



Berlin Centre of Public Health



DGSMP



EWHNET

Gender Based Analysis (GBA) in Public Health Research, Policy and Practice

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Preface

In the context of gender mainstreaming processes it became obvious, that special tools and instruments are necessary to gender research designs, health and health promotion programs or clinical services and instruments. A very fruitful approach in this direction comes from Canada, Margit Eichler's gender based analysis (GBA).

The aim of the documented international workshop was to learn from Canada and to present approaches of gender based analysis from several European countries. To publicize gender based analysis and to discuss it within the scientific community could be realized by this meeting: 84 participants from 12 countries came together in Berlin. The presentations refer to three reference systems: research, policy and practice. The discussions have been especially fruitful because the audience came from these three fields.

The idea to organize this event arose during a regional conference about gender mainstreaming in December 2000, realized by the network women/girls and health in Lower Saxony. The European Women's Health Network (EWHNET), the Berlin Centre of Public Health (BZPH), and the Section Women and Health of the German Society for Social Medicine and Prevention (DGSMP) put together expertise, resources and international contacts.

The European Women's Health Network (EWHNET) is an EU-project, funded since 1997 by the Medium-Term Community Action Programme on Equal Opportunities for Women and Men (1996-2001) and financially supported by the German Federal Ministry for Family Affairs, Seniors, Women and Youth (BMFSFJ). EWHNET is a transnational network of organisations in the field of women's and girls' health. The network is multiprofessional and interdisciplinary. Nine countries are participating.

The Berlin Centre of Public Health (BZPH) is a joint institution of the Technical University of Berlin, Free University of Berlin, Humboldt University of Berlin and several other research institutions in Berlin and the state of Brandenburg. The aim is to collaborate in public health research and in the postgraduate public health masters program at the Technical University Berlin. Women's health is one focus point of the research program of the BZPH. The workshop was part of the BZPH-project "Gender bias – gender research. Methodological standards for gender based analysis in public health research." funded within the public health research program of the Federal Ministry of Education, Research, Science and Technology (Funding No 01EG9821TPN11).

The Section Women and Health of the German Society for Social Medicine and Prevention (DGSMP) consists of health scientists and professionals who work on different topics of women and health, on factors influencing women's health and on gender adequate health practices. Members come from different disciplines (medicine, social sciences, public health) and are interested in working together on an interdisciplinary basis.

The organisers of the workshop hope that the discussion about gender based analysis in public health research, policy and practice will go on in the countries and that following conferences will take place. The documentation should help to orientate and to create gendered instruments, programmes or treatments. Conferences like this promote a mutual understanding and a progress in developing strategies to reduce gender-bias in all the fields of action in women's health.

Prof. Dr. Ulrike Maschewsky-Schneider
(Berlin Centre of Public Health)

Prof. Dr. Petra Kolip
(DGSMP)

Ute Sonntag
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Welcome

Angelike Diggins-Rösner, German Federal Ministry for Family Affairs,
Senior Citizens, Women and Youth (BMFSFJ)

Ladies and Gentlemen,

I am delighted to be able to attend this international workshop today and warmly welcome you here in Berlin on behalf of the Federal Ministry for Family Affairs, Senior Citizens, Women and Youth.

I welcome all of you who have come here because they wish to contribute towards adapting health care provision and health promotion to the special needs of women.

I am especially glad that so many women experts have come from other European countries and even from Canada, to report about the situation at home. Over the next days they will be presenting us with diverse programmes and projects with which gender mainstreaming in the health care system and health research is being implemented in their countries.

At this point, I wish to thank particularly the ladies of the Association for Health Promotion in Lower Saxony and the Berlin Centre of Public Health and the Women and Health Section of the German Society for Social Medicine and Prevention who organised this event, for having embraced this essential topic and brought so much expertise together here for this purpose.

Thank you very much!

Gender mainstreaming is the magical term that encapsulates a new and far-reaching concept of equality of men and women. This assembly knows what it stands for but I am sure that many of you have also experienced how difficult and laborious a job it can be to explain the meaning of this concept to other people and, above all, to win them over for the implementation of this concept. For far too long, thinking in most areas - also the political arena - has been gender-neutral. However, gender mainstreaming can only be translated into reality if, by means of and thanks to further training and coaching, all of those involved become willing to apply this new principle in their own fields of work.

Now I wish to briefly set out to you the stage of implementation which gender mainstreaming has reached in Germany.

The German Federal Government perceives the promotion of equal opportunities for men and women as a cross-cutting task. The equality of men and women is the governing principle that consistently underlies all political, normative and administrative measures pursued by the Federal Government. The principle of gender mainstreaming has been laid down in the new procedural rules of the Federal Government.

Thus, implementation of the gender mainstreaming approach was included among the tasks of the Federal Ministry for Women.

As a first step, May 2000 saw the setting up at the executive level of the interdepartmental steering group, IMA, which was centrally co-ordinated by the Federal Ministry for Women. Concrete projects will serve to develop criteria and ways to proceed, by means of which the organisation, improvement, development and evaluation of political decision-making processes and measures can be done in such a way that the respective baseline situations and gender impacts are taken into

account in each political field and at all levels. The aim is for gender mainstreaming to become a constituent element of the normal pattern of activities in all departments and organisations.

The long-term aim pursued by the working group is the consensual drafting of criteria catalogues and checklists for all kinds of political and administrative action in all ministries of the Federal Government. The idea is to compile a manual on gender mainstreaming that contains practical guidance and checklists for the entire Federal administration.

Within the current legislative period, the ministries are to implement at least one project using the gender mainstreaming approach and gain initial experiences which will be put to use in the drafting of the catalogue of criteria. Further training events on the introduction and implementation of gender mainstreaming will take place in all ministries under the individual department's responsibility. Gender mainstreaming modules will be integrated into the programmes of basic and further training institutions of the Federal Government.

One of the five projects run by the Federal Ministry for Family Affairs, Senior Citizens, Women and Youth is in the research field: gender mainstreaming will be taken into consideration in the department's research both as regards the research project itself and as regards the entities entrusted with it. This is a particularly important endeavour, for the implementation of the gender mainstreaming principle needs an appropriate data and information base.

With reference to the theme of today's workshop - the introduction of gender mainstreaming in the health care system - this means ensuring that the women's perspective is given increased consideration in health research, research funding and health reporting.

In this regard an important step has been taken in Germany:

With the "Report on the Health Situation of Women in Germany", that was commissioned by the Federal Ministry for Family Affairs, Senior Citizens, Women and Youth and drafted by women scientists - some of whom are here today - the first gender sensitive report in Germany was published.

It seeks to highlight the as yet inadequately studied health problems of women and thus complements the general health reporting of the Federal Government which is largely gender-neutral.

What is more, it supplies a first overview of women-centred approaches in health promotion and shows examples of good practice.

The report reveals a considerable paucity of women-specific data in health research - not only in Germany, but also at international level. In order to more fully consider gender aspects in health policy, a catalogue of criteria is to be developed on the basis of gender mainstreaming. The idea is to systematically integrate the gender perspective in the design, conduct and implementation of health projects within the framework of the Federal Government's programme called "Health research: research for the people". Thus, for instance, the gender perspective is to be adequately taken into account when setting up competence networks for cardiovascular diseases. This prerequisite was first formulated in this manner when the Federal Government invited proposals for major research projects. The same is true for the programme for applied nursing and care research which is under development. Of particular urgency is an intensified investigation into the causes of breast cancer. In the future, therefore, a priority area for funding in breast cancer research will be set up at the Federal Ministry for Research.

In order to develop a co-ordinated women's health policy in Germany, instruments must be created now to enlist the most important players for the design of this process and to network them. Decision-makers and experts, *inter alia*, policy-makers, representatives of service providers and purchasers, associations, self-help structures and academia must be involved in this process. What is needed is the co-ordination and onward development of skills in the field of women's health as well as networking and knowledge transfer through the development of a co-ordinated master strategy (gender mainstreaming). The aim is to stimulate a broad-based debate in public health policy and health care provision in an effort to launch better - gender-specific - care provision models and to establish them in due course.

This event will provide ample opportunity today and tomorrow to hold such a debate, including a transnational exchange of experience and know how.

I am eager to hear the presentations and listen to the working groups that are scheduled to take place here and I am positive that we will all be able to take home some valuable suggestions and inspirations for our day-to-day work.

In this spirit I wish you much success in implementing this workshop.

Welcome

Ingeborg Junge-Reyer, State Secretary for Social Affairs and Women, in the Senate Administration for Work, Social Affairs and Women, Berlin

Ladies and Gentlemen,

It is a great honour for me to welcome you here in Berlin and I hope you will have a successful and interesting conference which will result in an improvement in women's health care.

The subject of your conference is as well very relevant to the current situation of Public Health and women's politics in Berlin. Therefore, when working out effective Health Care concepts and means to improve women's health in Berlin we too must consider your question on how Public Health research and care should be arranged so that women's specific needs are adequately taken into consideration.

Being aware of the potential influence of the conditions of life on women's health, health improving programmes can be developed which adequately take into account the specific problems and needs by integrating the social and economic situation of life of women into academic research, practice and politics.

In this context the international outlook of your conference makes possible an exchange of experiences from which we in Germany only stand to gain.

Your conference picks out as a central theme the necessity of a close association between science and politics. As a politician, I can assure you that, for quite some time, we have been very concerned about this subject of gender specific Public Health promotion and prevention and we are very interested in working together with Public Health scientists, who use the strategy mentioned above in their research. In fact, there are already very good working contacts to the Public Health course at the Technical University of Berlin (TU).

In order to show you our involvement in gender specific Public Health care and prevention, I very briefly want to present to you some examples of our work.

Firstly, Gender Mainstreaming is to be "obligatory" in the development of concepts and programmes of Public Health care and in its translation into practice.

Secondly, the structures of work and organisation in this area are to be formed according to the principle of Gender Mainstreaming, including measures like gender coaching for executives and employees, the reporting of gender activities and the evaluation of achievements and failures. Since our administration includes the areas of Public Health and of women's politics, we thought our own organisation optimal for a trial run at Gender Mainstreaming.

This is going to be a very interesting and, I also think, a very exciting project, because for the first time it is not the Section of Women's Politics responsible in the first place but the special Section itself - of course, with the support of the Women's Politics.

I want to tell you about another project initiated by us, the "Initiative Berliner Frauengesundheitsnetzwerk" ("Women's Health Network of Berlin Initiative"). Berlin is the starting-point of the feminist health movement. By now there are a multitude of projects, initiatives and areas of

research concerning different aspects of women's health. What has not been achieved, I must say surprisingly, is the organised networking of the many activities.

The widespread wish for networking was, in the case of the Section of Women's Politics, taken up by us and an initiative for a Women's and Girls' Health Network in Berlin was set up. I must say this has been a great success. By now about 38 initiatives, societies, institutions and individuals have congregated in this initiative for a Women's and Girls' Health Network for an intensive and effective work. The current debate on the tasks and structures of a Berlin Women's Health Network will in the near future lead to the setting up of a well organised network.

Finally, I want to mention that we are just about to write a sequel to the last report on Women's Health in Berlin of 1996 for the Berlin Parliament.

I hope that I have given you a little insight into our work and objectives and demonstrated an idea of how to bring together science and politics.

I wish you an entertaining evening, many interesting conversations and contacts.

Moving Forward: Measuring Gender Bias and More

Margrit Eichler, Director, Institute for Women's Studies and Gender Studies, University of Toronto and Professor, Dept. of Sociology and Equity Studies in Education, OISE/UT

Introduction

I have entitled this talk “Moving Forward: Measuring Gender Bias and More” to indicate that we are dealing with a subject matter in process. I want to look backward and ask where we come from as well as forward to speculate where we might be heading towards.

The reference to “more” in the title has a double meaning - indicating that we do not only want to measure gender bias but eliminate it, and to the fact that we may wish to extend the approach we have developed to more than only gender bias.

Looking backward, then, we see a solid history of over 30 years in which there has been sustained collective work in critiquing gender bias in research.¹ The critique and the approach discussed here evolved through a number of stages. I will briefly outline some of these stages here, ignoring the many complications that were part of this journey. And of course, this charts the road that I have personally taken - although there were and are thousands of us who work in this area.

The Theoretical Basis for Recognizing Gender Bias

As we all know, gender bias is a systematic and pervasive problem that distorts our knowledge. Critiquing it is premised on the notion that socially dominant knowledge tends to be the knowledge of the ruling group.

On this basis, feminist scholars examined theories, empirical studies, concepts, language and methods in social science and humanities disciplines as well as in some life sciences and found that they displayed a systematic gender bias.

However, critiques - while crucial - are in and of themselves clearly insufficient. We also need, among other things, a new scholarship that explores and charts women's experiences, as seen by ourselves - not as attributed to us by men. For the other, we need some means not only to recognize gender bias but concrete suggestions how to avoid it. One of the tools to do achieve this is Gender-based Analysis (GBA for short).²

Stages in the Development of GBA

I look at the stages not as way stops - e.g. as plateaus we reached - but as intersections, moments where we paused and argued about where we should be going next.

1. Is there gender bias in research beyond the use of language? Yes

The first attempt to deal with the as yet only dimly perceived problem was to look at language. A slew of empirical studies demonstrated that sexist language results in sexist studies. The effort to eliminate sexist language has born fruit (at least in Canada). One unanticipated consequence was

¹ In other places, I have provided extensive references on this issue. For instance, see Eichler, 1991 and 1997.

² A note on terminology. The term „gender-based analysis“ is relatively new and tied to government initiatives. For instance, the Canadian government committed itself at the Beijing conference to apply GBA to all its policies. I use the term retrospectively to identify earlier efforts that described themselves in other terms, to avoid a confusion of terms with overlapping meanings.

that many people thought that fixing the language was all that was needed. Unfortunately, research can be sexist even though the language is nonsexist.

2. Does gender bias manifest in all phases of the research process? Yes

The next contentious issue that arose dealt with the scope of the problem. The agreement was that there may be biases in interpreting data, or in who is included within specific studies, but surely there can be no bias in methods. This was shown to be false. While the method itself may not be flawed, the way it is used certainly allows for gender bias to enter. For example, if an instrument was developed only on men, it is not sufficient to then apply it to women. It needs to be re-developed for both sexes if it is used for both. Stress scales (with items such as "wife takes paid job"), or stages of moral development³ are two famous examples.

3. Are there specific methods that are particularly useful for studying women in principle? No

A subset of the above debate was the issue whether there are specific methods that are more suited to studying women than men. This was often reduced to the rather simplistic formulation that qualitative methods are more appropriate for studying women than quantitative methods.

This view rests on a double misunderstanding. For one, it misunderstands the nature of qualitative methods by assuming that numbers and proportions do not matter. For the other, such dichotomization rests on misinterpreting a specific stage in knowledge production with a question of principle. When little is known about a subject matter, e.g. women, using explorative methods that have as their aim to re-conceptualize what the important issues are is usually more appropriate and likely to lead to richer insights. However, as more knowledge becomes available, the entire methodological tool kit becomes appropriate.

On the other hand, if all methods are potentially useful for studying women, it also means that we need to critically examine all uses of methods for potential gender bias, thus greatly increasing the scope of the problem to be addressed.

4. Are we dealing with one problem or multiple problems? Many

Early examples of gender bias usually point out the exclusion of women from various studies. If you only study men, e.g. with respect to voting behaviour, or in the workplace, you cannot generalize to the total population. The first solution to the problem of gender bias, then, was 'Add Women and Stir'. This approach understands the underlying problem as a simple one of exclusion or underrepresentation of women, and the solution therefore is inclusion and proportionate representation in all types of studies. The problem is located only at the level of the research design in terms of who is studied and at the level of interpretation of the data - the types of conclusions drawn on the basis of a one-sex sample. This fails to recognize that a study may contain an equal number of women and men, or may even be exclusively dealing with women, and yet display a gender bias.

Beyond focussing on exclusion or underrepresentation of women, the question of multiple vs. one problem was usually answered implicitly rather than explicitly. Two different but ultimately compatible assumptions are that we are either dealing with one sweeping problem, variously identified as a patriarchal, masculinist, androcentric, sexist or gender bias or to treat each problem as a unique manifestation. If this was the case, it is necessary to painstakingly start again from scratch every time another problem is suspected.

³ I have of course Gilligan's critique of Kohlberg's stages of moral development in mind, although Gilligan herself has been severely critiqued. For her original book, see Gilligan 1982.

A very important consequence of assuming the existence of one overriding problem is there would be one general solution which would suffice. It turned out, however, that it was possible to identify one problem and, in the intent to rectify it, substitute another one. For instance, treating the sexes as if they were two discrete groups is a sexist problem - true - but the answer is, of course, not, to therefore ignore gender differences, thus introducing the problem of gender insensitivity. Instead, we need to recognize both approaches as aspects of gender bias.

5. Is there a set of superordinate and subordinate problems that are non-reducible to each other? Yes

Once it was clear that gender bias does not consist of only one problem, but of a syndrome of related problems that are, however, non-reducible to each other, the task was to identify the superordinate and subordinate problems. This went through various versions, from the simple, to the extremely complex, and back to be simplified. We now recognize that there are three superordinate problems: Acceptance or maintenance of a gender hierarchy - the context within which gender bias occurs, the failure to recognize gender differences (or gender insensitivity) and double standards (instances in which differential treatment is unjustified). The two latter problems are mutually limiting, and must always be addressed together.

The insight that there are super- and subordinate problems opened up exciting new possibilities. If we could identify the underlying structure of a problem, it should be theoretically possible to transfer insights from one problem to a new problem, as yet unexamined. This, then, led to the next question:

6. Can we develop a set of abstract questions that allow us to identify the presence of problems and identify ways to avoid them? Yes

The issue was, of course, how to do this. It involved reading existing analyses of gender bias problems, reducing the issue to an abstract question, and then applying the question to other pieces and see whether it works. I will give only one short example here:

“Sociologist Van den Berghe interprets intergroup warfare as a rational means of gaining livestock, women and slaves, gaining territory or keeping territory, or gaining, controlling and exploiting new territory.”

At issue is the concept of “intergroup warfare”. If we ask from whose perspective it is constructed, we find that it is constructed from a male perspective - women, slaves and territory are gained, controlled or exploited. However, the concept itself does not indicate that it is limited in its scope - that is, it is not a question of language *per se*. There is therefore a mismatch between the empirical referent in the concept (dominant males) and the theoretical referent (two or more groups and presumably all its members, including its women). A male perspective is overextended to represent itself as if it is a universal perspective.

We now have generated a set of questions that can be applied to any other concept:

Who or what is the empirical referent? Who or what is the theoretical referent? Do the two match? If not, is the perspective of one sex extended to the other?

For instance, we can apply the questions to the issue of symptoms of heart attack. If female symptoms are identified as “atypical” - whose symptoms are seen as the norm? The term “heart attack symptoms” has the theoretical referent of all heart attack patients, but in fact, until very recently the symptoms were derived from and applicable to male patients only, hence the designation of female symptoms as “atypical”. We have now detected a mismatch between the theoretical and empirical referent within a concept. In this instance, the gender bias problem can be defined as using males as the norm (referring to the process) or overgeneralization (referring to the

outcome). We have successfully applied a set of questions derived from a prehuman prehistorical context to a very modern one. As we have seen, the logic underlying the identification of the problem is identical. This approach can be carried through with all other problems.

7. Can we combine the insights from step 2 - 6 into a comprehensive approach? Yes.

Assuming that gender bias can occur in all stages of the research process, checking for and avoiding it clearly must be an iterative process that needs to be engaged in at all stages. Of course, some stages are more encompassing than others. If the research design is sexist, then the interpretations will inevitably bear the mark of this. On the other hand, we may be dealing with a research design that is perfectly adequate for both sexes, and still come up with a sexist interpretation. We therefore need to identify the components of the research process and check every component for possible problems. This results in the following matrix:

Type of problem

Component of the Research Process	Androcentricity	Gender Insensitivity	Double Standards
Title			
Abstract/summary			
Language			
Concepts			
Visual Representations			
Research Question + Design			
Methods			
Data Interpretation			
[Policy Recommendations]			
Conclusions			

8. Is this approach culturally transferable? Yes

The next issue, then, was to examine whether or not this approach is usable only in North America, or also in other cultural contexts. We found that indeed, the approach is transferrable, for two reasons: most importantly, we supply only the questions, not the answers. The answers have to be provided anew within each context. The second reason is that the approach is not a closed one. Should it emerge that there are problems for which there are no abstract questions, these can be formulated and integrated into the current matrix, just as the components of the research process can be altered without any harm being done to the basic approach.

9. Is this approach applicable to activities other than research? Yes

For the Beijing conference, the government of Canada passed a resolution that all its policies and programmes would be screened for gender bias. This required adapting an approach that was originally designed for research to the policy process. It turned out that this was possible, using the same methodological approach as had been used for devising the questions for the research process. It required an identification of the elements of the policy process, and new subquestions needed to be developed.

10. Does the current approach deal adequately with issues of diversity/ intersecting forms of oppression? No

One question that was repeatedly addressed to us was whether this approach eliminated other forms of bias - specifically racist, ablist and heterosexist biases. The answer to this is a clear “no”. This approach was developed to deal with gender bias, not with all forms of bias. We tried to take account of the intersection of different types of oppression in the manner in which we chose examples, but clearly that does not eliminate other forms of bias.

11. Is it possible to devise a more comprehensive tool that would alert us to the presence of race, ability and gender bias? Hopefully.

This is where we are at present. We plan to use the same process - identify examples of racism or ablistism that have been discussed in the literature, determine their underlying logic, and formulate questions that will expose the problem, compare it to the existing questions and answers developed for gender bias, and develop superordinate concepts that apply to all three of them. In the process we expect to gain new insights into gender bias, as well.

12. Does this approach have other limitations? Yes

The three most important limitations of this approach are that first, as noted, it detects only gender bias - no other problems. It is therefore not a failsafe method to ensure a good study, since avoiding gender bias is only a necessary, not a sufficient condition for achieving this. A study may be flawed in other ways - it may be trivial, ask the wrong research question, etc. without exhibiting a gender bias.

Second, the best studies may be criticised the most. It is somewhat ironic that studies that provide more information about their methods, concept construction, processes etc. are easier to criticize than those that provide much less information. The extensiveness of criticism that can be levelled at any particular piece of work is therefore not necessarily indicative of its relative quality. Where a study is completely gender insensitive, for example by failing to identify the sex of the participants, then reporting the gender insensitivity simply at this level may be all that can be said about such a study.

Third, some forms of gender bias - e.g. hidden double standards - are very difficult to detect, and will require intimate familiarity with the subject matter. For example, an incidence of a double standard in Canada is the fact that legal aid is available for criminal cases, but not for civil cases. Men are more often in court on the basis of criminal matters, women on the basis of civil matters - usually related to family issues. One needs to know all of these facts in order to be able to detect that there is, in fact, a hidden double standard with respect to tax subsidies for law cases.

TYPES OF GENDER BIAS PROBLEMS

We have no time to go into detail on the various problems, subproblems, and the questions we have devised to alert us to presence of gender bias. I will therefore only present the types of superordinate problems and a selection of subproblems.

We have identified three superordinate problems: Androcentricity, which constitutes the context within which we are operating, and which is premised on male dominance and its maintenance, gender insensitivity - the refusal to see sex and gender differences in instances in which they are significant, as well as double standards - different treatment in instances in which this is not justified.

Androcentricity

In its broadest term, this signifies the adoption of a male perspective and the maintenance of system of male dominance. Androcentricity is a very frequently encountered problem, and may occur in any or all of the steps of the research process.

Several subtypes may be found. These include:

1. Taking males as the norm against which females are assessed

Historically the world has been seen and reported through the eyes of men. History books, for example, record the exploits of men, giving few if any glimpses of those of women. In so doing, the male experiences and condition are assumed to be also those of women. The criteria for diagnosing serious health problems such as heart attacks have been identified by looking at the symptoms displayed by men. The assumption has been that the same symptoms would be indicative of heart attacks in women; recent evidence illustrates that this is clearly not the case. As a consequence, women tend to be diagnosed later in the case of heart attacks, and are more likely to die of them.

2. Under-representation or exclusion of females in areas dominated by males

This occurs in studies that look only at male workers, or decision-makers, etc. but make statements about developments in the work place, the shape of democracy, etc.

3. Under-representation or exclusion of males in areas that tend to be identified with women, in particular in family, household, and community care-giving.

Ironically, this is a concomitant version of an androcentric bias. It derives from the notion of separate spheres for females and males, and is manifested, among other things, by internationally accepted definitions of fertility only in terms of women in childbearing age, by equating parenting with mothering, by a focus on female reproductive health hazards in the workplace while ignoring male reproductive hazards, even though men are fertile for a longer period of time than women. Similarly, most programs and most studies oriented to preventing teenage pregnancies have focussed only on young women. Indeed, data are not usually collected on those who impregnate them.

4. Accepting male dominance or gender-based violence

The old definition of rape as a property crime committed against a man who was seen as the proprietor of the assaulted woman - her husband or father, would be an example of accepting male dominance at the conceptual level.

Another manifestation would be the acceptance or justification of customs that violate women's bodies or that are otherwise damaging to them - e.g. breast-enhancement surgery for young girls.

5. Victim blaming

Victim blaming occurs when the behaviour and reaction of the victim are questioned rather than focussing on stopping the actions of the perpetrator. For example, in the case of a rape, violent assault or murder, research may focus on the behaviour of the victim, searching for a precipitating event. Women or girls may be criticized for being in the wrong place, for wearing the wrong clothes or for talking to the wrong people. Instead, perpetrators should be held accountable for their actions.

6. Gender Insensitivity

The overriding form that gender insensitivity takes is to **ignore sex or gender in a context in which they are, in fact, significant**. This problem is captured by the terms **gender neutrality** and **gender blindness** -- both of which refer to situations in which the effects of gender are assumed to be neutral or irrelevant. Adopting a gender neutral or gender blind approach may in fact introduce a gender bias, perpetuating existing inequalities for women and men. It is ironic that both these terms have been used (erroneously) to represent a movement toward gender equality.

Given the pervasive importance of sex and gender in our society, the safer way to proceed is to assume that sex and gender are socially significant, unless we have empirically shown that this is not the case in a particular situation or context, by conducting a gender-based analysis. Gender insensitivity tends to be easy to detect, but difficult to remedy. If a study fails to report the sex of its participants, then that is all we can note. In such a case, there is not sufficient information provided to probe for other problems -- however, one should be extremely wary of utilising such data.

Gender insensitivity also has several sub-forms:

1. Householdism

This occurs when the household or family is taken as the smallest unit of analysis in situations in which individuals within this unit may be differently affected by policies, situations, events, etc. Of course, it does not mean that one should never use the household or family as a unit of analysis. It is only when we are making statements about matters that may affect household/family members differently on the basis of sex that we are dealing with a gender bias. The point is to ensure that the unit of analysis corresponds to the level at which observations are made.

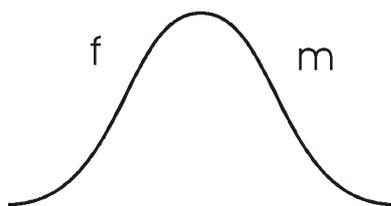
For example, when patients are discharged from an institution such as a hospital, the assumption will often be that their long-term care will be provided "by their family". In fact, not every family member will be affected in the same way. It is disproportionately women who are likely to provide the care. This may even involve giving up their paid work in order to be able to look after the person. Therefore, the differential gender effects need to be taken into account when dealing with a phenomenon such as de-institutionalization.

2. De-contextualisation.

This involves ignoring that apparently similar or identical situations may have different effects on the sexes by ignoring the context within which issues are located.

One example is the Canadian definition of young scholar. This used to be defined as a scholar under the age of 35 years. These young scholars had easier terms to compete for research monies. While the intent is admirable, it inadvertently disadvantaged women who have a different career trajectory than men, and often come back as mature students. Eventually we managed to have "young scholar" redefined as someone who had completed her or his highest degree no longer than five years ago. This eliminates the gender bias - and incidentally also benefits men who deviate from the more average male career pattern.

Gender insensitivity can be graphically depicted as follows:



f = female; m = male

3. Double Standards

Double standards involve **treating or evaluating substantially the same or identical situations, traits, or behaviours differently on the basis of a person's sex.**

They come in two versions: as **overt** double standards, and as **hidden** double standards. While overt double standards are relatively easy to detect, hidden double standards are, by definition, extremely difficult to identify -- because they are hidden.

Overt double standards may occur in all components of the research process. Whenever females and males are treated differently in situations where this disadvantages one sex, we are dealing with an overt double standard.

Hidden double standards are by definition difficult to detect and occur primarily at the conceptual level. Detecting a hidden standard and presenting a coherent argument as to why and how a particular concept or approach is premised on a hidden double standard is often a lengthy process. It usually takes many analysts and researchers working over extended periods of time and coming at the problem from many different angles and may involve a creative leap that alerts us to the presence of a hidden double standard. Part of the difficulty is that typically different terms have been used to describe two phenomena that are in fact the same. For instance, recognising that work in the labour force work and housework were two forms of work -- paid and unpaid -- exposed the hidden double standard that has disadvantaged women and resulted in an important re-definition of work as an economic concept.

There are two sub-forms of double standards:

1. Sexual dichotomism

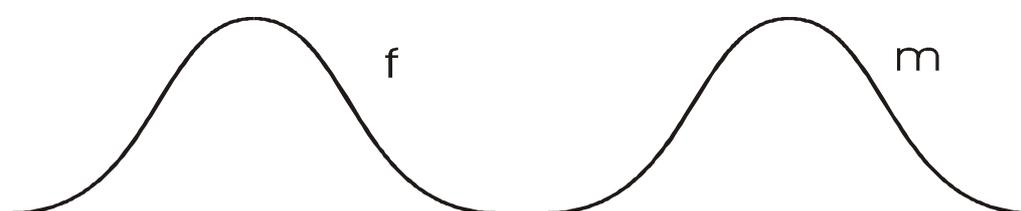
Sexual dichotomism, in many ways, is the inverse of gender insensitivity. It exaggerates sex and gender differences, (rather than ignoring them), by treating the sexes as if they were two completely discrete groups, rather than as groups with overlapping characteristics.

For example, some occupational health studies have attributed the higher number of poor health symptoms reported by women as being due to their hormonal cycles. In fact, the differences were attributable to differences in the nature of work and work conditions in which the women and men worked. An accurate picture of the issues involved could have been arrived at sooner had the work situations of men and women both been examined from the beginning rather than assuming that the women were different because of their hormones.

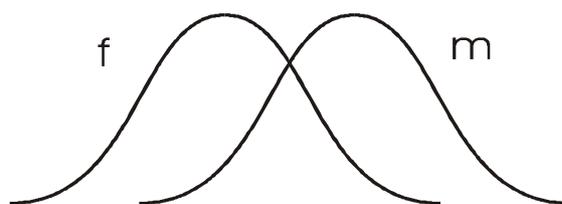
2. Reification of gender stereotypes

This involves treating a gender stereotype as if it were a sexual trait and a necessary part of our human nature rather than a socially-imposed expectation, and is often integrated into masculinity-femininity scales.

Double standards can be graphically depicted as follows:



What we want to move towards is an adequate and appropriate way of understanding both sexes:



This image also graphically depicts that gender insensitivity and double standards must always both be looked for, since they are mutually correcting.

Towards an Integrated Framework for Inequality Analysis

I have briefly described the process by which we arrived at the questions which are at the heart of this approach to GBA. We aim to repeat the same process with respect to applying it to racism and ablism.

We will start with a comprehensive review of the literature (as we did for GBA)⁴ and identify the various forms of racist or ablist biases that have been discussed in the literature. We will then compare them to our gender bias items, and see whether we can create a superordinate way in which to express the biases (although at the moment I will use only on the racist bias as an example).

For instance, androcentricity involves the maintenance of a gender hierarchy. Racism involves the maintenance of a race hierarchy. The overriding question is therefore: does this study support or maintain a hierarchy based on gender or race?

Ways in which this may be achieved include devaluation of people belonging to the subordinate group, objectification of group members, overgeneralization on the basis of gender and race, application of norms derived from the dominant group and applied to the subdominant group, exclusion, under representation and marginalization. Gender insensitivity is a failure to perceive sex or gender differences where they are relevant - the same applies to race differences, and it includes the assumption of homogeneity in both the dominant and the subdominant group, as well as the failure to contextualize situations.

Double standards again come in two forms - overt or hidden. It is the hidden double standards which are particularly difficult but important to detect, and for which we will search in the literature.

⁴ We examine over 100 other guides and lenses in order to be sure that we would include all types of bias that had already been identified.

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Gender Bias - Gender Research - Development and Implementation of Methodological Standards for Gender-specific Research in Public Health

Prof. Dr. Ulrike Maschewsky-Schneider & Dr. Judith Fuchs, Technische Universität Berlin

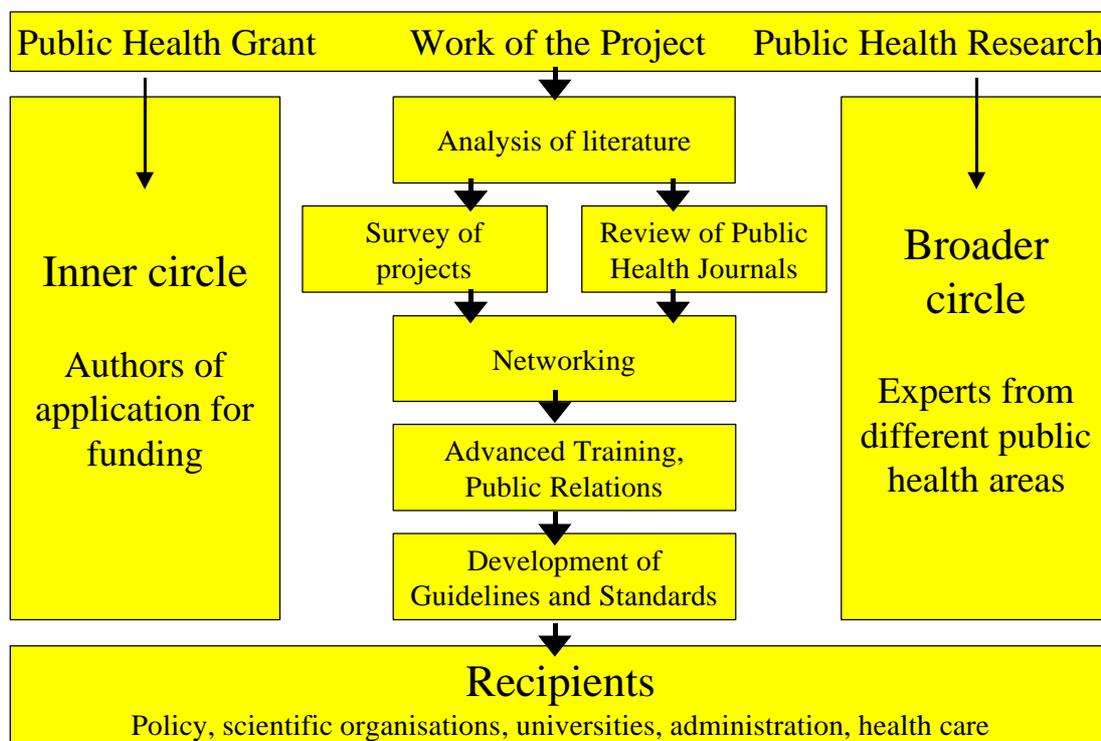
Description of the Project

The overall aim of the project ‘Gender Bias - Gender Research’ is the analysis of the situation of gender specific health research in Germany and the development of research standards for gender sensitive research in Public Health. The project investigates, to what extent gender issues are appropriately considered in German Public Health research in view of the theoretical conceptualisation and methodology in the study designs. Targets of the project are:

- to evaluate the status of research on gender and health in Germany which is relevant for Public Health,
- to identify gaps in research and knowledge and to work out the specific differences which influence the health of women and men,
- to find factors and conditions which determine differences in the health status of women and men from different social groups or specific situations in life and
- to reflect and discuss the actual research in view of the improvement of prevention, health promotion, and health care for women.

As a main result we expect to develop and publish guidelines for avoiding gender bias in Public Health research. These guidelines should enable Public Health researchers to appropriately conceive and execute their research with consideration of gender issues.

Image 1: Structure of organisation and work of the project “Gender Bias - Gender Research”



The working areas of the Gender Bias Project are:

- **Analysis of Literature:** Analysis of theoretical and methodological literature regarding gender bias in the international literature and German-speaking countries, in order to develop a questionnaire for the evaluation of public health research concerning gender issues
- **Survey of all Public Health Projects:** all projects carried out within the Public Health research networks funded by the German Federal Ministry of Education, Science, Research and Technology (BMBF) fill in a written questionnaire concerning the inclusion of gender issues in their research.
- **Review of German-language Public Health Journals:** all empirical articles are reviewed concerning the inclusion of gender issues in their publication.
- **Networking:** working with the inner network and building up an extended network with Email-discussion-lists and workshops.
- **Advanced Training, Public Relations:** Advanced training concerning the consideration of gender issues in health care and research of scientists and administrative staff; realisation of lectures, workshops and publications.
- **Formulation of Guidelines:** Development of a recommendation catalogue for gender-sensitive health research.

Results of the Survey

Between the years 1992 and 2001, in Germany, 317 projects were carried out within the Public Health research network. Based on Eichler's handbook (1999), we developed a written questionnaire which was sent to each principal investigator of current and already terminated Public Health projects. The project leaders came from many different research areas such as medicine, health sociology and psychology, or health economy.

The questionnaire covered different areas:

- The **subject:** Retrieving if the subject of the project is gender-specific.
- The **research process:** Following the research process we started the questioning by asking questions about formulation of hypothesis, including gender issues in design and methods, in the analysis of data and conclusions of the study.
- Apart from the project's topics we were interested in the **rating of the experts** concerning the requirements for gender-sensitive research for the future.

The survey was carried out from May until August 2000.

We developed two versions of the questionnaire: an online and a written version. The online version could be filled in during an internet session. The advantage for the respondents is, that they can login with a special password, fill in the answers and stop and go back at any time they want. The advantage for the researchers are immediate reception of data, no errors through transmission and quick access to the answers.

The sample

We had an overall response rate of 66.6%; 33.4% didn't answer at all. We consider the non-response-rate as moderate, because about half of the projects were already finished in the year 1995, that means they were finished five years before we started the questioning and some of the project leaders and even more research workers were working in completely different contexts. From the 210 respondents 148 (70.4%) used the online questionnaire, 36 (17.1%) filled in the printed questionnaire and sent it back by mail, 26 (12.4%) persons rejected to take part.

170 persons filled in the questionnaire completely. 77 persons (45,3%) were project leaders (41 males, 31 females), 83 persons (48,8%) research fellows (55 females, 24 males), 10 (5,9%) others like secretaries (6 males, 3 female).

A noticeable higher proportion of women (73,2%) answered the questionnaire than men (54%), the difference is significant. Women are obviously more interested in gender issues than men.

Topics of the research projects

About $\frac{3}{4}$ of all the projects (76.9%) worked on issues concerning women and men, a small proportion referred to women (8.1%) or to men (1,0%) only. 13.9% did work on other topics like methodology ('Quality assurance', 'Quantitative methods in Public Health – health measures and health indices') health economy, community health or dental care ('Dental damages caused by inhalations').

Is the comparison between women and men important in the hypotheses?

Only a small proportion (6.2%) answered that the comparison between women and men was a main hypothesis, 41% indicated 'auxiliary hypothesis', which shows that almost half of the overall projects had gender issues in mind while formulating their hypotheses. Four out of ten project leaders or research fellows answered that gender is/was not important. These projects cover areas like reproductive health ('Integration of health promoting and medical methods in pregnancy'), health technologies ('Control of quality of image-giving diagnostics') or work organisation.

How do you analyse your data? and Did you find gender-specific differences?

The questions were given only to projects focussing on human beings. 24.5% of these projects analysed all results stratified by sex, 32.9% did the analysis partly stratified by sex, 19.6% include sex as a control variable and the remaining 23.1% indicated 'others'.

From projects which included sex and gender issues in their work almost half (49.3%) did in fact find gender-specific differences in their results, 15.5% didn't; 35.1% couldn't answer the question. These results underline the importance of including sex as a central variable in research, in order to identify joint and specific women's or men's health influencing factors. The knowledge of congruent and different factors could lead to other hypotheses in future research.

Necessity of special consideration of gender issues in the research process

The experts estimated the importance of the consideration of gender issues in every step of the research process on a five-point Likert scale. Female researchers indicated that the inclusion of gender issues is important or very important in every step of the research process. In their view the most important areas are research question, design, sample and conclusion. Men rated all the steps slightly lower than women. Men obviously don't consider gender issues as important as women. But men's selection of very important steps in the research process is similar to the women's rating.

Conclusions from the survey

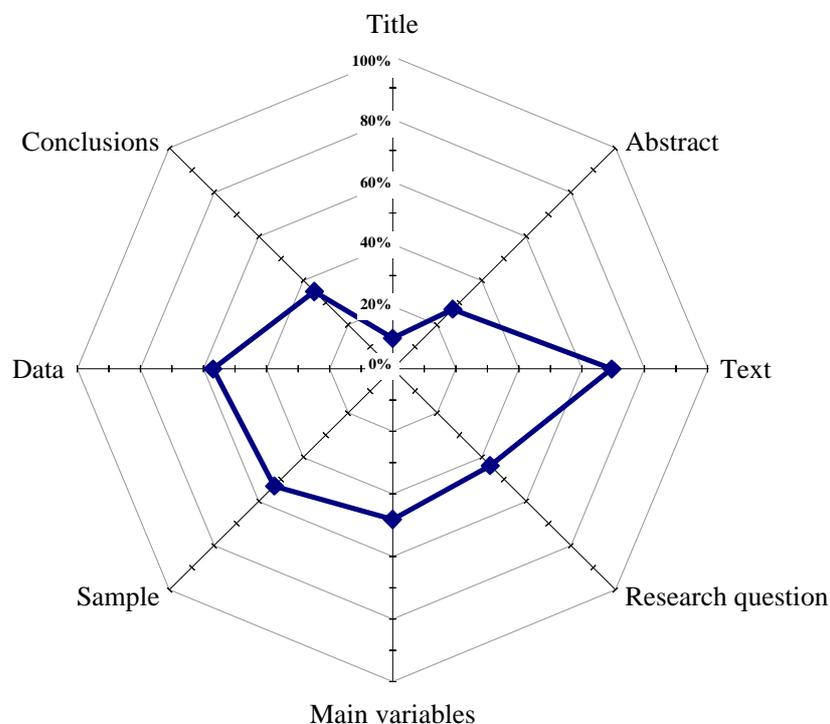
The participating women and men are comparably interested in doing gender-sensitive research, but we have a specially selected sample. People who aren't interested in this kind of research probably didn't fill in the questionnaire, while scientists who participated in the survey show sensitiveness for gender issues. This is a good starting-point for advanced training. The training should start focussing on the formulation of a gender-sensitive research question, design, and conclusions.

In future guidelines the inclusion of sex and gender in all analysis should be standard in the way that all results are broken down by sex (and possible other important variables like age, social class or migration) in order to seize the influence(s) and take them into account appropriately.

Results from the review of literature

Starting basis for the review of literature were 516 original articles in German-language journals ('Sozial- und Präventivmedizin', n=108, 'Das (öffentliche) Gesundheitswesen' n=354, 'Zeitschrift für Gesundheitswissenschaft' n=55) published in the years 1990, 1995, 1999. Publications indexed as abstract, letter, editorial, interview, etc. were excluded. 268 articles (215 empirical articles, 53 review articles) were included, rated by two raters using a specially developed standardised rating form based on Eichler (1999). 248 articles were not analysed because they were either publications not dealing with human beings or theoretical articles where special expertise for rating is necessary. Examples for excluded articles are 'Toxicological evaluation of transgression of limits', 'Question of infectiousness of tuberculosis' or 'Co-ordination and planning in community psychiatry'. Image 2 gives an overview of the main results from the 268 analysed articles of the review.

Image 2: Percentage of articles which consider sex/gender in...



Looking at the empirical (data collecting) articles nine out of ten (89.8%) include both sexes in the research. About 10 % focussed only on one sex; they mainly dealt with reproductive issues. Concerning the more formal criteria like title, abstract and language of the text we stated that more than 90 % didn't mention the sex of their research subjects in the title and about 73% didn't mention them in the abstract, whereas a closer look at the formulation of the text showed that the main part of the articles (69.5%) at least mentioned both sexes in the text.

Going into the contents we realised that more than half of the articles (56.3%) didn't consider gender in the formulation of the research question and only 48.2% took gender differences into account in the main variables. On the analytical level 53% described the sample and 57% analysed the data by sex. As an unsatisfactory result, we want to remark on the result of the inclusion of gender in discussion and conclusions of the articles: only 35% of all empirical or review articles regarded gender. This leads to the assumption, that recipients of these articles may not become aware of concordances and differences between women and men as a basic condition for further research.

Conclusions from the review

Advanced training to raise the sensibility for gender issues in the scientific community and guidelines for good publication practice seem to be very necessary, because

- the main part of the reviewed articles included both sexes, but the author(s) didn't make it obvious in title or abstract. To denominate the sample in title or abstract is a criteria which is found in all guidelines for good research and should be standard in every article.
- the majority of the authors of articles dealing with both sexes didn't mention gender issues in the research question and only half considered different life conditions of women and men in the main variables.
- a minority of authors paid attention to possible gender differences in their results and formulated corresponding conclusions.

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From Theory to Practice and Back: Gender Based Public Health in the Netherlands

Dr. Joke Haafkens, University of Amsterdam; Lea den Broeder, Netherlands School of Public Health

Important developments

In the past twenty years a number of developments took place in the Netherlands, which will be mentioned.

- Development of a women's self help movement:
Women's health centres, women's self help groups centered around specific health problems such as mastopathy, PMS, or around stages of life (menopause, elderly women). This has drawn attention to a more patient-centered approach in medical care.
- Development of women's studies / gender studies in medical science:
This started with a feminist approach towards gynaecology and reproductive health. Later, groups in different universities developed in different directions, varying from topics concerning medication and women (*Amsterdam*), to gender differences in complaints presented in general practice (*Nijmegen*) or gender and health in non-western societies (*Leiden*). The two fields (research in the academic setting and the autonomous women's health movement) mutually stimulated each other.
- Growing attention for gender factors in health promotion and prevention practices:
the methods and ideas developed by the women's health movement were taken over by regular health extension programmes. Although sometimes not exactly in the way the women's health movement would have liked: health extension activities very often reproduce stereotypes about women/men by the very fact that they want to fit to the target group.
- Process of integration of a gender perspective in curative health care:
this took place especially in mental health care, in general practice, and in gynaecology. This resulted in better awareness of gender specific health risks.

Coherence between science, practices, policies

However, gender based public health requires coherence between science, practices and policies which is currently lacking. How can this be accomplished?

Three points are vital here.

- Structural attention for gender in health policy and planning
- Evaluation of practices
- Strengthening evidence base

Let us have a closer look at each one.

Integration of Gender in Policy and Planning

First of all, in public health planning and policy the gender factor needs to be integrated. National policy currently aims at integration. While in the health practice science fields in the mid-nineties everyone thought a gender approach was outdated, the new programme of the MOH provides a boost for new developments in the field of public health.

The Dutch government has made a start by financing a programme aiming at four work fields in health: Medical Training, Quality Control, Patient's Perspective, and Research.

However, on local or regional levels, public health policies show a different image. Gender sensitive public health programmes are carried out on an ad hoc basis, completely depending on personal commitment of people involved. They are often temporary. Mainstreaming gender at policy level therefore, is necessary. Instruments such as those, used in Gender Impact Assessment should be developed for the public health field. These instruments, again, need a scientific evidence base to be effective and useful.

Evaluation of Practices

Secondly, practices, methods and instruments need to be evaluated for both effectiveness and efficacy. Moreover, health research should address new questions arising from gender sensitive public health practices, such as questions concerning gender differences in responses to health extension activities. 'Best practices' should be dispersed in the public health field. The circumstances are pretty favourable because of the specific way the Dutch health care system is organised, with a very strong primary health care (GP's, midwives, first line psychosocial care) which controls referral to the second line health care (medical specialists, residential health care).

There is a strong movement in the Netherlands regarding the development of standards. Including a gender approach into the already existing standards as well as in standards that are currently being developed is an important strategy working towards more gender sensitivity in public health.

Evaluation of Practices

- Assess effectiveness and efficacy
- Identify questions/problems to be studied
- Disperse 'best practices'
- Development of standards and protocols

Strengthening the Evidence Base

Thirdly, a strong evidence base for both policy and practice needs to be built up. Although excellent research has been carried out, this was mainly done in off-mainstream settings such as autonomous women's studies departments. Therefore, the body of knowledge built up is hard to integrate into the more established fields of medical science. A mainstreaming approach may be useful here. We should also co-operate with the scientific establishment. This is already happening more and more

often. The MOH programme is stimulating this by providing financing for research concerning diversity matters.

However, the existing networks in women's health and medical gender studies should be maintained to keep a critical glance at regular care, prevention, health promotion and science.

Strengthening the Evidence Base

- Bringing existing data/results into the scientific mainstream
- Co-operation with scientific ,establishment‘
- Building up and maintaining networks

Gender Bias in Research and Clinical Practice in Italy

Paola Vinay, Sociologist, Prospecta

Introduction

A recent technical paper on gender and health of the World Health Organization (WHO, Department of Women's Health, 2000) stated:

„The ‘natural’ course of disease may be different in women and men; women and men themselves often respond differently to illness, while the wider society may respond differently to sick males and sick females. Women and men may also respond differently to treatment, have different access to health care and be treated differently by health providers.“

In this presentation I will talk about the issue of gender bias in medicine drawing from the work done by the group „*Una Salute a Misura di Donna*“ (Health Made to Measure to Women's Needs) formally constituted in September 1999 at the Cabinet of the Italian Minister of Equal Opportunities. The group is composed of 11 women from different medical, health and social professions whose clinical practice and research in part address specific gender aspects of health¹. The aims of the group are: to create a unified field of observation of the most common diseases affecting women; to point out research biases against them; and to propose guidelines of intervention for a women - friendly healthcare system. The group recently produced a published Report (Dipartimento Pari Opportunità - Reale ed., 2001) underlining a number of relevant problems and prejudices that limit research and clinical work in behalf of women's health. I shall mention the most relevant ones with particular reference to cardiovascular diseases, mental health (depression and schizophrenia), tumours of the uterus and lung, gastrointestinal diseases and the impact of violence on women's health.

1. Health Research and Data Collection

The lack of gender-specific health data is the first problem to be mentioned. It is well known that women have longer life expectancy than men in similar socio-economic positions. Nevertheless, they suffer from poorer overall health because of age, biological factors, specific risk factors, poverty and loneliness. According to the data of the National Statistical Institute (ISTAT, 2000a; ISTAT, 2001), in Italy life expectancy is 82 years for women and 75.8 for men. This gap between women and men decreases with age and if we consider life expectancy free from disability. At age 65, life expectancy is 20 years for women and 16 for men, that is a gap of 4 years, but if we consider life expectancy free from disability this gap is reduced to one year only (15 years of life expectancy at 65 for women, 14 years for men). At age 75 the difference in life expectancy between women and men free from disability is irrelevant: only 0.3 years (Ministero della Sanità, **2000**). Moreover, compared to men, women report more illnesses and diseases (particularly arthritis, osteoporosis, hypertension, depression): survey data on self reported state of health show that a wider share of women than men report at least one chronic disease, and in 23 out of 28 categories of diseases, the prevalence is greater among women (ISTAT, 2000a; ISTAT, 2000b).

¹ The members of the group are: Terri Ballard, epidemiologist; Giuseppina Boidi, chief psychiatrist; Adriana Ceci, full professor of Pharmacology and Human Physiology; Laura Corradi, professor of health sociology; Irene Figà Talamanca, full professor of occupational health; Daria Minucci, full professor of Oncological Gynaecology; Maria Grazia Modena, full professor of Cardiology; Nadia Pallotta, gastroenterologist; Elvira Reale, chief psychologist; Patrizia Romito, professor of psychology; Paola Vinay, sociologist.

The report of our work group provides data on male and female prevalence and incidence rates for several diseases. Where national official data was not available, the experts of the group have drawn from international data or from data originating from their own research and clinical work.

More men die of lung cancer but in Italy, during the years 1984-1994, women's mortality rate for this cause increased by 18%, while the men's rate decreased by 4%. The World Health Organization estimates that lung cancer (together with tumours of the trachea and bronchus) represents the third cause of death in the European population. Moreover, a lung cancer emergency for women is foreseen for the coming decade. (Ballard and Corradi, 2001; World Health Report, 2000). Mortality among women for AIDS has reached the male rate: indeed, AIDS constitutes the main cause of death among women in the age bracket 15-44 and in this age bracket their mortality rate is higher than men's (Corradi, 2001; World Health Report, 2000).

As the World Health Report shows, all types of mental disorders, except for alcohol and drug abuse, are increasing and more common among women; in particular, unipolar depression ranks 4th for women and 8th for men in terms of the main causes of disease burden at the world level. Depression is 2-3 times more common among women compared to men and is the main cause for disability among women in the age bracket 15 - 44. In Italy, a recent study demonstrated that the prevalence rate for all psychiatric disorders is higher among women and that the peak incidence for depression occurs in the age bracket 35-44. In spite of the fact that depression is more common among women, there are no gender-oriented research and intervention programmes for its prevention and treatment in our country (Reale, 2001 and cited bibliography). Until recently schizophrenia was more commonly diagnosed among men, but according to recent data the trend seems to be on the increase among women, although among them this mental disorder shows less socially undesirable traits than in men. (Boidi, 2001; World Health Report, 2000).

Today the rate of death for cardiovascular diseases is also higher for women than for men. According to the World Health Report, they represent among women the first cause of death in all western countries and, in recent years, also in developing countries. In Italy, according to data of the National Statistical Institute, in 1991 cardiovascular diseases were the cause of death in 48% of adult women and in 39% of adult men. Hypertension, the most important risk factor, is more frequent in males up to the age of 45, while in females it is more frequent from the age of 50. Recent research on women of the age bracket 45-60 of the Province of Modena shows that 38.2% suffer hypertension; however it is striking that only 34% of them receive adequate treatment. There is much evidence in the medical literature of a general under-evaluation in the diagnosis of ischaemic cardiopathy in women. (Modena, 2001 and cited bibliography).

In spite of these data, in Italy a structured national system capable of monitoring social differences in health is not available; more specifically, aside from mortality and cancer incidence, data and research on gender difference are lacking and health data are not systematically collected and disaggregated by sex. The information provided by hospitals and local health units is incomplete, not divided by sex and often unreliable. There are no clear national norms for including gender as a basic variable in all data collection (Vinay, 2001).

It is self evident that gender sensitive research and data collection are very important to promote women's health. The cited WHO technical paper emphasized this matter with these words:

“First and more importantly, it is essential that the situation of women is more accurately reflected in routinely collected health statistics. It has been a frequent complaint of policy makers that most statistics are not disaggregated by sex. This makes it difficult to understand the specific situation of women (or men) and to plan in ways that take these differences into account

(i.e. making projects gender sensitive). If this is to be remedied, special care is needed both in the collection of data and also in its analysis and presentation. If the diversity of women's needs is to be acknowledged it is particularly important to have data that is disaggregated by sex and age as well as social class."

2. Gender Sensitive Research on Risk Factors

Another important problem underlined in the report is **the lack of gender sensitive research on occupational and environmental risk factors**. Little attention has been given to these risk factors for depression, ischaemic heart disease, breast and uterine cancer, since these diseases have been, up to now, considered to have mainly hormonal etiology. Let us make some examples.

Tobacco smoking is the main risk factor for lung cancer. Women start smoking earlier than men and have more difficulty quitting. However, primary prevention of tobacco smoking is gender-blind, that is, aside for the period of pregnancy, specific messages aimed at girls and women are lacking. Instead, an effective primary prevention should investigate gender and socio-cultural factors associated with smoking initiation and cessation.

In the field of mental health, research on etiological and risk factors are mainly oriented toward the evaluation of biological-hormonal factors, generally omitting for females (but not for males) the investigation of psycho-social and work factors. There seems to be gender bias in psychiatry that underlies the consideration of hormonal variations as the major risk factor for depression and other psychiatric disorders in women. As in general medicine where there has been an improper process of medicalization of the physiological stages of a woman's life, also in psychiatry there has been a process of psychiatrization of female physiology: this is particularly true for depression. Among women there has been a clear under-evaluation of environmental and psycho-social factors as well as of the impact of every day life on their mental health. Moreover, in studying etiological and risk factors for mental disorders in women, specific targets in the National Health Programme have not been foreseen (Reale, 2001 and cited bibliography).

In the research on risk factors for ischaemic heart diseases, for women there seems to be an over-evaluation of biological and hormonal factors and an under-evaluation of environmental and stress factors; stress is considered the main risk factor for ischaemic heart disease only for men (Reale et al. 1998; Modena, 2001).

Occupational health remains an area where we lack knowledge about occupational hazards and their effects on women's health: often this type of data is not disaggregated by sex or there is insufficient detail on women. However, in many occupations that may be considered „female“ hazards are very high: in the health sector 54% of accidents involve women. As more women work, occupational injuries are increasing among women (+ 8.4% from 1994 to 1997) while decreasing among men (- 9.8% during the same time period). More studies are needed to investigate whether occupational exposures have different effects on female workers than on male workers. One example is heavy physical work, which is less well tolerated by women. This is partly due to the fact that work organization is based on standard measures designed for male workers. Italian women more frequently suffer from musculo-skeletal disorders, compared to men, even in the same work environment. This is because women are given repetitive tasks in fixed and inadequate ergonomic positions which puts excessive pressure on their smaller and more vulnerable muscles (Figà Talamanca, 2001).

In studying risk factors for cancer, the type of work is always considered for men while the same emphasis on work has not always been taken into account for women. However, some recent studies have shown the correlation between some forms of tumour (kidney, lung, leukemia,

lymphoma) and exposure to solvents and hydrocarbon among female workers. Thus, also in the field of occupational health, information is lacking. The model of reference is the standard male worker and (except for pregnancy) there are no guidelines to measure work hazards for women (Figà Talamanca, 2001).

As we know, a very important risk factor for women is the **stress and strain linked to the multiple work** load for the family and for the labor market. Our work group has underlined that in medical research and clinical practice, great importance is given to **work** as a major risk factor in the analysis, prevention and treatment of diseases in men, but for women little attention is given to this factor or to other life conditions. In particular, little or no attention is given to the coexistence for women of a plurality of roles, responsibilities and tasks linked to their professional and family life. The risk of physical and psychological burn-out is neglected and parameters capable of measuring the hazards and satisfaction of family work are not available (Reale - Vinay, 2001).

Several sociological studies have underlined the amount of work done by women within the family in its various forms. This invisible work, indeed, goes far beyond what is commonly called housework, but involves also the production of goods and services for family consumption; the bureaucratic activities necessary to use the public services; the activities to promote health and cure the first symptoms of illness; as well as the activities necessary for the education, socialization and caring of the children, the old, the ill and disabled members of the family.

In this respect - due to the lack of public services and to the traditional division of roles within the family - Italian women's work burden seems to be particularly high. The study of family use of daily time has underlined that on the average, Italian women spend 5 hours a day in paid work and 8 hour in non paid work, while men spend 8 hours in paid work and 1 hour in non paid work (ISTAT, 1993). Moreover, men's pattern in the use of time does not vary significantly by the different type of family they live in, while women's use of time is significantly affected by the presence of children in the family and of a partner as well. In this respect, women with children seem to be advantaged by the absence, rather than by the presence, of a partner in the family (Sabbadini - Palomba 1993). In the end, as the chairwoman of the Italian Equal Opportunity Commission has underlined, considering both paid and non paid work, more than 50% of Italian women work 60 hours a week and over one third work 70 hours a week, while less than one third of men work more than 60 hours a week (Piazza, 1999). Thus, family work and its character of caring for others (as opposed to caring for oneself) can well be considered as a major risk factor for women's health. As a matter of fact, research on stress and women's daily life (Reale et al., 1998) suggests a relation between hypertension, breast carcinoma and depression and the increase in family work responsibilities.

Violence is a frequent experience in the life of women and is considered a risk factor for poor health among them. According to an Italian study on a sample of users of various socio-health services, one out of ten women in the sample and 18% of those in the age bracket 18-24, had experienced physical or sexual violence in the twelve months preceding the survey. The perpetrators of the violence are almost always men close to the woman: her partner, former partner, father, brother, school mates or work colleagues (Romito ed., 2000). It is rare that women are listened to, believed or given adequate help by the social and health workers of the services they resort to (Romito, 2001).

The WHO technical paper says this about violence (WHO, 2000):

“Male violence against women, particularly in the home, has many damaging consequences for women's health, including intentional injury. (...) In most communities women appear to be at

greater risk from intimate male partners or other men that they know, and the violence girls and women experience occurs most frequently in the ‘haven’ of the family. The damaging effects on women’s physical and mental well-being can be extremely pervasive and go far beyond injury.”

The effects of violence manifest themselves in common diseases for which women seek health care. A study in Italy on the relation between chronic gastrointestinal disorders and physical and/or sexual violence suggests that male violence against women has many detrimental effects on health status. This includes many types of disorders, in particular those without clear “objective” causes (Pallotta, 2001). In several countries, epidemiological studies have shown that from 30 to 60% of female patients with chronic gastrointestinal disorders also have a prevalence of a life time history of physical and/or sexual violence. In Italy, studies on patients referred to gastroenterological outpatient clinics have shown that the prevalence of physical and/or sexual violence was 32%. The results of the study suggest that the severity of symptoms, the unfavorable treatment outcome and the quality of life are correlated to the severity of violence suffered. Furthermore it was shown that 86% of non-patients women who submitted to severe physical and/or sexual victimization, and who received shelter and aid by anti-violence centers, reported on the average 8 gastrointestinal symptoms. (Baccini-Pallotta-Badiali et al. 1998; Calabrese-Baccini-Pallotta et al. 1999). Thus, physical and sexual violence represents an important detrimental factor for women’s health conditions.

3. Gender Differences in Diagnosis and Treatment

Another important problem underlined by our work group is the **inadequate consideration of gender differences in diagnostic and therapeutical practices**. These practices have traditionally been developed around a male model and applied also to women without taking into consideration social and bio-psychological differences between the two sexes. In this respect the lack of consideration of gender differences in research can cause problems related to the development of instruments and techniques for the diagnosis and treatment of diseases in women. Some examples will make this point clear.

Schizophrenia among women is undervalued. For this psychiatric disorder, priority is given to the most serious cases from the point of view of social disturbance. Women with schizophrenia often have more subtle symptoms which lead to an under-recognition of the problem. They often seek help later than men with the same condition, are treated more often on an outpatient basis and have fewer hospitalizations than male schizophrenics (Boidi, 2001).

For cardiovascular diseases, in particular ischaemic heart disorders, all diagnostic techniques such as imaging tests and stress tests used currently were created on the basis of a male model and are less effective for making the diagnosis in women. The interventional procedures for coronary revascularization (by-pass, coronary angioplasty) are the same as those used for men and little attention has been paid to the fact that women have smaller coronary arteries and blood vessels. There are no guidelines that define typical symptoms of myocardial infarction in women: the chest pain women report is considered “atypical” while male pain is considered “typical”. The diagnosis of ischaemic heart disorders is left up to the clinical skill of the individual physician, given the absence of specific clinical diagnostic guidelines for women. There is evidence, moreover, of an under-utilization of thrombolytic therapy in eligible women with acute myocardial infarction, leading to a higher female mortality rate in early stages of infarction. For all the above reasons women are admitted to the appropriate hospital and intensive care unit later than men and experience a higher rate of therapeutic and surgical failure (Modena, 2001 and cited bibliography).

On the other hand, for other specific female diseases we note excessive medicalization and surgical intervention. This occurs often in the case of breast and uterine tumours and other disorders. For

instance, hysterectomy is widely resorted to, but the rate varies very much from one country to another (one woman out of three over 60 years of age in USA and Australia, one woman out of five over 65 years of age in Great Britain). In Italy national data is not available, but according to several regional surveys the trend seems to be on the increase. In the Veneto region, for instance, the number of hysterectomies has been increasing between 1993 and 1996; according to the data collected, in that region one woman out of four undergoes a hysterectomy in her life span. Important variations between countries and physicians are reported also with regard to the choice of type of hysterectomy - whether limited to the cervix uteri or total, and whether involving also the surrounding tissues, the adnexa uteri and the ovaries. Other variations concern whether the intervention is done abdominally or vaginally, and the surgical technique used - traditional, laparoscopic or mixed surgery (Minucci, 2001 and cited bibliography).

Often hysterectomy is associated with removal of the ovaries (oophorectomy) for no clear clinical indication, thus making this practice the only case where a healthy organ is intentionally removed. There is evidence of an extensive and inappropriate use of hysterectomy, not supported by efficacy standards; in fact, in this field reliable protocols and guidelines for the appropriate surgical indications are not available. It must be recalled also that hysterectomy may have many harmful outcomes, mainly those linked to the hormonal, physical and psychological impact of the loss of the uterus and other reproductive organs. Therefore, hysterectomy is appropriate when it is the only possible way to prevent or to remedy a health condition and in any case should be limited to the removal of the smallest possible part of the organ, resorting to the less invasive procedure. Several surveys demonstrate that only 10-15% of hysterectomies are in relation to a malignant tumour, while 85-90% are in relation to benign conditions which could well be treated without surgery. Clear protocols are needed defining the clinical situations for which hysterectomy is appropriate and those for which a medical therapy or a surgical preservative therapy is adequate. The diffuse practice of hysterectomy undermines the criterion of integrity of the individual person, the uterus being considered only for its reproductive function (Minucci, 2001).

4. The Exclusion of Women in Clinical Trials

A very important problem that was addressed by the work group is the **exclusion or insufficient presence of women in clinical trials**. In spite of the physiological and pathological differences between females and males, up to now in medical and pharmacological research, adequate attention to women has not been given. In clinical trials conducted to test new pharmaceutical products, mainly adult males are employed. This means that, as a rule, the same right to an 'effective and safe' therapy – as stated in national and european norms – is not granted women since there is no way to know if a product shown to be effective and safe in men is likewise in women. Moreover, even when women are employed in great numbers in these studies, the data is not as a rule analysed by sex (Ceci, 2001).

The exclusion of females in pharmacological trials may cause problems related to dosages, efficacy and side effects. There are several classical examples we can site. Women have been excluded from the largest population study ever done, the "Aspirin study", designed to evaluate the impact of aspirin on the prevention of cardiovascular diseases. Because of insufficient numbers of women present in the study of pharmaceutical products for reducing cholesterol, these products have been shown to be dramatically less effective for the female population than documented in clinical studies and in the male population (Ceci, 2001).

All clinical trials for the treatment of ischaemic heart diseases have been conducted on the basis of the male model. In the example of pharmacological treatment of cardiac thromboses, doses inappropriately based on the relationship of body surface area to body weight in males (but which

varies by sex) has resulted in more frequent haemorrhagic complications among women (Modena, 2001).

Women come first as psychopharmaceutical consumers, however, because of their inadequate representation in clinical studies, knowledge on side effects and efficacy of psychopharmaceuticals on females is more limited than on males (Reale, 2001). Also in the pharmacological treatment of schizophrenia women suffer more often from several side effects due to high dosages made to measure for men (Boidi, 2001).

In every clinical area there exist examples of drugs that are tested predominately on men but that are indicated with equivalent doses also for women, giving rise to potentially higher risks of ineffectiveness or more severe side effects among women treated by these drugs. This points out the urgent need for European guidelines on gender-specific testing of pharmaceutical agents before they reach the market and are indiscriminately prescribed both for women and for men.

Concluding Remarks

In conclusion, the group work has underlined mainly two inappropriate criteria in approaching gender problems. The first one is the inadequate consideration of overall biological differences between sexes (aside from the reproductive sphere). Most essays in our report underline that man and his biology is being constantly taken as the sole reference point for clinical studies; this has favoured the exclusion of women from clinical trials, an inappropriate methodological procedure that puts in question the validity of this activity. In fields such as cardiology, pharmacology, oncology and occupational medicine, gender differences are not considered and the effectiveness of diagnostic tests and treatments is essentially measured on men. The exclusion of females in medical research causes problems of lower effectiveness and higher hazards of several medical practices in such matters as: the use of standard instruments for diagnosis; the dosages and side effects of pharmaceutical products; the definition of guidelines for prevention and treatment; the analysis of social risk factors - since the central point of reference is the male, his environment and his lifestyle.

The second inappropriate criterion underlined by the group work is the disparity in medical research in studying male and female diseases. As we have seen, health data disaggregated by sex is lacking and even when available it is often undervalued and does not provide the level of detail necessary to assess gender differences. Important risk factors are not taken into consideration for women: in primis violence - a risk factor that may cause severe harm to women's health - and also the environmental socio-work factor. Research on stress, cardiovascular diseases, cancer, depression and occupational diseases appear to be gender biased in their basic hypothesis and approach: on one side the studies of male diseases almost always include environmental, social and work risk factors; on the other side, the studies of female diseases focus on risks related to the biological - reproductive - hormonal sphere. As we have seen, the male model of work is taken as the sole reference point while the double work model of women is excluded. The most dangerous outcome of these biases is that **prevention is precluded to women**: indeed, the exclusion of the female presence in clinical studies hampers the analysis of **social risk factors** and therefore also **primary prevention** for women in mental health, stress-related diseases, cancer as well as many work-related illnesses and injuries.

In the end, as noted in the cited WHO's technical paper:

“There is now a growing body of evidence to indicate that medical research has been a profoundly gendered activity. The topics chosen, the methods used and the subsequent data analysis all reflect a male perspective in a number of important ways. (...) Gender bias is evident not only in the research topics but also in the design of a wide range of studies. Where the same diseases affect

both women and men, many researchers have ignored possible differences between the sexes in diagnostic indicators, in symptoms, in prognosis and in the relative effectiveness of different treatments. (...) So long as researchers treat men as the norm, the medical care of women continues to be compromised”.

All the experts in the work group “Una Salute a Misura di Donna” have underlined that medicine should assume as a whole the principle of integration of the gender point of view in all its ranges of action, from clinical practice to research, from diagnosis to prevention. The absence of this perspective apt to properly compare females and males results in inadequate answers to the health needs of women, as well as, in the end, of those of men. In the report the group gives **suggestions** to overcome biases in medical research, diagnosis and treatment and to integrate into the national health programme the viewpoint of a gender sensitive health system.

A synthesis of the main positive actions recommended follows.

- a) Every research project in health, financed with public money, should be requested to include gender indicators in data collection and analysis; in this respect clear procedures to include the principle of gender difference in the collection of information at central, as well as at local level, should be defined. Circulation of gender-specific information at every level between health providers should be encouraged. Specific research projects on prevention and risk factors for emerging female diseases such as cardiovascular diseases, mental health disorders, HIV, and cancer, should be promoted.
- b) It is important, to use appropriate gender-specific methodological instruments in all research fields. In comparing men and women, attention should be given to their different historical, biological and socio-cultural reality. In order to overcome disparity and prejudices, productive paid work should be considered in conjunction with reproductive non-paid work both for men and women; for this scope it is also necessary that these two aspects of work be comparable and evaluated both quantitatively (i.e. in terms of energy and time spent) and qualitatively (i.e. satisfaction, socialization, recognition).
- c) Adequate attention should be given to physical and sexual violence and to its consequences in terms of health damage. As we have seen there is a wide gap in medical information and knowledge on the physical, psychological and social aftereffects of violence and sexual abuse. We suggest, therefore, that the theme of violence be brought up with all women during medical interviews; in addition, specific protocols and guidelines are needed to assist providers to best address this topic with their women patients.
- d) More generally, we believe that there is an extreme need for training medical personnel; for that purpose specific programmes on gender difference should be promoted and become an essential part in the curricula of all health providers.
- e) Specific services for women’s health are needed in the field of mental health as well as in other medical areas; recommendations should be given to regional and local health authorities to promote gender sensitive health services and activities.
- f) Clear guidelines should be prepared to insert the gender point of view in diagnosis, prevention and treatment in order to make these activities more effective in behalf of women’s health. One of the recommendations of the work group to the national authorities in charge of the National Health Programme is, in fact, to integrate the National Guidelines with specific gender sensitive items. For instance: specific guidelines should be prepared to prevent and treat appropriately ischaemic heart

diseases in women and clear protocols are needed as well for the definition of the symptoms of myocardial infarction typical of women. Reliable protocols and guidelines defining when hysterectomy is appropriate are needed; research should be promoted on causes, risk factors and on the conditions for which miomectomy or medical therapy may be a valuable alternative to total surgical intervention.

g) The group has also underlined the importance of proposing recommendations to be addressed at the European Community in relation to the procedures of sample selection in testing new pharmaceutical products (including women in clinical trials, analysing results separately by sex, giving specific information on side effects for women and men).

h) Finally, the group recommends that the Italian Government and the Departments of Health, Social Affairs and Equal Opportunity create a specific Office on Women's Health (similar to the one set up in the USA), capable of promoting appropriate prevention, diagnostic and treatment services for women and to promote culturally sensitive practices in medical education and research in order to implement a women friendly health system.

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Interdisciplinarity in Public Health and Life Sciences

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1. Introduction

The chance of a new research category, launched by the Swiss National Science Foundation in the late nineties, calling for National Centres of Competence in Research (NCCR) on thematic focuses, has stimulated the creation of an interdisciplinary network on gender research in Basel and across Switzerland.

The call for research explicitly included structural requirements, such as a leading house collaborating in a national network, and regarding interdisciplinarity (and a few more things). Although the proposal that was submitted to the National Science Foundation has not been funded, a lively interdisciplinary exchange on gender research has started and a considerable network has been built up along the way of elaborating it. The university of Basel got increasingly involved in gender research, -and we hope to be successful in a second run of competition.

The first part of the presentation deals with the process of bringing together researchers from very different disciplines to get them involved in a common research programme. A second part will focus then on a specific interdisciplinary project that has been elaborated within this proposal and has subsequently received funding from the university of Basel.

2. Elaborating a Programme of Research on “Gender: Performance and Interpretation”

The effort to compete for NCCR was based on the conviction, that bringing together views, methods and resources of different disciplines would have a higher potential for success than working within single disciplines – and would also be more fascinating. There were also encouraging recommendations of international experts who had evaluated Swiss research and teaching in women’s studies/gender studies in 1999 on behalf of the Swiss Science Council, and who strongly called for an institutionalisation of women’s/gender studies.

Bringing together most forces active in Swiss gender research from more than 20 disciplines, the group agreed to submit a research programme “Gender: performance and interpretation” with the aims to focus

- on the construction of gender,
- on its functioning at the performative and interpretative level in different settings and
- to study the impact of gender on social practices.

Recognising gender as a mediating and organising structure in research and in social and cultural practices, the NCCR intended to critically evaluate the impact of gendered views on science, research and academic performance, - as a (self-) reflective approach.

The gender programme was conceptualised in form of the construction of a house (s. figure): columns are representing individual thematic fields of research (research subprojects). Horizontal structural elements represent theoretical principles crossing all areas of research.

This construction allows us to bring together researchers working in different areas and disciplines, to address current research topics (see topics of the single columns), to cover different theoretical approaches within gender studies, and to form an administrative structure. On the other hand, cohesion and collaboration should be realised not only by sex/gender as a common reference, but more specifically also by means of the four “structuring principles” (construction, performance,

interpretation and social practices): These conceptual notions should assure thematic connection and figure as subjects of research in all the subprojects. With regard to these principles, a programme of workshops, seminars and conferences was scheduled to facilitate exchange between and across the disciplines and projects involved.

3. The Project “Gender in Medical Communication”

Within the NCCR, the project idea “Gender in medical communication” had been part of the column “Health and Health Care”. This single project (lead by Annelies Häcki Buhofer, Benedict Martina, Elisabeth Zemp Stutz) could subsequently be further elaborated and has received, in the meantime, funding from the research programme “culture and life” of the university of Basel.

The setting of medical care provides the opportunity to study one of the areas of interactions of culture and life. The perception of physicians relies on both, cultural and biological phenomena: on the communication with patients (cultural features) and on the physical examination of the body and on bio-technical investigations (biological features). The perception of patients relies on biological and cultural phenomena as well: on the sensation of their body on one hand, on their own linguistic categorisation and conceptualisation of what they perceive on the other hand. The project tries to explore these interactions by evaluating the role of gender in the physician-patient communication.

While in the humanities, there exists an abundant literature on the influence of gender on discourse and on communication, the influence of gender on the communication within the medical setting and its potential impact on medical practice has been investigated much less. We know from differential treatment of men and women, especially in the cardiovascular area, but not how this arises. Gendered communication may be an underlying reason. Therefore, the project wants to study whether gender influences physician-patient communication and, if so, whether such a gendered communication has an impact on the diagnostic and/or therapeutic decisions of the physician, on the course of disease and on patient satisfaction.

Objectives: The study specifically wants to investigate, in a consultation of ambulatory patients with the symptom dyspnoea as their main (or one of the major) reason for seeking care, whether

- the description of the symptom dyspnoea by the patient, and of the patient’s history, has gendered characteristics,
- the interactive communication of patients and physicians has gendered characteristics,
- the physician-patient communication is perceived as influenced by gender according to the perception of the physicians and/or the patients,
- an eventual genderedness of the physician-patient communication has an impact on clinical decision-making (diagnostic and therapeutic decisions),
- an eventual genderedness of the physician-patient communication has an impact on patient satisfaction and on the course of disease.

Hypotheses: The specific hypotheses of this project are the following:

1. The description of symptoms and of the history, by the patients, has gendered characteristics.
2. The communicative interaction of physicians and patients has gendered characteristics.
3. Gendered physician-patient communication has an impact on clinical decision-making.
4. Gendered physician-patient communication has an impact on patient satisfaction.

Methods: The study is planned as an observational study and a prospective follow-up of 3 months. A descriptive part relates to the hypotheses 1 and 2, an analytical part relates to hypotheses 3 and 4. The study is located within the regular service of the Medical Outpatient Clinic of the University

Hospital of Basel. The study population consists of patients seeking care for dyspnoea, at their first consultation.

In the descriptive part, the main outcome of interest is a **gendered physician-patient communication**, as determined by a linguistic discourse analysis. Genderedness of physician-patient communication is conceptualised on three levels:

- The description of the symptom dyspnoea and of the history by male and female patients (the “performative” part of patients)
- Communicative interaction of physician and patient, according to different settings (male physician with male/female patients and female physician with male/female patient)
- The perception the communication by both, physicians and patients.

A linguistic analysis will be performed for each consultation that is acoustically recorded. Based on this analysis, a rating of the genderedness of the description of dyspnoea and of the history and of the genderedness of communication is provided for each consultation (genderedness as existing or non-existing as well as categorised according to different levels). This methodology has to be developed in the pilot study.

In addition to the acoustic registration of the first consultation, a short interview of both, the physician and the patient, is performed after the consultation, asking for the subjective perception of the communication.

As for the analytic part, the main outcomes studied are:

- The diagnostic and therapeutical decision of the first consultation, which is documented in a standardised way (the interpretative performance of physicians)
- patient satisfaction after the first consultation and after 3 months, based on two assessments: on a visual analogue scale, after the consultation and after 3 months, and based on an open, non-standardised interview at the time of the 3 month-follow-up
- The assessment of the clinical course after 3 months that is performed by telephone interview of the general practitioners and of the patients: whether disease has improved or worsened, whether the diagnosis has been confirmed by the clinical course, and whether something new has happened since the consultation under study.

The impact of a gendered physician-patient communication, as determined in the descriptive part (see above), is analysed by group comparisons on one hand, by multivariate modelling on the other hand.

A **pilot study** is planned to test the feasibility in the clinical setting, the logistics, and the feasibility of inclusion/exclusion criteria and of the standardised procedures (diagnostic and therapeutic). A major task is the development of the linguistic methodology (development of an methodology that allows to reduce the time needed for the analysis per consultation, and the development of a rating system). It also has to test the feasibility of including patients speaking other languages than german.

Interdisciplinarity: Interdisciplinarity will be achieved by several strategies:

The project combines methodological approaches from the participating disciplines (linguistic discourse analysis, clinical practice, epidemiological methods).

Interdisciplinary teams are formed on different levels: the project team itself includes the 3 disciplines linguistics, internal medicine and public health/epidemiology. It is also foreseen to build an interdisciplinary advisory group and an interdisciplinary group of interested persons. With these

groups, meetings are scheduled throughout the project that will address conceptual, methodological and epistemological issues as well as the practical impact of findings. Particularly, the following questions will be addressed from an interdisciplinary view:

- where/how genderedness arises on the interpretative level,
- whether/how it interacts with biological features,
- where/how it has a “harmful” or “beneficial” effect,
- whether/how it can be perceived and reflected by the patients,
- whether/how changes in practice may be achieved,
- whether there is potential for gender sensitive care.

Potential of the project: Bringing together disciplines, experiences, approaches and methods from cultural and life sciences, the project contributes to the integration of cultural and life sciences. Locating the project in a setting of social practice, it works against the separation of research from the cultural sciences on “lived experiences” and from the life sciences in laboratory settings. It may contribute to an expansion of explanatory frameworks.

We hope it produces findings that can be applied to increase skills in gender sensitive communication, - a field that has not yet been a topic in medical training. On the other hand, linguistic research may profit from the study in this particular setting for the theoretical development of discourse analysis.

Gender and Working Conditions in the European Union

Dr. Kaisa Kauppinen, Finnish Institute of Occupational Health (FIOH)

Introduction

In 1991 and 1996 the European Foundation for the Improvement of Living and Working Conditions carried out statistical surveys on working conditions in all member states. The Second European Survey was designed with gender specific issues in mind. The survey „Gender and Working Conditions“ revealed significant differences between the working conditions of women and men (Kauppinen & Kandolin, 1998). Men were more exposed to physical/chemical hazards than women. But women had less autonomy, and they did not have as much influence over their work situation as their male colleagues. Women also more frequently than men found themselves carrying out short repetitive tasks, and they were more often employed in part time work. The Third Survey, which was carried out in March 2000, produced more or less the same results (Merllie & Paoli, 2001). All surveys aimed to provide an overview of the state of working conditions in the European Union.

Women's Labour Force Participation in the EU

Women's participation in the work-force has been a growing trend throughout the European Union, an obvious change in the European labour market over the last ten to twenty years. There are many reasons for this increase, such as the recognition of women's high level of education, their wish for autonomy, and the necessity of a double income in the family. In 2000, women made up 42% of the total EU work-force. In the Nordic countries (Denmark, Finland, and Sweden) as well as in Portugal, France and the UK, the participation rate was slightly higher than the average, while women's participation was still lower in Greece, Italy, Luxembourg and Spain. About 80% of European working women were employees, about 10% were self-employed, and 4% were in paid work in family firms.

Structural changes are occurring, like the shift from a rural to an urban economy, from the production of goods to services. There has been an increase in the rate of female activity in middle-managerial and professional jobs and, in particular, in sales and service jobs. These changes will bring more competition to the labour market and raise the competence and skill requirements for both women and men.

Gender Differences in Working Conditions

Even though new work patterns are emerging, gender segregation on the labour market has remained strong. The segregation is both vertical and horizontal, forcing women into service, health care and clerical jobs. There is also strong segregation within occupations, resulting in task differentiation between women and men. Men are more evenly distributed across all occupations, although craft and trade workers or plant and machine operators are mostly men.

In the EU, the work has become more client-driven and oriented towards information technology. Particularly women's work is client-oriented; it is characterised by the elements of caring, nurturing and supportive roles, while men still monopolise the "heavy" manual, technical and managerial tasks.

Precarious work is slightly more common among female than male workers in the EU. In Belgium, Denmark, Finland, Ireland and Sweden, considerably more women than men are found in these

kinds of jobs. Fixed-term contracts are the most common in Spain. In the 2000 Survey, as was the case in the previous surveys, temporary workers report more difficult work situations than do permanent employees (Merllie & Paoli, 2001).

In general, women work fewer work hours per week than men (about 80% of men's time). One out of four European women work fewer than 30 hours a week compared to 5% of men. In male-dominated occupations, most women work full-time, while part-time solutions are more frequent among women employed in sales and service jobs, transport, and health care. Women's working time is largely determined by their family situation: working women with children often find it difficult to fit into male (full-time) work schedules

In 1996, one out of three women with one child, and almost one out of two women with two children or more worked less than 35 hours per week. In the Netherlands and the UK, the part-time employment of women was the most common. Reduced working hours were also common in Austria, Belgium and Sweden where more than half of the employed women with children had part-time schedules. Even the 2000 Survey proved that part-time work continues to be a female phenomenon in the EU (32% of women, 6% of men). About one-fourth of the part-timers would prefer to work longer schedules (Merllie & Paoli, 2001).

The Second European survey showed that reduced working hours for working women with children were linked with higher job satisfaction and lower stress (even though there were country-wise exceptions). Women seem to regulate their own health and well-being by working shorter hours in order to balance the demands of their work and career with their family responsibilities. Partly due to their shorter and more flexible working hours, the 2000 Survey indicated that women were more satisfied with the way in which their working hours fitted in with their social/family life than men (78% versus 84%).

Women's part-time work should not be seen as a work-load or stress problem only, but also as an obstacle to their competence development and career opportunities at work. (There should be other strategies to deal with the problem of combining work and family life.) One result is that across the EU, very few women are found in leadership positions, especially in the private sector. The senior management and line management are still largely male preserves.

In the Second European survey, 17% of the women and one-third of the men reported being in a supervisory position. In this regard, no change has happened in the 2000 Survey. When asked whether one's boss was a man or a woman, even here the situation had remained the same: about half of the women reported a man as their boss, while only 7% of the men reported a woman as their boss in 2000 (6% in 1995). Women's supervisory roles appear to be limited to middle management positions. They usually manage small work units with 1-4 persons, while men are supervisors of small as well as larger work units. Very few women seem to have broken through the "glass ceiling" in the EU.

The weaker position of women on the European labour market (combined with shorter working hours, precarious employment status, and strong segregation) is reflected in the income level. The 2000 Survey showed that a considerably higher proportion of female workers than male workers was found in the lowest income categories (9% for men and 26% for women).

Interaction Dynamics at Work: Participation and Communication

The Second survey revealed great differences across the EU in workplace interaction dynamics. The best opportunities for decision making, participation and consultation were found in the Nordic Member States as well as in the Netherlands, Italy and the UK. Less opportunities for participation and communication were found in Belgium (where women were particularly frustrated) as well as in Germany, Greece, Portugal and Spain.

Women reported having fewer learning opportunities, and they were less involved in decision-making at their workplace. Even if the differences were not very dramatic, there was more communication, participation and less immediate managerial control in female-supervised than in male-supervised workplaces. Women supervisors seem to rely more on team-work than on rigid authority. This may be partly due to the fact that women tend to be supervisors in the public sector where they supervise health care teams, child care units, social workers, etc. The culture in these workplaces emphasises collaboration and team-work instead of competition and achievement (Kauppinen, 2000).

An expert report for the European Commission found that sexual harassment presents a serious problem for many women in the EU (Rubinstein, 1988). The Second European survey reported that at least 3% of women (2 million) had been subjected to sexual harassment at work during the previous 12 months. Similarly, in the 2000 Survey, female workers reported more sexual harassment than male workers; 4% had been subjected to unwanted sexual attention at work over the past 12 months. Another 9% reported intimidation at work. Women with precarious employment were more often subjected to sexual harassment than those in permanent employment. Health disorders (fatigue, headache and stress) were more likely to occur in these situations.

The Second European survey found that women's jobs could be characterised as „high demand - low control“ jobs. Four out of ten women had such working conditions compared to one out of three men. Women less often had active „high demand - high control“ tasks; they reported fewer possibilities to manage their time, such as days off and breaks at work. The literature on work stress has systematically shown that jobs characterised by little opportunity for decision-making, close supervision, and underutilisation of skills have negative effects on people's health at work. Workers with high demands and low control are in a high strain situation and at higher risk of cardiovascular diseases.

Another new concept is status control, which may be of central importance for understanding the stress factors of the modern and future labour market, characterised by change and the need for adaptability. Low promotion prospect, instability, and lack of control are all examples of poor status control (The European Heart Network, 1998).

The European Surveys have shown that women's working conditions involve less exposure to physical and chemical risk factors than those of men. However, in some sectors women are more exposed to poor working conditions, suffer from musculoskeletal disorders which are associated with heavy lifting, awkward postures, monotonous and repetitive tasks, and improper work organisation. These represent a growing health risk for women. There is a risk that differences between women's and men's working conditions will increase.

Increasing Gender Sensitivity

The changes in working conditions within the EU affect both women and men, but women are particularly vulnerable. Both preventive measures and greater gender sensitivity are needed to counterbalance these tendencies. Gender sensitivity is the ability to perceive existing gender differences, issues and inequalities and incorporate these into strategies and actions. The opposite is gender blindness (or gender neutrality) which represents a failure to recognise that gender is an essential determinant of social outcomes, including health and well-being.

A gender-sensitive approach can represent a new way of looking at gender issues in work life. Directives, guidelines and exposure limits should be developed and assessed in a gender-sensitive way. More gender-sensitive methods of implementing directives, guidelines, etc., are required. Sexual harassment, bullying and intimidation are growing problems, and must be recognised as a new type of work environment problem. The 2000 Survey (like the previous surveys) proved that female respondents reported more violence, intimidation and discrimination as well as sexual harassment than male respondents.

Efforts must be made to improve work organisations in a gender-appropriate way. The growing trend towards more flexibility regarding the location of work (e.g., telework) and working times should be examined more closely from the perspective of health and safety, as well as of equality.

Be Equal, Be Different: Equality is not Merely a Gender Issue

In the Second European Survey, equality planning was introduced as a good strategy by which workplaces and work organisations can promote gender equality. Equality plans can promote both gender equality and better working conditions for both men and women, if they describe the job differentiation and their health and safety risks. If the management is committed to equality promotion, work organisations can become more sensitive to gender issues.

In a broader perspective, equality should not be seen as a gender issue only (Ojala, 2000). Equality, or the lack of it, can emerge in many other areas as well: people of different ages, people in different positions, people with different backgrounds, and people from different cultures can find themselves in an inferior situation, and be treated in a different way simply because they are different. Age issues have come to the fore as the shortage of labour has begun to be a problem in all sectors of economy. People from different cultures and different ethnic backgrounds exemplify the new emerging equality issue. Equality is increasingly a question of diversity and how to benefit from it. At their best, equality plans/diversity development plans can offer a forum for dialogue on gender and diversity between different partners in work organisations across the EU.

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Experiences in Canada

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This is a whirlwind tour of my personal experience in mainstreaming gender in the health sector. These are my reflections on the experiences I've had as co-author of the Federal Plan for Gender Equality and as Co-ordinator of Health Canada's Gender-based Analysis (GBA) Initiative. I'm going to start by looking at the Federal Plan because it grounds other work being done and then move on to look at GBA work in Health Canada -- where we've been, key challenges encountered and lessons learned.

The Federal Plan committed all Federal Departments and Agencies to do GBA of future legislation and policies. The process to develop the Federal Plan involved partnerships, collaboration, intense negotiation, finesse and careful wordsmithing -- central principles of gender mainstreaming. The Plan was a lever for sustained work on GBA, although it got off to a rocky start as resources were slow in coming.

Health Canada's GBA initiative was established in the Women's Health Bureau -- the machinery for women's equality in Health Canada. It went further than the Federal Plan, committing to do GBA of all substantive work of the department, past, current and future.

The approach we took to GBA meant doing business at Health Canada in a new way -- in an analytical, systematic and evidenced-based approach designed to uncover and eliminate gender bias at all phases and stages of work in the department.

Given the literally 100s of files that touched on women's health, I quickly saw that I had to think and act strategically to bring about any real change. We simply did not have the capacity to do a GBA of all the files; we would have to develop that capacity among staff throughout the department.

I identified four key areas for work. Putting the **infrastructure** into place to support the entire initiative was paramount. First we sought and received a mandate from our Departmental Executive Committee, including approval of a number of implementation mechanisms. Then we packaged this decision along with the GBA in the Women's Health Strategy and disseminated it as *Health Canada's Gender-based Analysis Policy*. Next we began to set up networks within Health Canada to support GBA work across the department and mainstream it in internal structures and processes. Then we began building an infrastructure across the country as we participated in a Gender Management System (GMS) Workshop sponsored by the Commonwealth Secretariat and by linking with others developing GBA training in Canada and around the world. To take advantage of the tremendous knowledge generated about women's health issues by academic, medical and community-based researchers, we began to look for creative opportunities to link them with conventional researchers and within the policy arena at Health Canada.

Simultaneously, I began to develop training materials. A quick review of 250 odd GBA documents collected from across Canada and around the world revealed that few had a health focus, and none had the conceptual clarity needed to do the job. The last two and a half years have been devoted to developing these training materials and Margrit Eichler has been an invaluable partner in this work. Margrit and I both realised that people respond well to a clearly laid out and articulated, intellectually engaging analysis. Spouting rhetoric and blaming men simply turns people off. We're now in the process of simplifying our draft GBA Guide following a series of workshops.

Besides our in-depth GBA training, we have had training to provide awareness and to sensitise people to gender equality issues in the work of Health Canada.

I'd like to share with you now some of the exciting developments that affirm for me the validity of the approach we've adopted.

Over the past year, we've had three pilots of our training materials. For the most part, I invited people who I knew would be friendly and who already had a fairly good understanding of gender issues. However, to each pilot, I also invited a few 'test cases' – men who had been particularly uncooperative in our past attempts to work with them to include gender in their policy work.

During the first day of the three-day course, we would go over concepts and definitions and carefully explore and explain the gender bias problems we have identified. Once people say that they have a good grasp, we give them an opportunity to practice identifying gender bias problems in samples of work from research reports published in academic journals, policy documents, and programme or service proposals, evaluations, etc.

At the end of the first pilot, my first 'test case' stood up unexpectedly and said that he was profoundly impressed with the rigour of the analytical process and that he would never again read a research report with the same eyes. Since then, he has been singing the praises of GBA in high level management meetings.

During another pilot, another 'test case' walked out of the room at one point. We had just given people reports to read and analyse individually, and they were in the process of reporting back to the plenary the bias problems they had uncovered. I followed him out of the room and he said that intellectually he had followed the conceptual material we had presented and had understood the bias problems, but had not seen any of them when he had read the reports on his own. As people began reporting back to the plenary the rather gross biases that existed in many cases, he was shocked that he could have been so blind as not to have seen them.

Since then, both these men, who work in the highest level of policy development at Health Canada, have been involved in a review of policy analysis work at Health Canada. This review found that policy analysis was, in general, weak, and their unit was charged with developing a 'Challenge function' to stimulate a stronger analytical capacity across the department. Interestingly, they have placed GBA as one of the central elements of that Challenge function, thus mainstreaming gender at the highest level.

But the impact has not been limited to Health Canada. I had also invited people from other federal ministries, from provincial ministries of health, from NGOs, and medical professionals to participate in the pilots. Since then, two provinces are taking the training materials and adapting them to train their regional health officials; one provincial representative recommended our training materials to a volunteer working with Canadian Executive Services Overseas. I worked with her over the summer and she took the material with her to Kyrgystan where she was training 15 GBA Trainers in the Ministry for Women's Equality. One doctor is using the material for a GBA course she is developing for medical students, and Margrit and I recently conducted a workshop in Costa Rica for people working in the Health Sector in various capacities.

Conducting GBA requires good data and evidenced-based knowledge. So too does monitoring the results of our GBA work. Work to monitor and evaluate our work toward gender equality has had to unfold at a number of levels.

The analytical paradigms that underpin most modern systems of statistics in many respects do not reflect women's reality. As statistical machineries tend to be conservative institutions it is not an easy process to have new paradigms put into place -- but some movement has already been made with respect to unpaid work. Consistent, persistent efforts in this area must be made.

Another area of effort has been to set up a process to monitor the implementation of Canada's Clinical Trials Policy, which stated that women could not be excluded from trials. I have also commissioned research to fill in data gaps and to do a critical analysis of studies conducted by Statistics Canada. However, one of the most exciting initiatives has been to begin work on the development of gender equality and health indicators, as Chair of a Commonwealth Secretariat working group. I brought together a group of out-of-the-box thinkers and told them that the only rule was that they had to flip the paradigms that underpin most existing indicators models. In December 2000, we published our conceptual on the internet, inviting feedback. It can be found at <http://www.socsciresearch.com/Dmodel.pdf>

I would like to sum up my presentation by looking at key challenges faced in trying to mainstream GBA.

Conceptual work is painstaking, challenging and time-consuming. It takes time to develop good analytical tools to recognise and eliminate gender bias.

Bureaucratic challenges were mostly at the level of structures and processes. Insufficient resourcing of Health Canada's GBA Initiative meant that internally I had to do most of the work myself — creating its own set of problems. Unclear lines of decision-making authority led to work taking one step forward, two steps backward at times.

The organisation of the department into silos made horizontal work such as GBA difficult to do. People with responsibility for specific policy files, such as mental health, held more sway over decision-making in a given domain than gender specialists, resulting, for example, in a failure to examine gender biases in the collection of mental health data.

GBA work could not continue at its own pace. It often fell victim to the timing of activities in the Minister's office, within the Women's Health Bureau and in key policy areas. Finally, the inevitable office politics, nasty, power-hungry people, back-stabbing and professional jealousies were energy draining, time consuming and harmful to progress.

Internal resistance to change, to a new approach also required time and energy. However, in many ways strategies could be found to deal with these. Some people, but really only a handful, were extremely negative, likening GBA to a feminist manifesto. In many ways, management supports helped to put many of these issues to bed.

However, the most difficult and potentially destructive resistance came from a most unlikely source - feminists - some in academia, some at the grassroots level, and others within the bureaucracy.

Some academics are critical that our approach does not use the feminist language currently 'in vogue'. Other grass roots feminists and 'femocrats' were quick to join them in their criticism, before informing themselves and trying to understand our conceptual approach. Some saw it not being confrontational enough, others criticised it for being too confrontational. If feminists can't see their favourite 'hobby horses' or pet issues, they're often quick to criticise - without taking the time to understand. Some don't have the patience to work through complex problems - they just want quick solutions.

We've encountered feminists who feel that they already know everything and are resistant to learning a new approach. Within government, one of the most difficult issues to deal with was the view of feminists in high level positions that gender equality is not as important an issue as work finance and other ministers have to do for budget-making, health care renewal, etc. This resulted in real difficulties in staying high on the agenda.

So, what are the lessons learned?

- Take advantage of strategic opportunities
- Ensure you have political will and commitment
- Develop a wide web of partners across sectors and jurisdictions
- Choose your words carefully, it can make the difference between acceptance or rejection
- Hone your negotiation skills
- Use every ounce of your innovative, creative energy to think and act strategically
- Progress is incremental - it's difficult to move ahead unless all the pieces are in place - take the time to do a good job
- Conceptual innovation is necessary at many levels - but again it is time-consuming
- Know when to cut your losses - don't waste energy beating a dead horse
- Watch your back
- Be Patient
- Be Creative
- Celebrate each small incremental step forward, otherwise it can be depressing to see how slowly everything moves.

I consider myself successful if I can bring us just a little bit closer to gender equality-knowing full well that change is not going to happen overnight.

Gender Equity and Public Health in the EU: A Strategy for Change

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Introduction

The European Union (EU) has a long history of concern with gender equality issues. However policy in this area has been narrowly focussed. The strategy of gender mainstreaming has been applied primarily in areas relating to employment and education and training. It has received almost no attention in the context of public health and related fields. The year 2000 saw the launch of a new Gender Equality Programme as well as a new Health Strategy. This provides an important opportunity for bringing these two very separate streams of work closer together.

This paper explores the potential for mainstreaming gender issues in the health sector. It lays out a plan of action and identifies the challenges that will have to be faced if gender equity in health is to be pursued in the manner recommended at Cairo and Beijing and required by the Treaty of Amsterdam.

Defining the Concepts

What do we mean by 'gender equity' in a public health context? The most obvious definition might be the achievement of equal life expectancy and health status for all. However this would clearly be unachievable since individuals differ enormously in their genetic inheritance. Moreover we know that women have the biological potential to live longer than men.

A more practical goal would be to ensure that women and men have equal access to the resources they need to realize their potential for health- whatever that potential may be. These resources will obviously include appropriate medical care. However they will also include the wide range of other resources individuals need to promote their own well being. Many of these will be common to both women and men. However there are also significant differences between the two groups both in their health needs and also in their access to the relevant resources.

Some of these differences are biological. Most important is women's 'special need' to control their own fertility and to move safely through pregnancy and childbirth. In addition women and men have different needs derived from their biological susceptibility to sex-specific diseases such as cancer of the prostate as well as their differential risk of developing other disorders. All things else being equal, men are more likely than women to die prematurely from heart disease for example. A recognition of these sex differences in patterns of need is an essential foundation for any gender equity strategy.

But biological or sex differences are only part of the story. Socially constructed gender differences between males and females also play a central role in determining whether individuals are able to realize their potential for a long and a healthy life. There has been a large body of work demonstrating the intimate interrelationship between these gender differences and patterns of health and health care found among women. Depression for instance, is more commonly reported by women than by men yet there is no evidence that women are biologically more susceptible to such problems.

Gender inequalities affect not just the health of women but also the availability of health care and other resources. In most EU countries women and men are offered equal access to basic health care. However women's use of those services is often hindered by gender related factors. These include lack of culturally appropriate care, lack of transport and lack of substitute care for

dependents. When they do get access to care there is evidence that many women receive treatment which is technically inferior to that received by men and may also be delivered in less respectful ways. Gender equity strategies therefore have to include policies designed to compensate for the discrimination women too often experience in the wider society.

What does this imply for men? It is clear that males have privileged access to a wide variety of health promoting resources. However it is also evident that masculinity itself may be hazardous. The stereotyped role of ‚provider‘ for instance, often puts men at greater risk of dying prematurely from occupational accidents. Many men also seem to feel pressured to engage in risky behaviour in order to ‚prove‘ their masculinity. They are more likely than women to be murdered, to die in a car accident or in dangerous sporting activities. Historically they have also been more likely to drink to excess and to smoke, which in turn increases their biological predisposition to early heart disease and other health problems. Hence a gender equity strategy must also address the very complex question of how to make masculinity less hazardous.

This paper will outline the basic elements needed for such a strategy. It will identify the different arenas in which more gender-sensitive public health policies need to be developed. The main focus will be on identifying existing resources within the Commission, which could be used to extend mainstreaming to this new area.

Putting Gender into Official Statistics

The development of an equitable strategy will need to be based on a clear understanding of how sex and gender influence patterns of health across the member states. There are currently major gaps in the health data available in the EU and one of the priorities of the new Public Health Programme is to remedy these deficiencies. If this is to provide an effective basis for policy making it is essential that (biological) sex and (social) gender should be a central part of the conceptual framework used both to collect and to analyse data.

Compilations of EU-wide statistics currently offer little in the way of sex and gender disaggregated information. This is especially problematic in the context of morbidity data. While men are more likely than women to die prematurely it is women who experience more chronic ill health, distress and disability, especially in old age. The World Mental Health Report has highlighted the increasing burden of psychological illness and its impact on women in particular. However there is currently no system for monitoring these problems across the EU.

There is also a marked absence of information on sexual and reproductive health, which again is especially significant for women. Few women from member states die from reproductive related causes but this does not mean that there are no issues of concern. More information is needed on contraceptive use and its associated morbidity as well as the availability and use of abortion services.

As well as making reproductive health more visible, there is also an urgent need for better monitoring of gender violence in the member states. A recent World Bank estimate suggested that domestic violence, rape and sexual abuse together account for 19% of the disease burden among women aged 15-44 in the developed countries. Yet EU-wide data on the scale of the problem are still not available.

Health information systems in the EU will also need to reflect the diversity that exists both within and between member states. The health needs of both women and men vary across the life cycle. However EU data currently gives us very little information about women (or men) at either end of

the age range. Individuals are also divided by factors such as class, nationality and ethnicity. There appear to be close links between poverty, gender and health for example but more work is needed to disentangle these relationships and this can only be achieved through regular monitoring.

As well as recognising the diversity of women (and men) it is also essential that the new EU database makes clear links between gendered patterns of individual behaviour and the factors that shape them. Poor nutrition, smoking and lack of exercise have all been identified as causes of disease. However there is very little gender-disaggregated data available at EU level. This makes it difficult to develop a proper understanding of the different pressures on women and men to make unhealthy choices.

Moving beyond individual behaviour there is also a lack of routine data on some of the more structural links between health and daily life. We know for example, that work can have an impact on health. However very little gender disaggregated data is available on injuries, disease or disability. Even less information is available on the hazards associated with informal, unwaged and domestic labour, despite their obvious impact on the health of women across all the member states.

Sex, Gender and Medical Research

Most biomedical research continues to be based on the unstated assumption that women and men are physiologically similar in all respects apart from their reproductive systems. In the context of coronary heart disease for example, many studies continue to be done on all-male samples. As a result, there are still major gaps in our knowledge about the differences between disease processes in males and females and both preventive and curative strategies are too often applied on women when they have only been tested on men.

Few women are currently involved in the male-dominated arena of medical research, either as investigators or as subjects. In the US this issue has been widely debated and applications for funding are now reviewed with gender in mind. The Commission could develop similar initiatives in Europe. Its expanded role in the regulation of pharmaceutical products through the Medicines Evaluation Agency offers an additional opportunity for removing sex/gender bias in medical research. This could be done through requiring an assessment of the sex/gender sensitivity of the safety and efficacy data for each product and an analysis of the differential implications of this information for male and female users.

The EU also has an important role to play in ensuring that women have a greater role as active participants in the research process itself. Again, the Commission has extremely valuable experience which can be mainstreamed into the health sector. A recent report from an expert group of women scientists (ETAN) proposed the monitoring of numbers of women holding scientific posts as well as their receipt of research funding. They also called for 40% of women on all decision-making bodies in research and technology by 2005. Those developing the new Public Health Programme could learn a great deal from these deliberations.

However the reform of biomedical research can only be a partial strategy for developing the knowledge base of a gendered public health policy. If both sex and gender influences on health are to be properly understood, the tools of the social sciences will need to be used alongside those of biomedicine. Again, the Commission is well placed to support this through its training and funding initiatives.

Developing Gender Sensitive Policies

The mandate of the EU Commission explicitly excludes the delivery of individual health care. However member states are now facing very similar challenges and this has led to a search for common solutions. Under these circumstances the Commission has an important role to play in disseminating good practice on gender, health and health services. This will require support from those parts of the Commission where expertise in work of this kind already exists.

One of the most important principles of gender sensitive planning is that women as well as men should be actively involved in the design, implementation and evaluation of programmes. This will require the development of more appropriate forms of consultation. Recent conferences held by the Commission on older women and social exclusion and on gender issues in smoking prevention provide useful examples.

If policies and programmes are to be gender sensitive, the importance of educating health workers and policy makers in relevant areas cannot be overstated. Indeed the Commission itself has already identified the lack of appropriate expertise as a key problem both in gender work more generally and in the arena of public health in particular. New courses will need to include broadly based 'gender awareness' programmes as well as briefings on topics such as domestic violence.

Across the EU, medical and nursing curricula also need to be reshaped to ensure that gender issues are integrated into the planning and delivery of services. Though the Commission is not directly involved in such training it can help to ensure that these concerns are taken seriously through its role in monitoring professional education and regulation

Finally there is an important role for the EU in promoting equal opportunities among those working on health issues both inside the Commission and outside it. Internally, it is important that gender-related issues are taken seriously as the EU's work on public health expands. Gender sensitive programmes will need to be accompanied by gender sensitive employment policies and this will necessitate closer cooperation between the new public health programme and the wider employment agenda promoted by the Commission across the EU.

Overall then, there is huge potential for developing gender sensitivity in the new Public Health Programme. As we have seen this will require the use of a gender lens in all aspects of the work as well as the greater involvement of women themselves. However this will take us only part of the way towards gender equity in health. Much wider social change will also be required to promote fairness in the allocation of the resources necessary for health.

Making Gender and Health a Wider Priority

Most areas of the Commission's work have some relevance to health. Sectors as diverse as education, agriculture, consumer affairs, industry, transport and social protection all need to be monitored to assess their implications for the health of both women and men. Policy in many of these areas remains largely within the control of individual member states. But again the Commission can offer added value through the dissemination of good practice, funding of demonstration projects and facilitating networks for the promotion of change.

Within the economic sphere, attention needs to be paid not just to the 'official' economy but also to the informal sector and to patterns of unpaid labour. The running down of social services in some countries, alongside the increase in the numbers of women in the labour force, has had significant effects on the well being of those required to carry a double burden of work. Similarly, industrial

strategies in some countries have led to very high rates of unemployment among men in heavy industry with consequent damage to both mental and physical health.

Gender bias in the allocation of health-related resources can also be controlled through anti-discrimination legislation and the use of a human rights framework. Again, the work of the Commission provides a number of examples of how this can be done. EU directives in the 1980s played an important part in promoting equal pay across the member states, thus enhancing women's access to a range of basic necessities. Reproductive rights have framed the EU follow-up activities after Cairo and it is important that future development work operates with the same philosophy.

In all these areas the Commission will need to work with a variety of partners in developing a gender perspective on public health. This will include not only member governments but also NGO's representing a wide range of interests and concerns. It will also be important to collaborate with the European Region of WHO whose Strategic Action Plan for the Health of Women is a valuable resource in the development of gender sensitive public health policies.

Further reading

A more detailed version of this paper which includes a full list of references is available from the European Institute for Women's Health www.eurohealth.ie

Gender Based Analysis in the Implementation Process of the Women's Health Programme in Vienna

Univ.-Prof. Dr. Beate Wimmer-Puchinger, Office for Women's Health of the City of Vienna & Dr. Erika Baldaszi, Ludwig Boltzmann Institute for Women's Health Research

“About twenty years ago, when we began to formulate theories based on the experience we made during the women's movement we knew that our task would be difficult - but as exciting! However, not in our boldest dreams we imagined that we would have to reinvent science and 'theoretical thinking' in order to take away the meaning and sense of what women have experienced in our society.”

(Sandra Harding, Professor of Philosophy and Head of Women's Studies at the University of Delaware, 1990, p. 274)

The differentiation between gender has moved our decade. Even though there has been a socio-political opening towards the world of women this opening remains only partial, as shown in the following three examples.

1. In one of the most important sectors - the economic sector - women's interests have not yet experienced a satisfying opening. According to the recent international OECD-report (OECD, 2001), the gap between the salaries of men and women is wider than ever before.
2. Another important goal is achieving equal and shared opportunities in childcare. In order to get there, socio-political structures have to be adapted - for men; thus far only the Scandinavian countries have reached this goal.
3. Another aspect that indicates only a partial opening towards the world of women is under-representation of women in medical or health related research. To give an example: in Vienna only about 10 percent of medical directors of hospitals are women and only 14 percent of the positions in medium level management are filled by female doctors.

To promote a differentiated view on gender, a reorientation of thinking and socio-political concepts has to take place - starting from the very beginning. For example, the meaning of the word mankind (Mensch, homo, l'homme) in numerous languages identifies 'humans' and 'the man'. Thus, the man “has been the subject, the discourse of theories, the moral and the political discourse - of all our cultural roots” (Lucy Irigaray, 1991). “Mankind” is an insinuated construct of men. This has implications for gender-neutral formulations in cultural history - with regard to the female role definition and its reflection within medical research and the biomedical-scientific paradigm, which has become even more important by results and efforts in genetics research. The historical period in which women have had the chance to sign published scientific studies is very short (Schücking, 1996).

A quantitative analysis of pictures and texts from 30 anatomy books published by major North American universities between 1890 and 1989 (Lawrence and Bendixen, 1992) showed, that there is a reason for excluding women even from anatomy. The authors demonstrate, that “female bodies are presented as variations of the male-model”. They analysed 6.196 illustrations to describe and explain human anatomy. Of these, 63 percent were not gender-specific. If the difference between gender is made, the classification is based on the male norm approximately 10 times as often. The authors summarise that: “modern texts thus continue long-standing historical conventions, in which male anatomy provides the basic model of 'the' human body.”

GENDER-SPECIFIC NORMS AND ISSUES AS HEALTH RISKS FOR WOMEN

Beauty Standards

The aggressive beauty-standards portrayed in advertisements are an artificial result of permanent exercise, dieting or even beauty surgery.

The market for girly-magazines and teenage-soaps is booming, which increases the pressure on girls to look beautiful. The following results of a survey of 1400 boys and girls age 14 years demonstrate the adolescent girls' feelings of being insufficient and dissatisfied with their own bodies (Figure 1 and 2).

Figure 1. Fear of Weight-gain

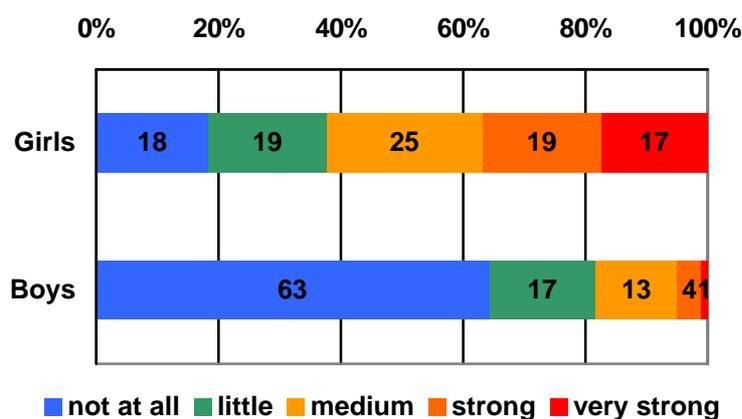
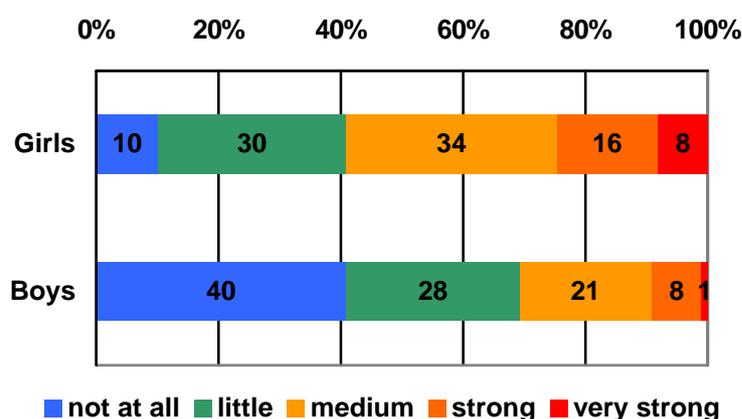


Figure 2. Dissatisfaction with own body



Issue of Power Relations: Sexual Violence Against Children and Women

The subject of violence against women and children and its disastrous effects on women's psychological health has been an extensive part of research.

International scientific research, as well as a multi-centered study at 11 gynaecological wards in Austria about gynaecological consequences of childhood sexual abuse (n=1.378 women; Wimmer-Puchinger and Lackner, 1997) show several severe and multiple long-term consequences of violence towards women:

- disturbances of sexual relationship and partnership, social anxiety, distrust
- disturbances of general well-being
- influences on reproductive decisions, pregnancy
- gynaecological complaints (menstrual pain and irregularities, vaginal infections, pelvic pain, etc)

However, violence as a relevant dimension is only slowly recognised by the health sector and by psychological and psychiatric services. It is astonishing that to date there is still no alliance against violence between psychiatric and psychotherapeutic institutions and psychotherapeutic schools.

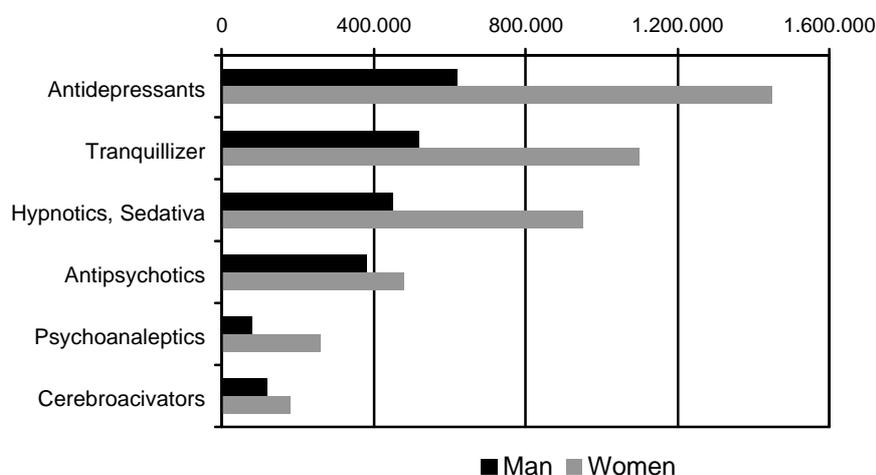
A standard protocol for how to deal with trauma and violence, sexual abuse and rape and how to react to the need for adequate and appropriate treatment and prevention is still missing in many institutions and hospitals. Only recently, a law was passed on the right for victims to obtain psychotherapy.

Pathologising of Women and Medicalisation of Menopause

This topic deals with the horrendous message that, for women, it is much less socially desirable to grow older than it is for men. This is underscored by the fact that there is a clear increase in prescriptions of anti-depressants during the climacteric phase.

Approximately 8 percent of all drugs prescribed in Austria are psychiatric drugs or psycholeptics. One third of these are anti-depressants, one quarter are tranquillizers, and one fifth are hypnotics and sedatives. In 1999, two thirds of all psychiatric drugs were prescribed to women. Consumption of psychiatric drugs increases with age, particularly noticeable from age 40 onwards.

Figure 3. Prescription of Psycho-pharmaceutics in Austria by Sex, 1999



Source: Institut for Medical Statistics, Vienna (Health Report Vienna 2000)

Does the fact that women are prescribed more psycho-pharmaceuticals (Figure 3), emphasise that women are more easily offended, more resentful, more emotionally unstable? Or is it due to role models? Or is it because women are more likely to talk about their problems?

The explanations are multidimensional:

- prescription of drugs happens according to a double-standard of mental health
- women use drugs as coping strategies to function properly
- there is an increased tendency of women to suffer from fearfulness, panic-attacks, depression, etc.

The works of Phyllis Chesler (1972) and Carol Gilligan (1982) gave very important impulses to critically review the mental health of women.

Gender-proportion in Health Professions

A recent study (Mechanic and Meyer, 2000) indicates that the more intimate, emotional and personal a disease or problem is seen by the patient, the more he or she desires to be treated by a doctor of the same gender. This concerns men and women equally.

THE VIENNA WOMEN'S HEALTH ACTION PLAN - FIRST RESULTS

A gender-specific approach to health has become a major concern of research as well as of policy recommendations by WHO, NIH and the European Public Health Commission. The health department of Vienna has published a women's health report (City of Vienna, 1996) and identified field-for-action areas. This was one of the first steps in the development of a women's health programme in Vienna by an experts committee.

The Vienna Women's Health Programme highlights 12 topics:

- cancer-prevention, care and follow-up,
- prenatal and post-partal care,
- health of mothers,
- mental health,
- substance abuse,
- violence against women,
- health promotion for elderly women,
- legal rights of women in the health care sector,
- psychosocial care and counselling in health care,
- health care services for migrant women,
- women in the work environment and
- women in health care professions.

Since the start of the women's health programme in Vienna in 1999 the following projects have been launched:

1. A Public Awareness Campaign Focussing on Eating Disorders

- The primary goals of the campaign are empowerment by education and creating awareness about the severity of the problem and its consequences and furthermore by offering psychosocial support to encourage affected adolescents and adults to seek support - the sooner the better.
- Community sensitisation and diminishing the taboo by increasing the knowledge about the disorder in all community members, especially in teachers, psychologists, paediatricians, gynaecologists, generals practitioners etc.

Awareness campaign components are a toll-free hotline, information folder (flyer), posters (at bus-stops, subways and other public locations frequented by adolescents), newspaper ads, radio-spots. Networking is done by creating a panel of representatives from school boards, youth associations and institutions and medical professionals working with adolescents.

2. General Public Hospital Training-programme on Violence Against Women and Children

- Aims are the training of medical and nursing staff in the target groups gynaecological, paediatric, emergency room and psychiatric departments. The training is targeted to sensitising, knowledge transfer of sociological and psychological background information, and training of communication-skills.
- Awareness methods are information folders for staff, posters and public exhibition about violence against women and children in three public hospitals in Vienna.

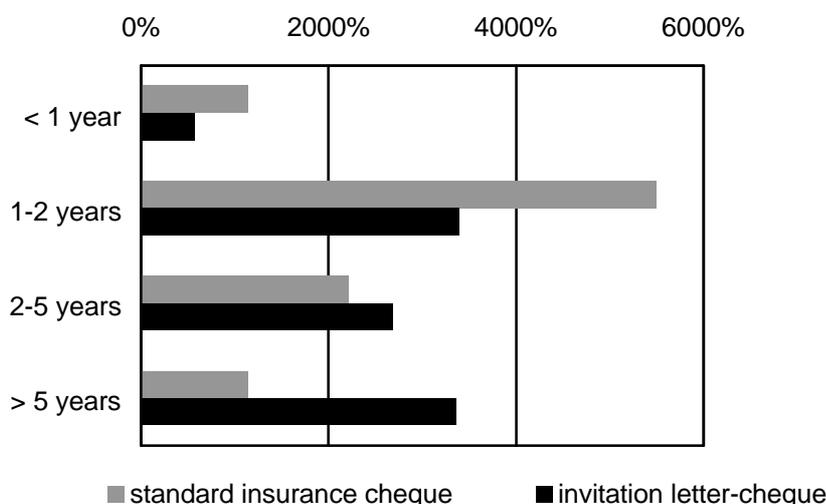
3. Postpartum Depression (PPD) Prevention Programme

- Aim of the programme is to reduce PPD in Vienna (incidence about 20 percent). The programme is implemented in obstetrical departments of three public hospitals in Vienna.
- Method is the screening for depression and other psycho-social risk-factors of pregnant women with self-administered questionnaires and face-to-face-interviews.
- Interventions: Pregnant women at risk are offered psychological counselling, personal support by midwives and social-workers.

4. Vienna Breast Cancer Prevention Programme

- Aim of the programme is to increase mammograms in women age 50 to 70.
- Method is a mailing of a personal invitation-letter for mammography to women age 50 to 70 years. Radiologists participating in the programme are specially trained in quality assurance. Women who are diagnosed with breast cancer are offered psychological support and are invited to breast cancer self-help-groups. Communication training programmes for health professionals working with breast cancer patients.
- One of the most positive results of the breast cancer prevention programme is, that we could reach primarily those women, whose last mammogram was more than 2 to 5 years earlier (Table 4).

Figure 4. Elapsed Time Since Last Mammogram



Conclusion

In the process of the implementation of the Vienna Women's Health Action Plan we are striving to realise the chance to establish adequate and appropriate structures to facilitate the struggle of women in achieving equity. Our work aims for the empowerment of women in all aspects of their lives by promoting and implementing models of good practice in women's health and health promotion in general.

However, we must not forget that there are also specific health issues for men to be addressed (e.g. alcoholism, homelessness, suicide). Therefore, the future direction of our work will be towards more gender-equality and a gender-specific approach to health.

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Gender Equity in European Public Health (Women's Health Perspective)

Peggy Maguire, Director General, European Institute of Women's Health

Women's health is an inter-generational continuum that begins at birth and carries into old age. While female morbidity and mortality are gross indicators of women's health status, equally important are the changes in the quality of women's lives and their participation in society. Reproductive health is now a broader concern that grows from recognition that decisions women must make are critical in assuring health and security for themselves, their children and families.

Women's health needs can be best understood within this larger context. Illnesses from which they suffer, and the resulting deaths and lifelong morbidity, are rooted in the socio-economic systems and cultural situations within which they live. Women and their families are deeply affected by the realities of globalization, by access to health and educational services driven by macro-economic policies, and by empowerment and rights issues driven by political forces.

Gender Mainstreaming was one of the main themes during the platforms for action in Cairo in 1994 Beijing in 1995, and Tunisia in 1998. The European Institute of Women's Health held the first International conference in Dublin in September 2000 to discuss mainstreaming gender in the new Public Health Strategy. The EIWH commissioned Professor Lesley Doyal, to produce a discussion document for the conference outlining the need for mainstreaming the gender perspective in European Public Health.

The consensus from the conference, was that professionals, policymakers and NGOs involved in promoting gender equity in health never had a better opportunity to make a significant contribution to the future of the EU Public Health Strategy, which was adopted this year. This was the unanimous view of keynote speakers and delegates at the recent European Institute of Women's Health

While the promotion of gender mainstreaming has been a long-standing ideal of the philosophy of the EU, the reality is that gender as a whole has actually received very little attention in Public Health Policy. The launch of the new Public Health Programme brings with it the possibility of remedying this, if a gender-based analysis is applied to all policies, programmes, and services included within the Public Health Agenda as a matter of routine practice. This would set an example for member states to do the same, thereby safeguarding women and men's equal access to resources and services.

The **mainstreaming of gender** was formalised in the **Treaty of Amsterdam** with the pursuit of equality between women & men incorporated into articles 2 & 3. This has brought equality into the general competencies of the community, alongside economic development and cohesion. The wording of Article 152 of the Treaty represents a move to a more positive perspective of 'Improving Public Health, Preventing Human Illness and Obviating Sources of Danger to Human Health'. The Treaty also includes a statement to the effect that human health should be protected in '**all community policies and activities**'.

WHY GENDER MAINSTREAMING?

One of the basic problems facing policy makers at EU and national level is the lack of specific and comparable information data on the health status of women and men. The failure to separate women from men in national and regional statistics can make it difficult to plan effectively to meet the particular needs of either group.

Research has highlighted the fact that apart from biological influences, the different roles and responsibilities women and men have in society, their socio-economic background, class, culture and ethnicity are all reflected in their vulnerability to illness, access to preventative and treatment measures and quality of care.

People in the EU are now living longer than ever before and women, representing approximately 52% of the EU population, live longer than men but report being less healthy than men.

Life Expectancy Statistics

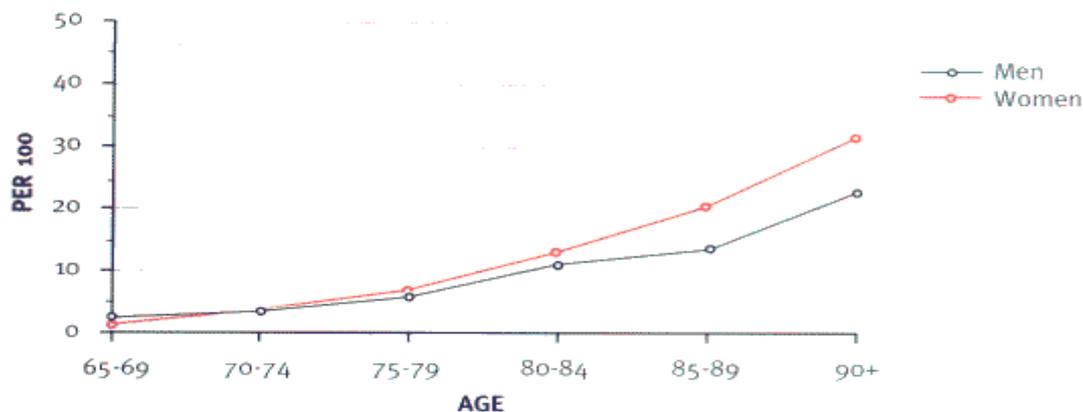
Country	Total pop (000)	% of pop. 60+ 1999	Life expectancy at birth (years) Female 1999	Life expectancy at birth (years) Males 1999
Austria	8 177	19.9	80.4	74.4
Belgium	10 152	21.6	81.3	74.5
Denmark	5 282	20.0	78.1	72.2
Finland	5 165	19.7	80.7	73.4
France	58 886	20.5	83.6	74.9
Germany	82 178	22.7	80.1	73.7
Greece	10 626	23.6	80.5	75.5
Ireland	3 705	15.2	78.3	73.3
Italy	57 343	23.9	82.1	75.4
Luxembourg	426	19.4	81.4	74.5
Netherlands	15 735	18.3	81.1	75.0
Portugal	9 873	20.8	79.5	72.0
Spain	39 634	21.6	82.1	75.3
Sweden	8 892	22.3	81.9	77.1
UK	58 744	20.9	79.7	74.7

Source: United Nations (2000) *The World's Women*.

Across the EU family life, social attitudes, values, gender roles and working arrangements are changing. Economic, social, political and cultural trends influence how women age. These trends have important consequences for women's health and quality of life.

The changing demographics in Europe, and longer life expectancy is creating its own problems to policy makers, such as a rise in age related diseases, (Alzheimer's), which has a major impact on women both as carers and sufferers of the disease. Much of the responsibility for long-term care continues to fall on families, and it is largely women who continue to meet the majority of society's caring needs. Many of these women are over 55 years of age. However, with increasing participation in the work force, the restructuring of families that follows divorce, and geographical mobility, the pool of women available as carers may begin to fall.

Prevalence of dementia by gender



Prevalence of all dementia by sex. Pooled analyses. (Fratiglioni, 1998.)

How in the future will we measure the health status of women?

As the EU enters a new phase of enlargement, there will be new risks to health not least as a result of increased mobility of citizens. Future European Public Health Strategies must be carefully planned and sufficiently comprehensive to meet the growing challenges.

The focus of the new public health strategy emphasises the following:

Improving health Information.

Enhancing capability to respond to health threats.

Addressing health determinants.

There is a need to encourage the development of appropriate indicators for measuring the health status of men and women in Europe. Here the health-monitoring programme established in 1997 can have a major influence on the development of gender sensitive and comparable information systems between member states. This is to inform policy and programme decision-makers on the health status of EU citizens, resulting in priority setting and targeted health promotion and disease prevention policies. Some diseases strike women and men at different ages; e.g. cardiovascular disease is diagnosed at a later stage in women than men. Some diseases have different prevalence rates, such as Eating Disorders, Musculoskeletal Disease, Depression and Stress. It is essential therefore that the gender perspective is taken into account and that data is desegregated by sex so that results can be presented for easy use.

Research undertaken by the European Institute of Women's Health has demonstrated that women in Europe are:

- Less likely than men to be included in clinical trials for new medicines
- Disadvantaged because less money is spent on research into women specific illnesses and diseases
- Less likely than men to have private health insurance as coverage for women specific illnesses is often more restrictive
- Grossly under-represented in managerial and medical hierarchies.

Concerns about bias in medical research has led to attempts by funders in a number of countries to include women in study samples whenever appropriate. However funding biomedical research can only be a partial strategy for extending understanding of gender inequity in health and illness. In particular, governments should encourage an integrated multi-disciplinary approach to research involving all stakeholders, social, medical, economic research sectors and women themselves so that findings can be used to develop more comprehensive health policies.

Women scientists must also be encouraged to lead research of projects, which are funded, at a European level. Apart from tackling inequities in research, a gender sensitive needs assessment must also be encouraged in the delivery of health services. This will involve a comparison of the numbers of males and females in the target population and an assessment of the gender patterns in current service use.

In order to do this the following questions should be asked:

- How can we explain the different use of services by men and women?
- Can any difference be seen in the quality of care women and men currently receive?
- In what ways are health services themselves gendered?
- Who currently controls access to health-related resources and do the allocation criteria take into account the different needs of women and men?
- In order to plan for effective service delivery, women themselves, NGOs and health advocates need to be more involved in the design, implementation and evaluation of services
- Training materials should be developed to assist in conducting gender analysis in policies and programmes

Lobbying Strategy for Gender Mainstreaming

Lobbying is now an established part of the European decision – making process. Up until recently, the industrial and corporate sectors were the pro-active and powerful groups in the lobbying arena. However, the growing organisation and co-ordination of social, health and environmental interest groups has begun to redress this imbalance.

Health is now a priority issue for all citizens living in the European Union. The rapid changes Europe is undergoing will have a huge impact on peoples' lives and on their health. There is now a need to develop a community health strategy that is comprehensive enough to respond to present conditions and to emerging trends. This new strategy must reflect the new public health powers in the Treaty of Amsterdam, and, must be able to meet key challenges to the health of women and men.

The European Institute of Women's Health, launched in 1996, is a non-governmental organisation, with an extended network throughout Europe. The EIWH has been working over the last number of years, promoting Gender Equity in EU Public Health, through research, lobbying and information provision.

We have contributed to the debate, through participation in the following:

- EU Commission Expert Advisory Group on Ageing and Disabilities.
- Contribution to the 6th Framework Programme for Research.
- Consultative Forum on Gender Mainstreaming, -6th Environmental Action Programme.
- WHO Panel for Gender Mainstreaming.
- Developing a Global Portal for Women's Health (under construction).

The European Institute of Women's Health, based on discussions at a European Conference in Dublin from 9th-12th September 2000, prepared a position paper on Mainstreaming the Gender Perspective into the Health Sector. Since the conference the EIWH has been actively lobbying the EU Commission and EU Parliament to create awareness of the need to mainstream the gender perspective into the new Public Health Strategy. The EIWH tabled several amendments on gender in February this year, which were successfully voted through Parliament in April 2000. The EIWH also met with the Cabinet of the Commissioner for Research, Mr. Busquin and the Director of the Research unit, Mr. Peter Kind, to ensure that Gender was a criteria for funding in the 6th Framework Programme for Research, which will be implemented in 2002. The EIWH has also been invited by the WHO to participate in the expert group on gender, to devise a strategy to mainstream gender at national level. The EIWH intends to continue this work by seeking support to create a Gender Equity Network across Europe. Working together to strengthen and develop Public Health Policy in Europe.

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Working Group “Gender-Based Analysis in Public Health-Research”

Lecture: Dr. Judith Fuchs, Technische Universität Berlin, Dr. Ingeborg Jahn, Bremer Institut für Präventionsforschung und Sozialmedizin & Anne Hammarström, Family Medicine, Noorlands University Hospital

The central task for the working group was the compilation and discussion of arguments for the necessity to include gender issues in public health research which could be useful for advanced training and publishing and finding strategies for the proceeding.

International research shows a variety of results concerning the proper inclusion or representation of women in health research. Meinert et al. (2000) analysed a huge number of medical contributions if there was any gender bias. The ‘handicap’ for public health researcher is, that they analysed only clinical trials and published contributions, which leads to a selected sample. In addition the baseline for analysis was the inclusion of female and males, independent from the number of participants enrolled in the trials.

The results show, that 603 trials indicated gender; 78 (13 %) are male-only, 90 (15 %) female-only and 435 (72 %) involved both gender groups. The authors conclude, that women are NOT underestimated in clinical trials.

“The differences in observed versus expected female to male ratios correspond to a slight excess of male. Only trials in the decade of 1966-1975 and to sizeable excesses in female-only trials in the decades of 1976-1985 and 1986 to 1995. The results do not support the perception that women have been understudied relative to males in clinical trials. Most differentials favour females, whether based on mortality or years of potential life loss due to mortality before age 65 years.”

The reviews of Niedhammer et al. (2000) and Zahm et al. (1994) concerning epidemiological publications on occupational health revealed different results. Niedhammer et al. (2000) investigated original articles in six journals during the year 1997 with regard to the number of women and men involved in the studies, the design and strategies of analyses in terms of gender. The authors concluded:

“Firstly, the occupational risks for working women are still less often investigated, than those for working men, and secondly, the differences between the sexes are not given enough consideration in the choice of the strategy of data analysis” (S. 524).

In 11% of the studies there was no information about the gender of the study subjects, in 31% exclusively men, and in 7% exclusively women were investigated. 51% included both genders, but only 42% of these studies presented gender-specific analyses. These results are in correspondence to Zahm et al. (1994).

These results were discussed in view to the European and German public health research under consideration of the different research realities in Europe. European Public Health research is based on different conditions and might contain more gender bias than in the US, because of missing guidelines for research funding and publication.

The results of the German-language literature review, which has been carried out within the project ‘Gender Bias – Gender Research’¹, show the following results:

¹ The project is carried out within the Berlin Centre of Public Health (BZPH), a joint institution of the Technical

Only 10 % of all authors name in the **title** about their subject of analysis; in 86% of all reviewed articles we do not get to know the sex of the participants. If we go on reading the **abstracts**, we'll learn in 27% of all empirical articles, who is in the sample. This changes if we read the **text** of the article: in 70% of all articles women and men (boys and girls etc.) are named. These are very basic, mostly linguistic considerations, but it is important for recipients of scientific articles, because it trains them to be obvious and aware about women's and men's different situation if both appear in the written language. Authors always should be precise in telling about their sample.

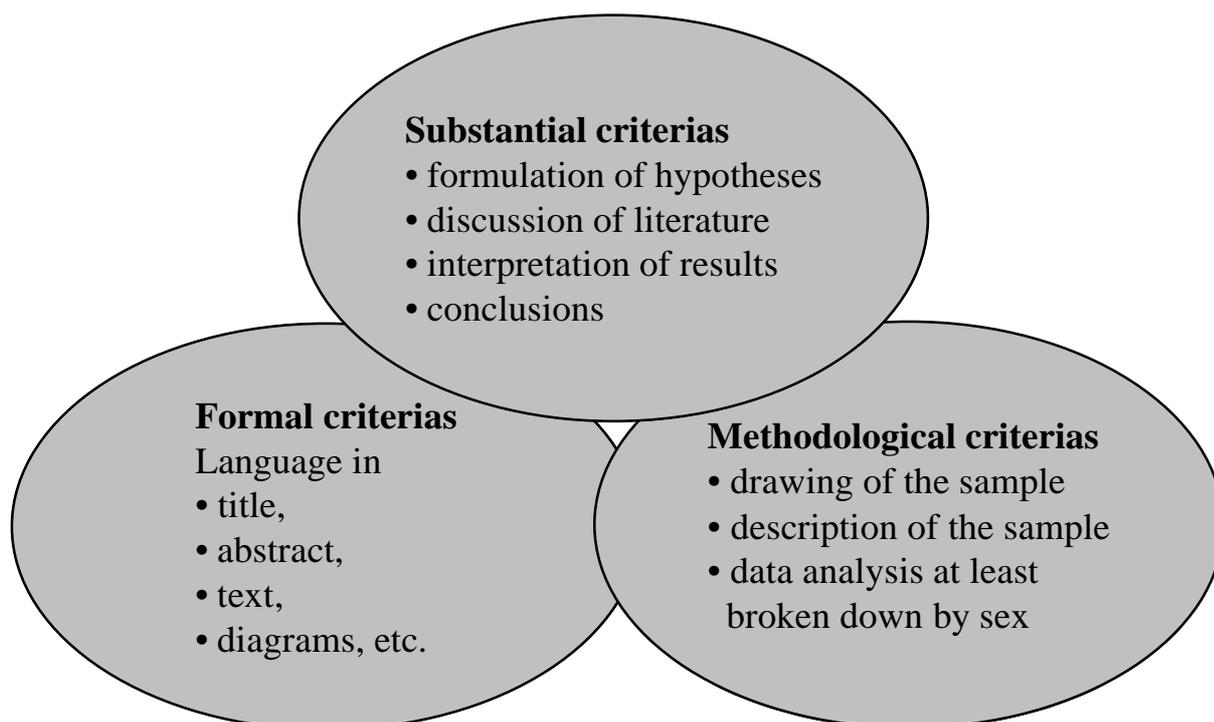
In the majority of the analysed empirical articles the author(s) declare that both women and men are **units of analysis**. Looking at the **data analysis**, we find that only 28% did all or the most part of the analysis by sex; another 25% did it partly.

Despite including females and males, in almost four out of ten articles the analyses were not carried out for both sexes separately. For all these articles it can't be expected to find much about including both sexes in the **conclusions**. Only about one third did refer to women and men or include gender in the conclusions.

These results of German-language publications are critical, because research, programmes and planning based on overgeneralisation or gender-insensitivity might set up the wrong conditions: women and men might have different needs, therapies, living conditions, which are not considered or taken into account. Differences can only be seen if the data analysis takes both sexes into consideration.

It is not enough to include women and men in the study sample, if the results are not analysed separately and described adequately, so the conclusions show, how far differences persist. In analogy to 'No result is a result' we would say 'No differences is a presentable result' and should be discussed and presented.

We consider three main areas to be important: **the formal, the methodological and the substantial area**. The following image shows the areas and gives some examples.



The three areas influence each other and require different approaches. Quality standards should cover the formal and methodological criteria. The introduction and inclusion of gender issues into the substantial criteria appear more difficult, because it requires the creation of gender awareness, which can't be 'produced' by guidelines. But the more publications fulfil the formal and methodological criteria the more 'receiver' will learn about gender topics. This might lead to a greater awareness in view to gender issues.

In Germany, there are no recommendations or guidelines to promote women's health research as well as criteria for gender-adequate health research. Since 1994, in the US, the "NIH-Guidelines on the Inclusion of Women and Minorities as Subjects in Clinical Research" (Department of Health and Human Services, National Institutes of Health 1994/2000, NIH o.J.) were forced; a guideline, which included all NIH sponsored „*biomedical and behavioral projects involving human subjects, unless a clear and compelling rationale and justification establishes that inclusion is inappropriate to the health of the subjects or the purpose of the research*" (Pinn, 1999, 4).

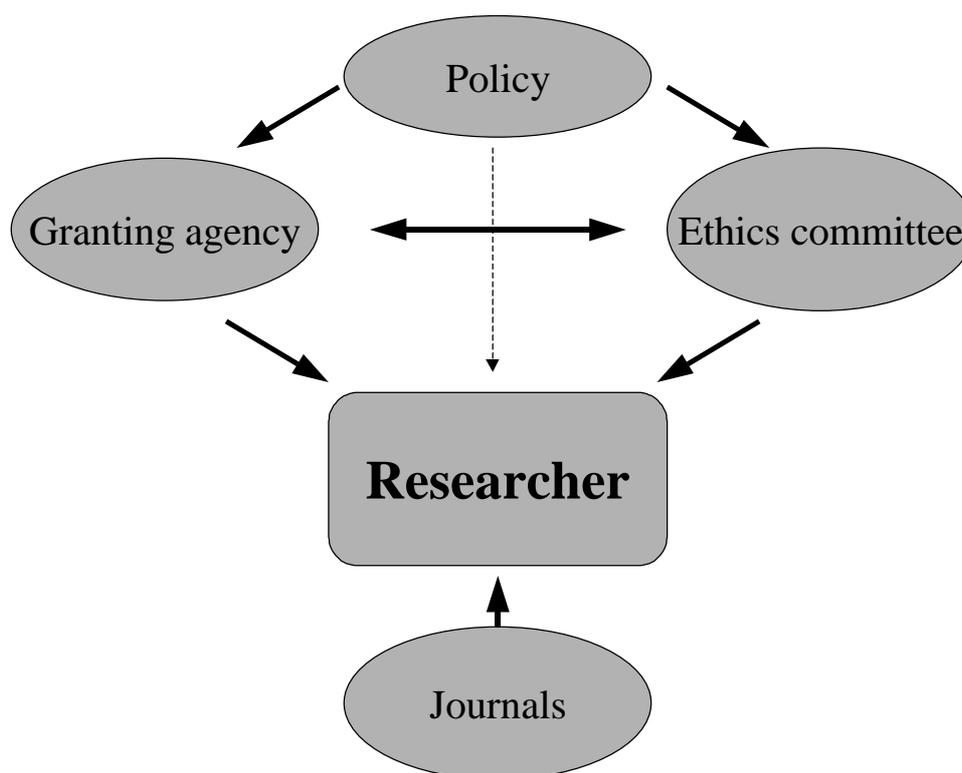
The epidemiological scientific community in Germany (Deutsche Arbeitsgemeinschaft für Epidemiologie (DAE), Deutsche Gesellschaft für Sozialmedizin und Prävention (DGSM), Gesellschaft für Medizinische Datenverarbeitung und Statistik (GMDS) und Deutsche Region der Internationalen Biometrischen Gesellschaft (DR-IBS)) worked out guidelines for "Good epidemiological practice" including the following recommendations referring to gender (DAE 2000, S. 297):

"Bei Themen und Fragestellungen, die beide Geschlechter betreffen, ist eine Begründung erforderlich, wenn nur ein Geschlecht in die Studie eingeschlossen wird."(„If issues and research questions are concerning both genders, a justification is needed, if only one gender should be included in the study.“)

„Zum Beispiel sind Studiendesign und Untersuchungsmethodik so anzulegen, dass die geschlechtsspezifischen Aspekte des Themas bzw. der Fragestellung angemessen erfasst und entdeckt werden können.“ (“For example the design and the methodology used should refer adequately to the gender-specific aspects of the issue and the research question respectively”).

Although these guidelines have been unique in Germany until now, their application into the daily practice must be actively supported. What are the criteria for assessing a specific issue as being relevant for both genders? Which are acceptable reasons to include only one sex? What is a gender-sensitive research question and what is an appropriate research design? Which gender-specific aspects of a research question have to be taken into account? Which methodology is needed to investigate these aspects adequately? What are gender-sensitive recruitment procedures? Which strategies for analysis should be decided and what are the characteristics of non-sexist interpretation, conclusion, and risk communication?

In the discussion we identified various ‘factors’ who or which could take influence in the consideration of gender issues in current or future research: public policy, the foundations of grant givers, the ethic committees and the publishers/editors of scientific journals.



The researcher in the centre of the image is or can be influenced by various ‘authorities’. The institutions in the upper part will influence her/his work before and during the research process by granting (or not-granting!) specific projects and evaluating and criticising the results. The journals in the lower part of the image take influence on the researcher by accepting publications, advising a revision or denying the publication.

This image shows the variety of levels where starting points could be found and that different strategies are required to provide properly done gender based analyses.

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Working Group “Health Care”

Gender Differences in Health Research and Practice Guidelines in the Netherlands

Lecture: Dr. J.A. Haafkens & Dr. Clara J. Moerman, Department of General Practice, Academic Medical Center, University of Amsterdam

In 1999 the Dutch minister of health took the initiative to integrate gender sensitive health care within the regular health and medical care system. In Dutch medical practice a substantial shift is taking place from clinical decision making based on opinion to decision making based on the results of biomedical research and practice guidelines. For the successful integration of a gender sensitive approach in regular health care, in our opinion it is crucial that appropriate attention is given to gender issues in biomedical research and the development of practice guidelines. Therefore we just started a research project that is being funded by a Dutch research organization called ZON. In this presentation I will briefly outline the project and I would like to discuss your opinion about it and experiences with similar projects.

Research question

The aim of the project is to examine if and how gender related aspects are currently attended to the production of an evidence base for Dutch health care providers, whether more attention is needed and, if so, how this could be accomplished.

Research activities

In order to answer the research question we have planned the following activities:

1. A systematic review of current medical research financed by major Dutch research organizations on four selected (chronic) conditions to evaluate what attention has been paid to gender differences at various stages of the research process (e.g., design, data collection, data analysis and the presentation of the research results)
2. An investigation of the possibilities and the impossibilities of enhancing attention for gender related aspects in Dutch health research through interviews with the project leaders and invitational meetings with representatives of the major funding organizations for health research and significant others.
3. A review of currently produced practice guidelines for Dutch general practitioners and/or medical specialists on four (chronic) conditions to evaluate to what extent attention has been paid to gender related aspects in the production of those guidelines (e.g. the synthesis of the research evidence, the recommendations)
4. An investigation of the possibilities and the impossibilities of implementing attention for gender related aspects in the production of practice guidelines through interviews with the guideline developers and invitational meetings with representatives of the major guideline organizations and significant others.
5. The development of recommendations for improving attention for gender related issues in research and practice guidelines for Dutch health care.

Discussion

1. Are there any similar projects in other European countries?
2. Do you know of any European guidelines for gender based evaluation of research protocols and guidelines for medical practice?

3. What are important issues that should be addressed in gender based evaluation of research protocols and practice guidelines?
4. What criteria should be used to evaluate quantitative research protocols?
5. What criteria should be addressed to evaluate qualitative research protocols?

Key words: Gender differences, health research, practice guidelines, clinical decision making.

Working Group “Health Promotion and Prevention”

Prof. Dr. Carol Hagemann-White, University of Osnabrück

In the German context, health promotion and prevention appear to be largely women’s domains, with regard to both supply and demand. A large proportion of activities in this field emerged within settings that in fact, although not by intent, primarily reach women. After 25 years of women’s health initiatives, many areas of practice can be identified in which consciously woman-oriented approaches have been developed and refined. However, these are often not located within, or recognized by, the health insurance and care systems, but defined as belonging to the area of personal growth and adult education (e.g. Volkshochschulen), or as a segment within social problems and social affairs (e.g. sexualised violence). What does this state of affairs mean for women’s health promotion?

First, existing practical models are not gender-based, but at best woman-centered. Furthermore, these are highly dependent on local contingencies; there are few mechanisms for dissemination of good practices:

Example: the feminist women’s health centers’ movement, initiated in the mid 1970s, has resulted in a relatively small number of stable organizations – 22 at last count – of which only some actually meet the needs of women seeking practical advice or resources. Their impact on the mainstream has been indirect at best.

Due to lack of integration into the health care system, many projects and approaches depend on uncertain or inadequate funding; this creates income barriers to access even for measures and programs of recognized excellence.

This is true, for example, for the specific services addressing eating disorders: they have been successful both in establishing structures recognized as helpful, and in bringing the “Orbach approach” into mainstream thinking. Within the regular health care system these disorders are often not even identified, much less adequately met. Yet our study in 1999 found that cutbacks in the health care system meant that only women who can self-pay have access.

Since emphasizing women’s special needs has been a relatively successful strategy for acquiring modest funding, there has been an inclination to present such approaches with reference to questionable generalizations about women (and implicitly, men), this reinforcing gender stereotypes.

We found this in our study when seeking to identify woman-centered approaches in psychotherapy. An obvious choice of issues was depression, diagnosed much more frequently in women than in men. Among feminist psychotherapists specializing in women and depression we sometimes found the problem depicted entirely in terms of the middle-aged woman who has devoted her life to her husband and children and now finds herself “superfluous”. Of course, these women exist, but we were astonished to find the need for gender-sensitive understanding of depression framed as if women’s lives all followed this pattern. Another example is the tendency to describe the need for a gender-specific approach by pointing to sexual abuse and trauma. It is not at all clear that men experience trauma differently when sexually abused.

Finally, there are blank spaces: In many significant areas no practical responses to the need for gender-based prevention and health promotion have emerged. An important area is occupational health: In typical fields of women’s work, little attention has been given to the health burdens – for example, the noise level and the physical stress of working with groups of small children all day. The health hazards (for example, dangerous chemicals and their effects) involved in housework are rarely studied. The risks around reproductive functioning are another area of low concern. Only

infrequently and unexpectedly have the effects of environmental chemicals been noted –most recently, the hormone-equivalent impact of sun-blockers which may increase the risk of breast cancer.

The workshop focussed on discussing how these limitations might be addressed, and in particular, how to build a convincing case for a systematic and reliable structure of gender-sensitive health promotion. Four themes were central:

I. What are the advantages and disadvantages when health promotion is outside the medical/health care circuit? Negative aspects are the lack of health insurance funding: Women who have the greatest need may have the least access. On a policy level, the cost-reducing impact of prevention becomes invisible. The circulation of knowledge is interrupted: Physicians do not profit from what is learned in the course of preventive and rehabilitation work, and they, in turn, are less likely to refer women to appropriate services. Positive aspects were seen in the greater diversity of approaches and resources, whose development is not obstructed by status hierarchies of expertise. Physicians are not educated to see gradations of difference between disease and health, or to understand social and biographical context; they are trained to help the sick and not the healthy.

Ideas collected were:

1. encourage inter-professional co-operation in all parts of the health care system; including hospitals, on the basis of equal recognition to different kinds of expertise;
2. build partnerships systematically between medical and non-medical services and increase referrals;
3. use these alliances to secure continuity, access, and professional development for valuable health promotion programs.

II. What are the most promising points of departure for implementing a gender approach to health promotion more broadly? A wide span of possibilities came to light-

One approach is to address those who are still healthy, perhaps beginning in schools, train and empower teachers to do health promotion with children in the framework of overall social prevention, e.g. how to handle conflict constructively, balance needs and make school a comfortable and enjoyable place to be; the explicit focus might be on “well-being” rather than specifically “health”.

At the other end of the scale, hospitals offer largely unused opportunities for health promotion and prevention: People are often at a point of crisis and change in their lives and their bodies and particularly sensitive to the future importance of self-care. To draw on the potential of this situation requires including other professions than medicine and nursing.

III. The growing emphasis on gender sensitivity and meeting women’s needs is in danger of reifying stereotypes, as well as providing resources to only a portion of those who need them. This could lead to reinforcing the deficit approach to gender and to health problems, despite all rhetoric about women’s strengths and skills. A similar effect has been noted when working to make medical care more sensitive to the needs of migrant women or to cultural differences: valuable and relevant information is generalized, transformed into a stereotype and then into a deficit. This points to the need to re-conceptualize health promotion with an orientation to resources and to diversity.

Ideas:

the argument must be made and repeated that health promotion starts outside the health care system (for example in schools, in living conditions) and must, in a democracy, be of the highest priority, and that it is cost-reducing:

but we must be aware that powerful economic interests drive the cost explosion in health care.

IV. Should we be asking for evidence-based health promotion with a gender perspective?

Following the suggestion by Lesley Doyal that health promotion means reducing the health-damaging effects of gender roles throughout society, a broader scope of evidence might be considered. We have accumulated a great deal of evidence (including statistical data) on gender inequality and gender role expectations: Could this be re-framed as an evidence base for health promotion? Time did not permit exploring the possibilities of such an approach.

Minutes from Working Group Session “Planning and Programs”

Impulse lecturers: Regina Jürgens & Ines Zimmermann, Hamburg Authority for Work, Health and Social Affairs, **Notetaker/moderator:** Dr. Kim Bloomfield, Free University of Berlin

From where have we come? Where do we go?

Regina Jürgens and Ines Zimmermann have written the health report for Hamburg and have developed a concept for such reporting that they present in the lecture. The health report should provide data for action. The form of the report is also important in how it presents information. It should motivate. It should lend itself to evaluation, as well. Also for co-ordination of health activities.

Hamburg is different in that it has its own concept for health reporting. See the public health action cycle (overhead diagram) which includes assessment (information and orientation), policy development (co-ordination and motivation), assurance (co-ordination), and evaluation. Health reports should include all four aspects, not just assessment.

The authors have used this format for their report on children and health in Hamburg. After that report, came the topic of women. There was not as much data on women as for children, and there already was a general health report. Also the question arose as to whether we need a separate women’s health report. They decided to start with evaluation and assessment of the topic.

An experience with the children’s health report was that such reports do not end up with the proper policy makers in the community, although they had tried to write the report with the proper experts, actors and consumers.

With the women’s report, the health minister had the initial motivation to write such a report, based on recommendations to improve women’s health.

An interdisciplinary expert commission was called together in spring 2000 to choose the topics for the report. Ten topics were chosen (see overheads). The health minister chose the 18 experts making up the commission and representing various areas of expertise. Three men were on the commission.

Seven subheadings were given to each of the 10 main topics (see overheads). These were in effect a rubric to be applied to each of the main topics.

Conclusions: This report of forming recommendations for women’s health reporting revealed the political obstacles of the process; e.g. a top-down strategy of identifying topics. Topics were chosen either by chance or on purpose. The path to implementation remains unclear.

Working Group Discussion:

The question arose as to why nursing was not a part of the report...

There was another question of how one can then implement action regarding the topics. Here Jürgens & Zimmermann displayed the overhead regarding “innovation and diffusion” as to how and when players in the community then take up action, and reported that it was planned that smaller working groups stemming from the expert commission would be formed to implement the recommendations of their report.

A question regarding the process of choosing the topics was posed. The commission met 11 times and chose and worked out the 10 topics. A final meeting was held to bring everything together.

Concern was voiced over the lack of participation of local community to express needs and identify health problems in the topic selection process. It was commented that this has also been a problem in Berlin where politicians do not want to accept ordinary people as their own experts.

Another comment was made regarding differences in how interests are represented. We need a systematic approach. There is a gap between basic activities and the experts. We need to sensitise the elite to the topic. How can health reporting break through the middle management that stops and hinders actions?

In Graz a health report was also made, and there was a desire to develop a program in order to implement the results of the report, but no funding was available. Because of this a "Gender Health Audit" was chosen as a compromise. This form of reporting was developed to encourage organisations to do more since official state funding was lacking.

When the Hamburg women's health report appeared there was a lot of resonance with local organisations that then wanted money to implement programs. And other organisations in Hamburg have written reports on the status of women (e.g. role overload of women), but such projects need money, too.

Another comment was made about how women in the general (urban) population may not know precisely what kinds of health problems they actually have and therefore may have problems to accurately report them in questionnaire form.

One could use indirect indicators of health problems in order to find out more. One can also collect data on other determinants of health such as housing, sanitation, noise, etc.

However, concerns were also raised about the participation of some of the affected groups, e.g., homeless. This can be problematic if they are invited to participate in hearings.

Recommendations/Summary of the Working Group:

- There are hurdles and obstacles that arise in developing recommendations for topics for a women's health report
- One must be realistic about the process
- There is a concern about how to include average women (i.e. the woman in the street)
- How can these hurdles be cleared?
- It is important to try to develop policy not only from top down, but also bottom up.
- Developing countries must always include citizen participation otherwise they are not funded. But this is not the case for developed countries. This should be made a requirement in public health protocols for planning from the very beginning.

Working Group “Mental Health Promotion and Prevention”

Strategies for Implementing GBA in Mental Health Field

Lecture: Elvira Reale and Vittoria Sardelli, La Magnolia, Naples

Introduction

Magnolia Centre

Our out-patients centre is a public health care centre specializing in women's mental health problems. The team is made up of psychologists, a psychiatrist, a medical doctor specialised in homeopathy, a sociologist and nurses. The centre exemplifies the possibility of carrying on, within the Public Health System, activities of gender oriented prevention, treatment, research and training. We have been treating women for more than twenty years.

Up to this time, about 6.000 women have been treated in our mental health service, and 1503 women have been treated in the last five years. From an epidemiological point of view, this population corresponds to the general female population of Italy. It consists mainly of adult married women, with children. Main symptoms are anxiety, depression, and/or psychosomatic troubles. In recent years the demand for care has been growing, also from younger women, aged between 15 and 44. Our statistics are consistent with international ones.

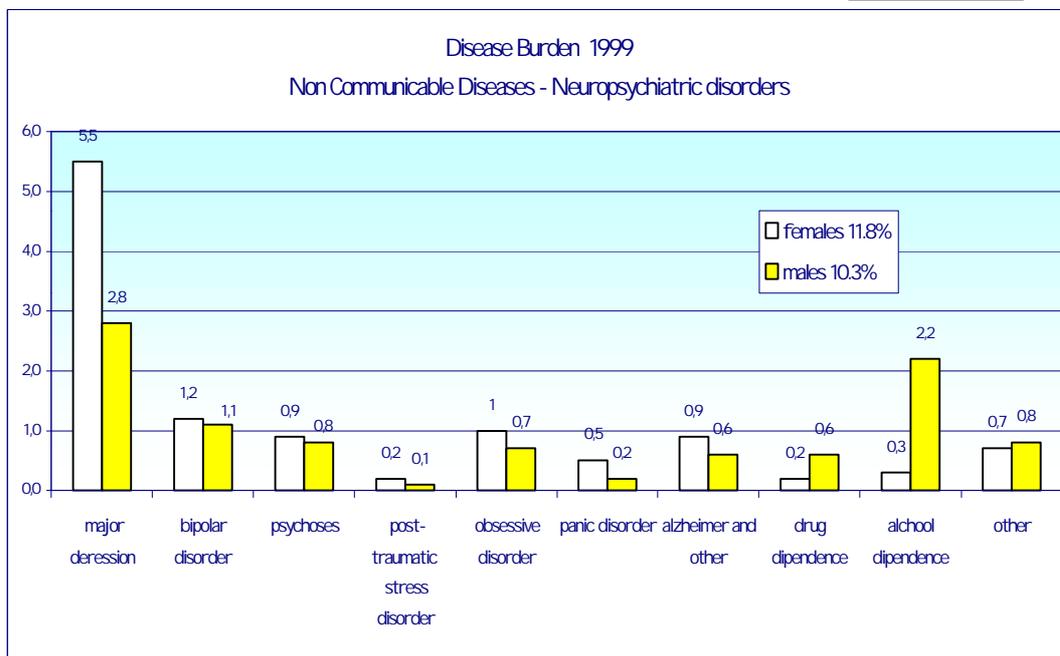
International Data on Depression and other mental disorders

International statistics show that mental disorders (particularly depression, anxiety, eating disorders) are prevalent and rising among women within the general population. Depression, specially, is the main cause of burden diseases in women between 15 and 44 years of age: Unipolar Major Depression takes 1st place in ten leading causes of female burden of disease (Source world health report 1999, Database).

Research has highlighted that children's mothers and girls are at the highest risk of depression. The prevalence rates, in depression are between 2 and 3 times higher in women than in men. Female adolescents run a much higher risk of disease compared to boys, and in some cases, like eating disorders, the rate for women goes up to 9: 1 (90% of the total cases).

There is evidence that women's cases exceed men's ones in all types of mental disorders, excluding alcoholism and drug abuse (see graphic 1).

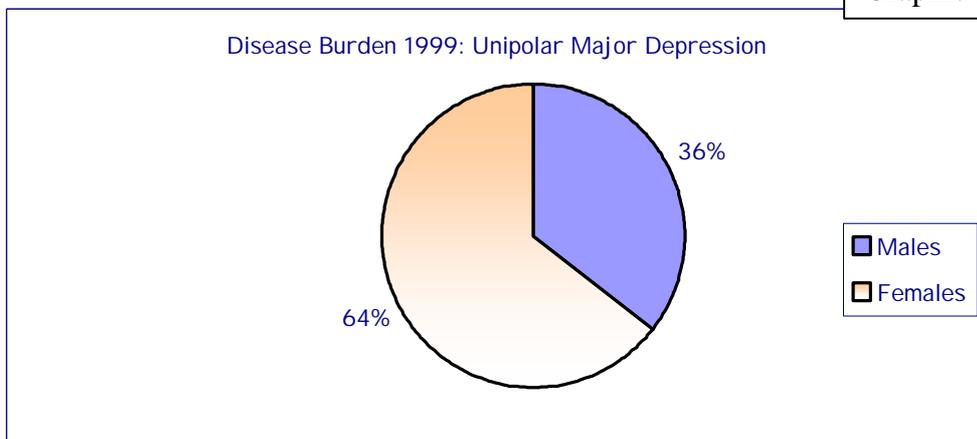
Graphic 1



Source: The World Health Report 2000

There is evidence also that the high rate of depressed women is an alarming problem which society and health care institutions must focus on (See graphic 2).

Graphic 2



Source: The World Health Report 2000

There is evidence that pharmacological consumption is rising and women occupy the first place in psycho-drugs consumption. In Italy, ISTAT (Italian National Statistics Board) says that there are 5.5 million of medicine users (psycho medicines particularly anti-depressants); among these, there are 3.7 million women and 1.7 million men. Women in treatment for drug abuse often experience paradox symptoms and more side effects. Medical treatment is often ineffective and causes psychological dependence.

There is evidence that several studies on the consequences of violence against women point to psychic damages. Particularly, they show these consequences:

Health Consequences of Violence against Women	
<ul style="list-style-type: none"> - Depression - Suicidality - Fear, feelings of shame & guilt - Anxiety, panic attacks - Low self-esteem 	<ul style="list-style-type: none"> - Sexual dysfunction - Eating problems - Obsessive-compulsive disorder - Post traumatic stress disorder - Abuse of medication, alcohol & drugs

Why do so many women suffer from mental disorders?

The answer from the traditional medical world

◆ About research, even though it is difficult to prove genetic, hormonal and personality structure hypotheses the research is mainly oriented to evaluate the correlation among women's mental pathologies, particularly depression, hormonal, biological and personality factors.

These research projects are carried out with large financial support and with the contribution of pharmaceutical industries, which are profit oriented. The outcomes of psychosocial research lead to different explanations of the higher morbidity in women compared to men, but this kind of research does not have an adequate financial support.

The traditional projects do not yet study the interconnection of many relevant factors: being married and having children; lack of trust toward the partner; lack of social support; low self-esteem; violence, battering and dependency.

◆ In clinical practice we find sexual prejudices: the fact that mental illness, particularly depression, is more widespread among women, is considered by the majority of psychiatrists as related to female biology (hormonal fluctuation and so on) and personality traits (passivity, low self-esteem, dependency).

Treatments for women, compared to those for men, are more traditional: pharmaceutical treatment is prevalent, at times associated with psychotherapy.

Treatments in a mixed environment (both in or out clinic) do not fulfil women's needs: often they are involved in an abusive relationship with a violent male, for they do not appreciate sharing a common therapeutic space with men.

Women, compared to men, are objects of longer medical and pharmaceutical treatments, and run a high risk of becoming chronic cases.

This data on longer therapies for women might be due to a lower effectiveness of pharmaceutical treatment, which seems to miss the goal more frequently compared to men in terms of improving women's health.

◆ About prevention, existing studies have not developed indications for acknowledging risk factors and protective factors in everyday life, to be used in prevention campaigns.

Prevention should have priority in any health system, or any pathology, yet in the field of mental illness we notice a lack of interest in developing studies and indications toward primary prevention. Such a lack of interest damages women in special ways, since they become mentally ill more frequently than men and are much more exposed to risk factors in their environment.

Inappropriate prevention (often overlapping treatment) is connected to the recommendation to begin drugs consumption as early as possible, i.e., at the first symptom, even during adolescence; to avoid interruptions and to continue psychodrugs consumption for long periods of time.

◆ As for the organization of services few mental services are focused on women: most services ignore women's health needs in this field and are not equipped to deal with them. In health programmes there are no indications to lower female rates of mental illness; there are no gender-oriented health activities for risk groups such as adolescent girls or employed women with family commitments and children (overload).

In synthesis: mental health services seem to correspond to men's needs. They are oriented toward "returning the person to his activities, in order to take up interrupted activities" without observing if these interrupted activities are the very cause of discomfort and disease.

The answer from GBA can be summed up in the following 4 points:

1. Everyone is subjected to different kinds of pressure (economical, political, cultural, psychological, etc.) that contribute to psychic troubles.
2. Gender and sexual difference are additional causes of general pressure for women.
3. The sociological notion of *female role* implies a number of rules of private and public behaviour aiming to create and increase a social and psychological subordination.
4. The weight and the oppression of this role can increase and become unbearable for the woman. When this happens, psychic trouble may occur as a possible expression of her suffering, of which she cannot recognise the source.

Daily life analysis is the relevant field of research and treatment. It shows that two main factors contribute to the oppression linked to the female role:

- the burden and stress connected with motherhood;
- the pressures exercised by the social and family environment, which leads the woman, from an early age, towards role behaviours and induce her to accept the global burden of motherhood.

The analysis of being a mother and its characteristics (that is responsibility, expectations, models, tirelessness, her psychological dependence on the satisfaction of other's needs, etc.), can be the central point of observation of the risk factors of mental illness for women.

The characteristics of being "maternal" are part of gender identity and they do not apply only, nor specifically, to those women who have children.

Maternity is a social model which determines woman's behaviour and makes her neglect personal needs to the advantage of others.

Maternity is the prototype of a relationship of dependence: the person who is defined as socially in need of protection, must accomplish tasks which are not considered as a real work but as activities to carry out in the interests of personal realisation.

GBA Proposal

❖ *Mental Health Research*

In the field of Mental Health Research the GBA highlights the necessity of:

- collecting data by sex, and showing the results according to this distinction;
- using case-control samples;
- including patients of both sexes;
- relating the different variables to the sample divided by sex.

In the field of pharmacological research, it is necessary to acknowledge the biological difference between women and men.

In the field of clinical research it is necessary to set up new and specific therapeutical tools for women focusing on the link between illness and everyday life.

❖ *Clinical Practice*

It is necessary to integrate and modify the traditional ways of working by the elaboration of :

- diagnostic protocols able to point out the pathogenic pathway which leads to mental illness.
- Sex specific protocols for pharmacological treatment and recommendations that suggest caution in dosages for women.
- Treatment protocols apt to:
 - guide health care providers in singling out the causes undervalued by women themselves;
 - give suggestions apt to help women to lighten the burden of responsibilities and to assume styles of behaviour more suitable to individual well-being.

❖ *Prevention*

According to GBA, primary prevention should focus on environmental and social-relational factors. These are factors in which it is possible to intervene before the overload of "pressure" becomes a psychic pathology.

Prevention should be gender sensitive and mainly addressed to the most vulnerable subjects: female adolescents and women (in the range 15-44).

Prevention in Age 15 - 44

The Gender Bias Analysis, made in our clinical centre, has pointed out the following risk factors in the range 14-23 and 24-45:

1. In adolescents

- Early adult role playing for supporting mother
- Study and hobbies lowering
- Peer relationship reduction
- Trust only in parents
- Skills unrecognised
- Conditioned planning for the future
- Feeling unwell

2. In adult women

- Increasing family work (work characterised by care for others and lack of self-care) connected to lack of "gratitude"
- Unrecognised tiredness as connected to family work
- Decreasing personal interests and activities
- Decreasing/lack of supports
- Lack of confidence in extra-family relations
- Low self-esteem connected to undervaluation by others (family-social context)

❖ *Mental Health Services*

It is necessary to direct health services towards:

- prevention and therapeutic activities for women;
- offering women specific services.

Three types of activity or services for women:

1. The first type relates to preventing specific situations of distress.
2. The second type of service is addressed to women who have already begun to develop an illness and manifest symptoms, and who have already had psychiatric treatment.
3. The third type relates to setting up "women's refuges" (women in situations of distress and violence).

Strategies for GBA Implementation

Until now we have evidenced bias and gaps in the mental health field (research, clinical, prevention, services) and we have also evidenced in the light of GBA the corrective actions for woman-friendly psychiatry and psychotherapy. In fact, the actions to modify scientific theories and clinical practice cannot be lead by single persons, alone, or by single groups gender oriented. It is necessary to involve in this plan women's associations, university researchers, professionals who take care of women with mental disorders in different European countries. For these reasons we propose a new European network on women mental health made up by technical groups gender oriented and women/consumers associations. These groups will be able:

- to collect in each country and exchange epidemiological and clinical data, critical observations on **gender bias**, **sexual prejudices** and **inequalities** presently in existence in research and clinical practice (medical, psychological and psychiatric);
- to analyse the data pointed out by each group, and to elaborate the synthesis on which the consensus will be reached;
- to develop indications, recommendations, guide-lines, for the inclusion of gender point of view in research and clinical practice in mental health field;
- to exert pressure on mental health orientation of decision making European institutions;
- to propose to the E.C. (European Commission) the funding of a project on network organization.