, as it exemplifies how we are envisioning preventative services: the so-called FrauenBewegungsKur (FBK, Women's Movement/Exercise Cure) that the IZFG is about to develop. The name was consciously chosen. In times when the traditional German "Kur", or "Spa cure" is becoming limited as a medical treatment, the FBK is aimed to filling the term with a new meaning. The FBK is a preventative offer based on the knowledge that 1) the greatest part of contemporary disease is caused partly or totally by a lack of exercise, and 2) therapeutic exercises as well as sports do not differentiate for gender.

Women's abstinence from sports, especially among older women, is larger than that of men. During the time of early socialisation there are already significant differences between girls and boys regarding the kind and extent of bodily exercise. In many regards, sports still are a men's domain. Women, and especially elderly women, only have restricted athletic opportunities. Often they only feel attracted to those kinds of exercises that emphasise traditional female behaviour patterns. A relatively new trend is for women to engage in a fitness culture that is only aimed toward body shaping and functioning. Thus, tendencies of alienation from their own bodies, mechanisation of the body, and self-hatred can be enforced.

The principle of the FBK is to approach women from where they are in order to provide them with access to new potentials. It combines bodily self-awareness with athletic exercises and offers possibilities for exchange and talk. Thus, psycho-social conditions will be integrated in order to construct a basis for a transformation of its ideas and

experiences into everyday life. Trial offers will be an invitation for self-daring. The concept is based on the approach that "body and movement play a central role for the building of active competence as well as for the identity development" (Pfister, 1999, 57). It should have a compensatory function in many ways: It is meant to have an effect on the empowerment of women, to allow them to gain more self-esteem, self-confidence and control over their lives. Research results from the USA prove such a connection. In addition, it also aims to strengthen self-awareness in the sense of women's boundaries and needs, and thus to oppose the purely functional fitness ideal. Besides, we assume that sports have a trigger function that influences other risk factors like nutrition, smoking, alcohol and drug consumption.

These are the working hypotheses for our pilot project next year whose results will be documented and evaluated. We aim to create a service that will be funded by health insurance as "ambulante Badekur" (outpatient preventive measures), and thus is open for broader circles of women. With this standard, we will also look to reach women for whom this "Kur" model is not accessible, for example with health promotion at the work place.

But the name FrauenBewegungsKur stands for a further goal that we want to reach, which is to create a movement that inspires women to start moving (on). Perhaps this will lead to a women's movement of a different kind. Although I have to admit that this goal will only be a small step in view of the numerous problems world-wide, I think it is a good possibility to make women more expansive, in their private as well as in the public space.

Women's Health Politics in Europe - On the Fringes or Jumping into the Mainstream?

Panel discussion

The participants in the podium were: Lea den Broeder (Netherlands), Audrey Deane (Ireland), Sue Laughlin, Alison Miller (Scotland), Dr. med. Gisela Gästrin (Finland), Dr. med. Marina Chaborowa, Dr. hist. Tatjana Schipulo (Russia), Susanne Schmörlzer (Austria), Regina Stolzenberg (Germany). Moderation: Hanneke van Maanen

The first question asked of the international forum was:

- Which strategies have been helpful in the development of women's health in your countries?

The reactions of the forum representatives:

Chaborowa:

The creation of a network of women's health centres which are independent of the state system, is necessary. Considering the paternalistic nature of the state, the first aim should be to strengthen women in their sense of personal responsibility. The educational work involved should be done by the women themselves as they have nothing to expect from the state system.

Deane:

For me there are three questions to answer organisationally and personally: Where are we at the moment, where do we want to go, how can we get there? Look at your internal resources and capabilities, and use them to move into the political arena. That means, stepping back from the operations, the doings, and the blood, sweat and tears. If you stay on that level, you miss the strategic level where you need to go to push your agenda. Some might have feelings about going into mainstream politics, but I have the firm belief that unless you play inside the box, you will always remain on the outside and will not get the resources that you need. So maybe we don't want to play that game, but I'm sorry, I don't think we have an option. Make sure you are very clear what the policy framework is, be very clear that you tell your local and regional politicians that you know what the commitments are that the government has made, and that they are aware of them and know what they intend to do about it. Look for allies. Often it is good to look for allies in the opposition. You may find that you have to form alliances with people you might not necessarily like to do business with. If you want to be pragmatic and get to your goal, maybe it is worth this compromise. I think there are always trade-offs in politics. Take child care as an example. In Ireland we have no statutory childcare; we have the worst statistics in Europe. My organisation finds itself in the strange position of being totally in the same box as the employer association and the trade unions, and that is because we all want proper childcare. So we have joined forces, not because we like each other, but because we want to lobby the government with a lot of force. Look at people in power blocks that you would not necessarily regard as your friends, but try to think: What do they want, what are their needs and is there a possibility for co-operation. Lobbying is strength; don't always be on your own.

Laughlin:

The situations in Ireland and Scotland are similar, although our experience is based on a city and not a national level. I think the analysis of the problem is crucial; we have to be very clear of the type of analysis we make with regard to women's health. We cannot look at health problems per se, but have to look behind those problems, at the determinants of those problems and seek to find ways to change these

determinants as much as finding ways of responding to the problems. We have found that we have to operate in the political sphere, but this is limited, if there is no pressure from women's organisations. You can't just work from inside, you have to work from outside as well. You have the most success when you are working the two sides simultaneously. And it is important not to neglect your roots. You have to remember who your constituency is.

Miller:

There has been a lot of discussion about the split between the immediate practical level of work and the political level. Sue and I represent the two ends of the spectrum from Glasgow. Sue works much more on the theoretical and strategic level, and I work much more on the level of provision for women who come into the Centre for Women's Health. It's very important that we have both these ends of the spectrum and everything between. It is very easy if you are involved in the face-to-face, day-to-day work that you lose sight of the bigger picture, and not have enough time to address these issues. So for me, coming out of a situation where I see women every day, and to come to a conference like this, and to have space to think about things, is very important. For Sue and me, it is a very good way to catch up with each other. It might sound silly, as we work in the same city, but we don't often have time to talk to one another.

den Broeder:

The most important development came from working with women directly at a local level on typical medical issues to a more public health-oriented way of looking at women's health. When you look at the last two centuries, you see that people's health has been improved and the life expectancy has increased not because of medical development, but because of better nutrition, housing, higher income etc. Also today - A. Brandrup-Lukanow said it yesterday - there are very important determinants of health such as housing, social and economic status, education, social legislation and other determinants that should be addressed. I think the future of the women's health movement is an intersectoral approach towards women's health, and this means a public health and preventive approach. In this aspect, I fully agree with S. Laughlin, that this is what we have to address in the coming years.

Schmölzer:

We all know how difficult it is to make an analysis, to collect all the data. We should not forget that it is important to ask the right sensitive questions, if you want to obtain a good analysis of the situation. To refer to Alison: It is important to work on all levels, each on the level which she feels most comfortable. We should ask ourselves: What happens when a woman shows up who does not agree with our ambitious constructs, who says: " I don't want empowerment, I want to surrender a bit of my health", as U. Hauffe addressed it. There may be a discrepancy between what we want and what women want. We should have an open ear for the woman to know what she wants.

Gästrin:

In Finland, at the beginning of the seventies, we got an Act for public health, and we also had very active women in the Finnish Parliament. We have strong national basic programmes for women and men. Since 1964, gynaecological screening, and since 1987 mammography screening and programmes for the support of mother and child care have been established. That is what the national budget is paying for, and the counties decide about the use of this budget. Communities can work very differently with primary and secondary prevention and treatment. Health promotion programmes are voluntary programmes run by voluntary organisations or private persons like myself. Most of the organisations get their money from the gambling machine

organisations in Finland that have big amounts of money. We have no women's health movement because women think they are served well by national and community programmes. They are voluntarily accepting and carrying on such programmes in different large women's organisations like the Marthas. The interest in health politics especially for women is not there in Finland.

van Maanen:

Finland has a unique health care system. It is very people oriented, has a low threshold and people don't hesitate to go to the community clinic in search for services. So it is easier in your system to access community care. Finland is in WHO terms exemplary for a people-oriented health care system. I think we have to judge your experiences in the light of a democratic society that is very well organised with fewer people than in many other European countries, and that functions well. You belong to the privileged nations when it comes to health care distribution.

Stolzenberg:

In Germany, we are still miles away from a democratic health care system. We should separate from the clinch with medical science, our "favourite opponent", as Sylvia Groth put it, and concentrate more on structures. It was very helpful what you all said about how to systematically create a women's health policy. Here, we are still influenced by the women's health movement of the seventies: "My belly belongs to me", and there is a lot that still seems to turn around this issue. I think we have to watch what is moving around us, and what we ourselves can move. We know so little about how the health care system functions. Where are the decisions made that have an impact on all of us as patients or professionals, and how can we influence these decisions in a systematic way? How did you in Glasgow, for instance, develop your strategies, top-down or bottom-up? I see it as rather complicated and wonder how you handle it with all these different committees and grass-root activities involved. I would like to hear and learn more about your strategies.

van Maanen:

Scotland and Finland are countries with socialized health care systems, in contrast to other countries where free enterprise plays a much more prominent role. There is a difference in structural conditions under which programmes are developed. This is just one factor. The other factor is the influence of the medical profession which is strong and dominant in Germany.

At this point, the audience was invited to express their opinions. Participants from other countries had the chance to express their particular viewpoints:

Beck: (Participant from Germany)

I am from the Fachstelle Women and Health in Munich, and have been working with the grassroot movement in women's health for 24 years. I want to talk about how formal and informal networks work together in Munich. We have something similar to the "Round Table Women's Health" in Bremen, called "Expert Committee Women and Health". We saw that there are various models to combine the different levels. We rather have a bottom-up model. What seems important to me - as C. Hagemann-White already mentioned - is to constantly take care of the quality of communication between activists of local women's health initiatives and politicians, so that a communal health movement can be successful over a long time, and to prevent that frustration develops in the committees and networks and eclipses the themes. We used models from the Netherlands in our first foundation of a "Round Table" which was situated at a doctor's office. We were careful to have the same speaking time allocated to politicians as to grass-root women, and to provide the politicians with the

feeling of not only giving something to the base but also receiving something. They can relieve themselves, talk about their problems in the implementation of women's interests into daily politics. This encouraged them to hold on to the project, and to push things through for us which they probably would have had more difficulties to do without this support. This is what I perceived from Glasgow as well. Longtime personal relationships, longtime support for each other are relevant for a sustainable perspective.

Participant from Germany:

I am from the "Network Women and Health" in Halle. The woman from Russia spoke about the necessity of the political independence of their work. From other countries we heard that political interference and support are necessary. Are there politicians and institutions that support your work in Russia?

Chabarova:

We are not totally independent. Our centre in Tambov was founded in connection with the "Movement Women of Russia". This organisation is represented in the Parliament by a deputy. This is the woman who has contributed the most to the development of the centres for family planning. For two years, she was chair of the committee Women and Family. She has done a lot at this time for women also on a judicial level. But now the communists, who are as nationalistic as the church, are dominant in the Duma. They strongly attack her because they don't want her to fight for contraceptives for women. She is called a "criminal of the nation". There are also political relations at the local level. We have a Parliament where we work in a team. I am Chair of the Health Committee and thus have the possibility to exert influence. But it is my opinion that the newly existing initiatives and centres will not develop in a positive way if we integrate them into the health care system.

Participant from Turkey:

While I was listening to all these projects, I was thinking you only deal with people who have the habit of seeking medical help. This is a big advantage. Depending on the causal attributions, seeking medical help could only be one of the solutions people would go for. They could go for religious solutions, for herbal or local medicine, for social solutions. I think this is very much the case in my culture, especially in the countryside. You have to start from the very beginning in order to be able to get people to seek medical help, to make them aware that seeking medical help is an important thing. It may bring, in some cases - not in all cases - a better solution for what they have. Even realising that they have a disease, getting them to that point, will need a lot of effort. In the mentioned projects I miss that point; fortunately you don't have to deal with that issue very much as we have to in my country.

van Maanen:

Turkey has a rich tradition also in non-western medicine, in dealing with local communities. The basic needs in women's health care might be at another level of development. How do we take into account the values and traditions of local communities, how do we mobilise women to focus in on their rights and their needs in an appropriate manner?

Deane:

Sensitivity training for the professionals who deliver services to groups like that is very important. In Ireland, we have a high number of travellers (Zigan, Roma). They have very specific needs -the women, of course - and these are very appropriate to their own culture. So we would put a lot of reason and energy in ensuring that people who come in contact with them are trained in a sensitive and appropriate manner. But

it is an uphill struggle, because getting resources from the government to stream down into very specific minority areas is always an uphill battle. But it must happen.

Participant from Australia:

In Australia, there is an overall national health strategy and agenda. Funding was provided about four years ago for a national women's health project to identify the health needs of Australian women. There was a study conducted, divided into smaller projects to look at various aspects of women's health. In 1986, a national women's health agenda was drawn up and this was based on a social model of health. We were looking at health needs in terms of women's employment. We have many women in Australia who are working in so called "piece work"; these women are working in the garment industry, working at home under very difficult conditions. They are mostly migrant workers. Frequently, they are engaging the children as well in the home factories which is really a tragedy. Also domestic violence has received considerable funding for research. One strategy is to train case officers who are able to negotiate on behalf of the women. They have been very effective.

Elliot:

I want to make two remarks, one referring to what Audrey Deane said before. It is money that we are entitled to. And I want to tell you about a wonderful trend from California: Many people are turning to more traditional ways of healing and curing so that the health maintenance organizations are beginning to incorporate offers of traditional and Chinese medicine into their programmes. This is a very hopeful trend.

van Maanen:

There is also a tendency in Western Europe to return to more traditional forms of health care. It is a signal to the professionals that something in our Western system does not function.

Participant from Turkey:

I was expecting you to react to my comment, especially the people coming from Germany and the Netherlands with such a high migrant Turkish population. Actually, I implied that Turkey is not very far away from you. The health models you are using would not be so successful with the migrant women in your country because they need some other approaches. I would like you to comment on it.

Stolzenberg:

We are very much aware that this is a problem. Within the Turkish population, these are especially the women who don't speak German well and they are not treated well by the German health system. There are some but not many projects which address this. It's of course also a problem when we say as Germans: "We want to offer something for Turkish women." I agree with you that there have to be new approaches but I think these mainly have to come from Turkish women themselves in coalition with German healthworkers in the women's health movement.

Schmölzer:

It is clearly demonstrated by our studies that migrants have a lower life expectancy than the average Austrian women. Our approach of locating ourselves in a clinic was very important because otherwise we wouldn't have reached those women. There are actually women who come with diabetes or are HIV positive and have no idea if and how they have to take medication or who realise that they have to take care not to infect the rest of their families. One way that was successful in Vienna was that we sent our German-speaking Turkish colleagues into the parks with informative material, which means going to the women no matter where they were. We also try to encourage Turkish women of the second and third generations to go into medical professions and to network with each other concerning language and the medical sector in order to do something helpful for their female Turkish compatriots.

den Broeder:

It's true that also in the Netherlands we have a large population of migrants, especially Turkish or Moroccan people, but also from other countries. I also see that the Dutch health care system does not address the health needs of this population, women and men alike, in a proper way. In the women's health movement there is a shift from gender and health towards diversity and health which includes gender as well as ethnic and cultural differences. There are some groups that try very hard to work on some programmes aiming specifically at Turkish and Moroccan women. What I feel is very much needed at this moment is the participation of migrant women themselves in these groups. In my opinion this does not happen often enough. Then there is a second comment I would like to make, and this is a strategic matter. It has been said many times in the Netherlands that the health of migrants should be looked at in a better way. But it does not happen as much as it should. Some time ago there was a big scandal in Amsterdam because it was discovered that the infant mortality was very high, whereas we do have a very good health care system for mother and child health as well. And then it was found that the infant mortality was not high amongst the entire Amsterdam population, but was prevalent amongst migrant groups. This is something to be picked up by the women's health movement, by saying: Okay, if you don't improve health care for these groups and answer to their needs, this is what is going to happen: high infant mortality. This is a very important strategic point. You have to find out something that people respond to within the health system and which they are sensitive to. And these are numbers, mortality rates, and so on.

Participant from Brazil:

As a Brazilian, the most important thing during my time at IFU was to note that here in Europe women's empowerment is associated with de-medicalisation. It is very new to me and very important to bring back home, because coming from a developing country, we know that health is not an individual issue but depends on a large set of factors. But when solutions are thought of, they are seen as medical solutions. I heard a few weeks ago something about "safe motherhood". We know that social status is very important, but to face maternal mortality, we do need medical assistance. It was very hard for me to hear, because in Brazil nearly 100% of deliveries take place in hospitals and are assisted by medical doctors. Nevertheless, we have a maternal mortality rate of 150/ 100,000. So to hear that women's empowerment is associated with de-medicalisation for me is very important to bring home.

Jöllnbeck: (Participant from Germany)

Coming from the experience of working in a very stressful area in the San Francisco airport for three years - and it is one of the most stressful surroundings you can ever think of - one of my colleagues said one day, "I think my hormones are going crazy," and then we started to look at the work environment. The whole room where we had to work was filled with garbage cans. These were very unhealthy conditions. We started to work at this project for two years to better the conditions of women in terms of: How does the room look, how noisy is it, and all this. My question is: How deep can you get into work areas, work places where women work? I'm very interested as a movement teacher to look at that which makes us sick

van Maanen:

What should be the conditions of work at a micro- and a macro- level, the conditions under which we develop women's health care? The working climate could be one factor. What would be your criteria for the development of a women's health care system?

den Broeder:

I think a very important condition to develop good practices in women's health is that you have the support of women themselves, grassroot support; and you should remain in contact with the basis. That is one important point. The second point is you need a beneficial policy. You need to influence policy makers so that they support a gender approach to health. But what I think is also needed is a lot of power, that means you have to find people in powerful positions and make them into allies for your own sake. You can look for these people and address them but you can also think of becoming a powerful person yourself. This does not happen enough. We stay within our movement but we should proceed. Maybe step out of the movement and become one of these powerful persons. And from this position of power, you can do a lot from the top-down approach.

Chabarova:

It depends on where I work. For example in state hospitals where I work as a specialist I only have fifteen minutes for each patient. And I have thirty or more patients a day. This is very stressful. This bureaucratic machine has an influence on me which is incredibly strong in our state sector. The material motivation, though, is incredibly low. In my private practice I have organized everything and I can work the way I want. I get support from those who think the same way I do and with whom I work, and support from my patients, the women who come to me. And I'm very grateful to these women; they are the source of my good mood.

Cipulo:

For women, the climate at the workplace is extremely important. But for me, personally, and I also tell this to my students, it means that the woman has to find a point where she has to say, "NO." This is what we all have to learn. I see a huge difference between men and women at work. How men take it all easy and how scrupulously women fulfil their tasks until late in the night and on weekends, with children and all. It seems to me that we never speak out on this!

Deane:

You have to agree if you want to engage on the political level. If you don't agree, forget it. Find the politicians who are accountable, find the policies that they are accountable for, find the money that they have at their disposal and then put pressure on them.

van Maanen:

I think it is important never to go into a strategic meeting without being excellently prepared. You never take the chance; you prepare eventually in a role-play for the events that can occur. You never take a chance when you play high politics.

Deane:

One more thing: B A T N A: Best Alternative To The Negotiated Agreement. So always have a number two available in case your planned strategy does not work.

Laughlin:

Something that has to be reiterated, something that we heard from all the representatives in one form or the other, from every country here: We still have the problem of women's inequality and we cannot divorce the fight for women's equality from the fight for women's health. We cannot take it out of the context of women's inequality. Whilst women are still the "other" in society, even in Scandinavia where it appears that women have some more equality, they are still the "other" in society. That is the crucial issue in terms of our health. When we are devising our strategies and tactics for health, we have to operate in the context of the struggle for equality.

Miller:

I want to say something about healing the split between the political and the practical aspect of work. Not all of us can work on the strategic level. We do need people who

can develop good practice and we must have the good practice fed back into the system so that it can be used within the strategic level. They are mutually dependent on each other. They don't have to be in competition.

Schmölzer:

I only can say it on a personal level: I always have to check where I'm standing and pick up the women from where they are standing.

Gästrin:

To provide practical health care in primary and secondary prevention of diseases is important. I would stress that equality has been reached between men and women when it comes to smoke-free environments. That is a very important thing for workplaces and also for the health of workers. Inequality is when we decide only to help some age groups of women in the early detection of breast cancer. I would agree to the idea to see larger prospects and more holistic prospects when it comes to secondary prevention as well.

Stolzenberg:

I would like to emphasise two points: I thought it was very important what Sue and Alison addressed in their speech yesterday. We should not only demand change in women, but also in structures and organisations. I see it as crucial for the German health care system. What we are lacking is a culture of partnership and respect. And this is something we should try to systematically develop. Perhaps we won't reach it, but could at least have some improvements. Referring to what Dorothea said: We should look for new subjects to address, and women and occupational health is a very important subject. While we were circling around the subject of body and soul, we should realise that the situation of women in western societies has changed dramatically. We are a completely different generation now than our mothers were. There's a lack of research about the impact of this development. I'm sure that out of such research, innovative and new approaches to women's health will evolve.

In conclusion, the presenter thanked the forum and the participants in the audience for their enthusiastic participation in the discussion and for the many suggestions made regarding the implementation of women's health in the future with female elan and political strategy.

There is no Progress in Women's Health Policy Without a Strategic and Systematic Approach

Summary of the conference results

Regina Stolzenberg, Christiane Niehues

"We cannot divorce the fight for women's equality from the fight for women's health." (Sue Laughlin) This was one of the main insights of the conference, formulated in many speeches and contributions. Inequity as a constituting element in the impairment of women's health was not only detected in gender relationships but also in other structural conditions of health care systems and societies: in disparities between patients and care providers, between the members of different health professions, between different social classes and ethnicities and between European countries with their different health systems. Thus the issue is not only gender but diversity.

The second fundamental insight was that we need a systematic and strategic approach to achieve and strengthen success in women's health. Assia Brandrup-Lukanow, with her presentation of the draft of the "Strategic Action Plan for Women's Health in Europe", offered a political framework for this approach. The speakers from the different European countries with their "models of good practice" presented excellent examples of how respective strategies can be developed on national or regional levels and successfully implemented into practice. In workshops and discussions, the participants of the panels as well as the other participants of the conference contributed a whole host of ideas and experiences.

Crucial elements and prerequisites of a successful women's health policy due to the participants are as follows:

Theoretical and Political Concepts

A successful strategy needs political clarity and the agreement of all partners about principal goals and concepts. The "social model of health" could be such a theoretical approach. The multitude political decisions, declarations and programmes launched by different agencies and institutions on world, national or regional level should be taken seriously and be used in the practice of women's health work. They can give our work a political legitimacy, and allow us to take politicians for their word also in the respect of financing of projects. "The money goes where the mouth is." and "We all have a vote as electors."

This work, however, needs some effort in order to reify the general political message for the needs of local work, and it also needs actors with enthusiasm as well as experience in political discussion and committee work.

Analysis

A prerequisite for a successful strategy is a clear scientific and political analysis in order to define the needs, demands and problems, and to formulate adequate questions. The "Women's Health Action Plan" could serve as a guideline for this enterprise. It can be necessary to include the structures of the health care system into this analysis. This is especially true for Germany, where the structures here more than in some other European countries are lacking in transparency and democratic inclination.

Objectives

Objectives should be derived out of the theoretical and analytical work, and can aim for change in the social or economic fields, environmental factors that influence women's lives, or the health care system with its structures and services. They can be set on a national, regional or local level. Successes will be the more sustainable the more the objectives are aimed toward the elimination of causes of women's ill health.

Themes and Fields of Action

In accordance with a social model of health, a successful women's health policy should focus on the social sector in order to change social determinants that affect women's health and cause medicalisation. Medicalisation means, that social problems of women are solved with drugs. Transitions in women's life, e.g. menopause, is treated by medicine and drugs. In order to prevent a situation that causes women to "repair with their bodies a social scandal" (Ulrike Hauffe), social and structural deficits and abuses, like the lack of child care or physical and sexual violence against women, have to be addressed as determinants for women's health and eliminated.

The subject of breast cancer will remain high on a women's health agenda because of its urgency, and because deficits in health care have a particular impact on women with the disease. But it will be necessary, though, not to forget the healthy breast and to consider programmes like the "Mama Programme" from Finland that focuses on communication and women's expertise.

As the health of migrant women has been neglected for a long time, it should become a priority field of action with demands like: provision of basic care for all, including translating facilities, recruitment of experts from the respective ethnic groups, beginning with a culturally sensitive education in kindergarten.

Target Groups

It is important to define target groups towards whom measures are directed. As an example: the health activists in Glasgow address three different target groups: politicians, professionals and women, and among women they also differentiate between various groups. A women's health policy needs to take special efforts to reach out to disadvantaged and discriminated groups as, for example, migrant women or women from lower classes.

Methods

The policy of gender mainstreaming can be used as a means to get women's health demands accepted. It can be seen as an instrument to bring inequality between the genders into the consciousness of decision makers and the public. It was formulated in a conference discussion: "Each form of treatment, that is not gender specific, is a mistreatment."

A combination of bottom-up and top-down strategies is necessary to create a successful women's policy. This can be seen as a characteristic and specific quality of projects initiated by women. The mobilisation and participation of women as a target group was emphasised by all speakers as an important principle. But while especially the

representatives from Glasgow and Ireland mentioned the significance of central strategic planning in spite of its risks and dangers (s. Audrey Deane), the situation in Germany is characterised by a lack of central strategies in the field of women's health.

Successful strategies have to be supported from inside and outside of organisations and institutions. Pressure from outside and co-operation from within complement each other. Initiatives from outside of institutions need allies from within. In order to reach them it is necessary to speak their "language", which can mean to argue with health authorities not with needs but with mortality statistics (Lea den Broeder).

There is no way forward without women in leading positions. Women have to aim to get into these positions, to support each other on this way, to learn from each other, and to acknowledge each other's competence.

Interdisciplinary and intersectoral co-operation is indispensable in this process. It does not come easily, but has to be worked at in a permanent process. It needs "bridge-builders" (Lea den Broeder) as well as the capability to "listen in an intelligent and attentive way" (Carol Hagemann-White). Models and model projects for its implementation could be helpful.

Women's Health Forums or Round Tables can be such models, as they can serve as platforms for co-operation between different actors in the health sector like representatives from politics, health insurances, health professions, the social area as well as women as users and experts.

This form of organisation is in itself an expression of a democratic culture that has to be both developed and cared for at the same time. The participants should feel obliged to the principles of equal rights and dialogue that should apply to co-operation with allies and officials as well, and include the readiness for compromises.

For these forms of political work, instruments of quality- and resource-management are necessary, too. More money should be invested into them, not only from the public but from the private economic sector as well.

Campaigns and lobbying, and the development of guidelines and standards can be further elements of women's policy.

Conclusion and Outlook

An overall outcome of this conference was inspiration on an intellectual as well as on an emotional level which gave impetus for further ideas and actions. An experience shared by many speakers was the fact that the effort of presenting one's perspective to people from other countries was a welcome occasion to analyse and rethink one's own practice, and thus lead to new insights and a new view. A further experience consists of the knowledge that integration into a global picture diminishes many of one's own problems. Another important insight is that we might move towards each other coming from different directions, cultural backgrounds and historic situations. For example: For one participant from Brazil, it was an important new insight to see the fight against medicalisation as a fight for empowerment, while it has been an aim for Brazilian women to get medicine. Others, though, stated this fight against medicalisation as insufficient. A participant from Turkey argued to promote access for Turkish women to the modern

health care system with its technical possibilities in contrast to the traditional and religious methods in her country. This is in contrast to the development - mainly in Germany – to criticise the level of technisation in the health care system.

After the conference, the real work will be to translate the knowledge of experience that the speakers conveyed in a very concentrated way into practical steps. It will need much further effort to make the experiences and lessons of one country available and usable for others. It also will be a long way to a common European policy for women's health. The approaches and structures of EWHNET as well as the activities of the European Women's Lobby are an excellent base that should be used and strengthened .

The question is in the end: From where will we get the joy and energy to go this arduous political way? The conference also found answers to this question. One suggestion was to prepare oneself carefully, and to consider, for example, committee work as "improvisation theatre" in order not to be rolled over by the dominance and boredom of the political business. Another suggestion was to organise get-togethers of women from traditional and autonomous organisations for exchange and emotional support. The conference itself was an example of learning from each other and experiencing solidarity, a good platform to start in order to

GO FOR THE POWER!