Gender, Health, and Cultures

Networking for a better Future
for Women within an enlarged Europe

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Foreword

An important milestone for the increasing realisation of gender-sensitive approaches was the Ottawa Charter for Health Promotion, adopted in 1986. Principles anchored in it, such as emancipation, participation and also the gender-specific approach, constituted fundamental elements of what was then a new concept of health promotion. Since that time, the research in and practice of health promotion have seen a development that has led to greatly increased sensitivity for gender-specific viewpoints. The Federal Centre for Health Education (Bundeszentrale für gesundheitliche Aufklärung, BZgA) took up this development and carried it further. In all subject areas, such as child health, AIDS and drug prevention, and particularly sex education and family planning, it implicitly examined the gender-specific special features of target groups by means of expert reports and studies, subsequently implementing the results.

Under the heading *gender mainstreaming,* it is now generally a question of specifically examining the gender-based situation of men and women. It is of particular importance in health promotion to separately examine the respective circumstances, lifestyles and health dispositions of men and women, in order to identify the effect of the different realities of life in relation to health matters, and thus to enable the development of efficient and effective health promotion strategies.

The task of the BZgA as a platform for *knowledge transfer and cooperation* at the national and international level is a central concern and constitutes a core area of the content-related and strategic orientation of the agency.

The BZgA has thus been active for many years in international organisations, such as the WHO and the European Network of Health Promotion Agencies (EuroHealthNet), in which, for example, national institutions and organisations in the field of health promotion and public health from almost all EU Member States are organised. In the context of this European collaboration, the BZgA implements EU projects together with numerous cooperation partners, thus actively participating in the international exchange of experience in health promotion and prevention. This applies to virtually all departments of the BZgA.

The *international exchange of experience and the communication process* are essential, constituting an indispensable element for the development of standards and the transfer of knowledge in health promotion and women's health in Germany.

The BZgA online database on the subject of 'women's health and health promotion', created several years ago, also caters to the concern of the BZgA of generating further expertise in this field by means of collaboration with partner organisations in Germany and abroad. To this end, several international workshops have been held, dealing with issues relating to the quality and further development of information offers in the field of women's health and health promotion.

Consequently, the BZgA was pleased to support the workshop of the *European Women's Health Network (EWHNET)* on *'Gender, Health and European Cultures'*, since it particularly discussed current issues of relevance to health promotion or the public health sector in Germany. In view of European integration and international cooperation, as well as the associated growing mobility of the population, attention is increasingly focusing on discussion of the understanding of cultural, political and societal differences in dealing with sickness and health, as well as strategies deriving therefrom.

Dr. Elisabeth Pott

Director of the Federal Centre for Health Education (BZgA)

Gender, Health, and European Cultures. An Introduction

Walburga Freitag, Vera Lasch & Ute Sonntag

> *"You have a big task ahead in explaining to your fellow-citizens what EU accession is really about. It is not just a matter of politicians signing a deal, or technocrats deciding on a few legal changes. No, joining the EU is about changing the whole political system and legal order, which affects the whole society"*
> *(Rehn, 2005: 3).*

The entry of ten new countries into the European Union can be seen as a great chance and challenge not only for the countries' political system and the EU as concept or idea. In respect to the field of gender, women's health and health promotion, we – the book editors – perceived the accession and enlargement as an opportunity and necessity to build up and strengthen networks and to learn about the countries' situations. As Kreutzner puts it in this book:

> "the political realities of the post 1989 era decidedly call on those identifying as Europeans to engage in ways of thinking and acting that go way beyond the narrow limitations of the local and of national borders".

Networking for a better future for women's health within an enlarged Europe seemed to us a central goal for an EU-workshop, an opportunity and process to widen the horizon and to learn mutually.

The book represents the output of this EU-workshop: "Networking for Women's Health across Regional Diversity in Europe: Experiences, Concepts and Strategies" which took place in Kassel, Germany, in 8.-10. October 2004. The publication includes conference participants' papers, the Open Space results as well as additional articles which deepen our understanding for central questions.

The goals of the workshop were to create a space where culture- and region-specific conditions and requirements could be described and under which the optimum interactive communication concerning women's health across regional diversity in Europe could be created, where an intercultural community including the 'New EU-countries' could be built. The specific country cultures are not only different in regard to their health systems. The

very definitions of health, illness and health related social problems are different. If networks try to focus on gender specific aspects of health and illness, the healthcare system or the question how gender gets a footing in research, it becomes even more visible that the necessity for transnational communication rises. "Trying to understand" means recognizing the language, conceptual and cultural differences between the countries, highlighting the country- and culture-specific developments and strategies and clarifying common questions and interests. To us central elements in a process of networking are sensibility for dominance, empowerment, respect and the acceptance of 'not knowing' or 'not understanding' in the process of communication. This is what we tried to realize during the workshop. The workshop was organised by the European Women's Health Network, a formally EU-funded project, which still can contribute with experiences and connections but is without funding at present.

The concept of the book corresponds with this described central conference goals. We summarised the papers under the four headlines "Understanding and Networking within a New Europe", "Identifying and Applying Gender Aspects in Health", "Gender-Relevant Issues and Debates" as well as "Facts and Figures on Gender and Health in the New Europe".

Understanding and Networking: *Gabriele Kreutzner's* article is the starting point. "There is more than one road to gaining knowledge and insight" is her conviction. For this reason, she introduces us to what she calls the "four essentials for any engagement in intercultural work and communication". By doing so she reflects the importance of the WHO definition of health and the role the 'New Europe' can play to come closer to the ideal concept. We can also learn a lot about the relationship between the New Europe and the European Union as a concrete political body.

Gesine Sturm, Ethnopsychotherapist, opens up a topic – psychotherapeutic situations with migrants –, the relevance of which still is highly underestimated. From her point of view building bridges between different symbol systems is the central activity in transcultural communication. Actors engaged in therapeutical settings do "translate" cultural representations. So, working with 'interpreters' (often misleadingly called translators) is a great challenge and offers excellent sensibility for other communications in health related situations.

Networking is strongly relayed on and connected to one central information system: the World Wide Web (www). Without doubt the World Wide Web as an information resource for networking activities has increased in importance in recent years. *Vera Lasch's* contribution focuses on the question how Gender and Health are represented in the www, which

institutions and topics are represented and which are not. She concludes that over the last two decades women's issues have moved rapidly up the policy agenda of international organizations and national governments.

Open Space as a method to meet participants' interests is in the centre of *Walburga Freitag*'s article. She presents the basics of the technique, and some reflection on process and results of the Open Space, which was organised during the workshop to enhance answers to the question "What are the Future Issues, Opportunities and Strategies for Women's Health Networking across Regional Diversity in Europe?"

One central question which moves everybody networking for gender equality is: What are the ways to bring the gender aspects into health related research, prevention and health care activities and to enhance gender equality? This is focus of book section two. *Birgit Babitsch* und *Judith Fuchs* introduce the reader to 'gender based analysis', a concept to support and improve gender equality e.g. by offering tools for a gender analysis of research/projects. *Brigitte Neumann* has written an article, which can be read as an excellent example for gender sensitive research, realising a high sensibility for dominance, empowerment and respect. The research project goal she is writing about, tries to improve the understanding of the relationships between women's paid work and unpaid caregiving, empowerment and health status. She describes in great detail the partnerships by means of which the research is conducted, the collaborative relationships between academic, government and community partners.

Last but not least: Gender Aspects in Health can better be realized, if data, information and literature are available. *Birgit Heidke* introduces us to Databases for Women's Health. Since many disciplines are relevant in the field of women's health – including medicine, education, psychology and sociology – the database wants to interlink these single information pools and to provide resources that are not always easily available. Although this database is available only in German, it can prompt people in other countries to imitate this kind of knowledge collection via the internet.

Chapter three tries to sketch important and up to date gender relevant debates. Globalisation, GATS, EU-directive on services are terms used to indicate changes which influences women's health to a growing extent in all EU-countries. But what does GATS mean? What is behind this policy and how does it influence women's health? *Arnd Hofmeister's* contribution tries to give answers to these questions.

Without doubt during the last decades the public health concern 'violence against women' has entered the action plans of many health institu-

tions. *Verena Kaselitz* describes the developments to acknowledge violence as an important public health concern and the role WHO plays. Whereas Kaselitz refers mainly to the discourse in Western Europe, *Malgorzata Tarasiewic* writes about the importance of the Polish Edition of the U.S.-classic 'Our Bodies, Ourselves':

> "It aims at helping women with respect to their treatment by state institutions such as maternity wards and prosecutor offices where they report domestic violence cases".

The book is released two decades after its success in the so called western world. The idea behind the book was to initiate a public debate and draw attention to the issues of women's health and public health care, because women's health is seen as a relationship and process between subjective identity and therapeutical concepts and the editors of the Polish version believe that this relationship can be enhanced by reading the book.

With the final chapter on 'Facts and Figures on Gender and Health in the New Europe' the book gives an insight into the situation of women's health and gender in the field of public health within the EU as well as specific country situations, with a strong focus on the EU-joining countries.

Peggy Maguiré not only gives an EU-overview but also allows us to identify and discuss the policy implications for health issues more prevalent among women, those specific to women, and health issues which affect women differently than men. The country reports concentrate on specific aspects. *Csilla T. Csoboth* discusses reasons why, while the life-expectancy rates are increasing in Western Europe and North America, the health conditions of the Hungarian population are decreasing even though the political and economic system has improved through the past decade. *Beata Tobiasz-Adamczyk* discusses the health status of older women in Poland, the socioeconomic development and the historical background for gender roles and behavioural patterns which influence older women's health status. From their perspective as political consultants, *Irena Fazarinc* and *Dunja Obersnel* point out necessary changes in Slovenia to improve a declining reproductive health status and maternal care due to changes in financing the relevant health services. Last but not least in this section, *Monika Scheffler* gives the reader an idea of the theoretical background of Glasgow women's health policy by relating the objectives and principles of the Women's Health Movement to those of the New Public Health Movement. The principles of this model are particularly well defined by the Ottawa Charta of the WHO and can serve as a model for other projects.

We hope that the book will contribute to a better understanding and networking within a New Europe.

References

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Understanding and Networking within a New Europe

Intercultural Work and Communication:
Challenges for the New Europe
Gabriele Kreutzner

It was a great pleasure to accept the invitation to contribute to the discussion about strategies and concepts of working for better, and gender-sensitive health conditions in Europe in late 2004 (workshop of the European Women's Health Network EWHNET). While the complex and so far mostly unexplored territory outlined by the dimensions of gender, age and health has come to capture my full personal and professional attention more recently, the terrain of culture and communication has been my field of work since my student days. Thus, my decided interest in forms of intercultural communication led to a special commitment to this issue in the context of the International Women's University (German abbreviation: *ifu*) which held its first, and so far only, semester from July 15 to October 15, 2000 in Northern Germany. With invited lecturers from more than 60 countries worldwide, 60% of its participants coming from Africa, Asia, Latin America and Eastern Europe, 20% from the USA, Australia, Canada and Western Europe and the remaining 20% from the hosting country, *ifu* provided a unique framework for first-hand explorations in intercultural work and communication. The essential facts about *ifu* as an innovative academic reform project have been published elsewhere so that it will suffice to complete my reflections by pointing to the respective English publications on *ifu* in the bibliographical references.

Is there any legitimation for drawing on experiences gained in one historically specific, science-related context and to pass them on to a second, and considerably different one? I think there is. For one, we are talking about two projects with a concern for issues of gender and the political goal of overcoming the social inequalities between men and women in our societies (*ifu* and EWHNET-workshop). Put differently, both projects are marked by a decidedly feminist orientation. Secondly, both *ifu* and the project of a gender-sensitive improvement of health conditions across Europe share the essential necessity to rely on successful cooperation and communication across national borders and cultural differences. Based on this common ground, I think that it is not only reasonable, but also a matter of urgency and of making the best of one's resources, to pass on experience from one feminist venture to the next.

In what follows, I am going to deal with my subject matter of intercultural work and communication by introducing what I consider to be four

essentials for any engagement in such an enterprise. While this short essay cannot cover the implied problematic in a systematic and detailed way, it can provide the reader with an experience-based introduction – something to start thinking with. My contribution is based on the conviction that there is more than one road to gaining knowledge and insight. Its chosen path is essayistic in nature. What it has to offer does not come with any built-in insurance against the risks and challenges of a given intercultural project. After all, everything that is lived and alive necessarily implies its dose of risk.

Europe As a Field of Cooperation

Before turning to my four points, however, I would like to briefly comment on the "New Europe" referred to in the title. The term is a deliberate choice made after thorough reflection and discussion.[1] Its main function is to mark the considerably altered historical constellation on the continent following the political events of 1989 and 1991. This definitive end of the post World War II era has opened up the chance to broaden our horizons previously framed by Cold War mentality. Thus, we are given the opportunity to explore the variety and diversity of European experiences and accomplishments. Put differently, the political realities of the post 1989 era decidedly call on those identifying as Europeans to engage in ways of thinking and acting that go way beyond the narrow limitations of the local and of national borders.

However, we cannot ignore the fact that Europe is a deeply ambivalent entity. The "New Europe" does not come to us with the innocence of a newly born child. In its short existence, it has seen the blazing up of old sectionalisms and hostilities as well as civil war and genocide in former Yugoslavia. Moreover, Europe is tied to a long tradition of war, oppression, of social and cultural conflict and to an imperialist and colonialist past. To my mind, the best, indeed the only productive way forward is to acknowledge this heritage and to simultaneously seize the great chance opened up by historical development to explore Europe as our wider framework of place-based cooperation. Against this background, the "New Europe" is conceived both as a historical reality *and* an open project – to be shaped by all those willing to participate and to productively contribute to its formation.

Due to its open nature, it is up to participants to agree on the project's concrete goals and visions. However, I think that most contributors to this volume would agree that health should be given high priority in such a project. In conceptual terms, this argument relies on the WHO definition of

health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"[2]. With this understanding in mind, the New Europe provides the historical constellation and the locale in which we can and must combine efforts across national and cultural boundaries in order to work for a life in good health and social well-being for all. And indeed, the issues of health and health care can no longer be conceived (nor solved) in terms of national affairs. Thus, while opening up horizons and chances, the New Europe also demands, and urgently so, that we combine our efforts in order to analyze the health-related situation across nations and cultures and that we move our efforts towards improvement and working out solutions beyond the national level. Taking the situation in Germany as a case in point, it is easy to see that health and health care have indeed ceased to be merely national concerns. For example, care of the elderly has come to heavily rely on a migrant work force (both within and beyond the limits of the legal), particularly from Eastern Europe. (In actual fact, the practical functioning of our care for the elderly would probably break down if it were no longer able to rely on that resource). On the other hand, German citizens are travelling East in order to access less costly health services. Meanwhile, health insurance companies have followed suit and are – at least in part – working out contracts with local service providers (particularly in the area of rehabilitation) in Eastern Europe. All of this creates so far unheard of and increasingly interrelated social realities and opens up new opportunities. Yet, it also produces new inequalities and considerable problems that must be met by working out socially acceptable solutions on a supranational level.

What exactly is the relationship between the New Europe and the European Union as a concrete political body? In a way, it makes good sense to consider the now enlarged (and still enlarging) European Union (EU) as the basis and concrete framework of place-based cooperation and interaction conceived in supranational terms. But what about its concrete goals? Turning to the European Union's internet presentation, we learn that the EU "is a family of democratic European countries, committed to working together for peace and prosperity." So far, so good. But does prosperity really provide the kind of glue that has the power to hold the heterogeneous "European family" together? A glance into the dictionary reveals that prosperity is defined as "economic well-being, the condition of being successful or thriving".[3] With regard to stating what has held the EU together in the past, the reference to prosperity is certainly adequate. Yet, in terms of appealing to the future, prosperity alone will not do. In this respect, it has been argued that the European Union must intensify its efforts regarding the social dimension of the New Europe. Here, I take the freedom to hand in my per-

sonal vote in favour of basing our thoughts and discussions on the goal of social well-being. This would place health and all health-related issues in a center-stage position. As a common goal, well-being can enable the people of Europe to work together towards a set of social standards while at the same time allowing for different roads on which to travel towards their realization.

And yet – as a vision and a goal, well-being cannot be restricted to a particular space. We are all part of an increasingly interconnected world. In that respect, it is greatly discomforting to revise this text on days that start with the upsetting front page appearances of the fences in Melilla and Ceutra bringing once again into public awareness the harsh realities of "Fortress Europe". These pictures cry out that it is unacceptable for Europe to pose a hazard to the health and life of thousands of men and women from the southern parts of the African continent. The fences of Melilla and Ceutra teach us that in order to provide an acceptable framework for shaping the New Europe, the European Union will have to live up to its own values and act accordingly. In direct relation to this, working for better health conditions across Europe cannot ignore that the majority of our 585 million fellow inhabitants on this planet who are sentenced to live in a state of permanent undernourishment exist in our immediate continental neighbourhood, i.e. in Asia (515 million) and Africa (186 million)[4]. In that regard, I am deeply grateful to *ifu* and its – at times quite difficult – discussions about Eurocentrism and particularly to those participants who have insisted time and again that the two most important risk factors with regard to health and well-being are extreme poverty and undernourishment.

The Challenges of Intercultural Work and Communication –
An Approach in Four Entries

Let me now sketch out a set of aspects which I consider to be essential to the course of any intercultural venture striving for well-being and social improvement – in this case: a gender-sensitive improvement of health conditions – carried out in European and, more concretely, in EU-determined contexts. In doing so, I expect major parts of intercultural ventures and concrete cooperation projects to take place in a EU-defined framework. Indeed, much of this work can only take place if the European Union – in the concrete context of the European Commission's upcoming (seventh) framework programme – will provide sufficient financial resources for such projects to become a reality.

Challenge 1: *Intercultural work relies on sophisticated communicative competences.*

In order to cooperate on a cross-national and intercultural context, we have to base our interactions on the use of a language that for most of us will not be our native tongue. As readers will be aware, this produces all kinds of difficulties including the fact that the use of a common language (which, like it or not, in most cases will be English) inevitably functions as a social barrier to participation. While this certainly holds true for each single national situation and tends to function as a social filter there (experts from institutional contexts invited to participate in an EU-funded project must also qualify in terms of their capacity to communicate in English), it also tends to produce – at least for the time being – unequally distributed chances to access between East and West (due to differing histories and, thus, differing traditions with regard to the cultural orientation of the respective educational systems).[5] Fortunately, acquisition and use of English, it seems, is making tremendous progress in East and West. Nonetheless, to communicate (in speaking and writing) in a language that is not my native tongue inevitably implies that my communicative potential is subjected to definitive limitations and that I have to live with a dose of constricted fairness (just because s/he has been raised with English, any native English speaker is in a much more favourable position to make his or her thoughts and arguments understood). This, I am afraid, is something we all must live with – at least for the time being.

However, the difficulties of intercultural communication do not stop there. In our usual daily practices, we all rely on the terminology used in our professional context. We have become used to paying the price of living in a professional world characterized by its highly advanced division of labour (including the labour of knowledge production). While this kind of specialization is helpful in many ways (if not imperative), it is extremely unproductive in that it prevents us from bringing together and making the best use of different kinds of expert knowledge and experience.

This is all the more unfortunate since the effort to synthesize knowledge might be able to help us bridge the gaps opened by the blind spots that come with the exclusive focus on one particular theoretical model or concept. However, in order to do so, all partners in a given cooperation would have to be able to understand the different kinds of terminology used by their fellow participants. Moreover, they would also have to be familiar (at least to a certain extent) with the models, concepts and assumptions underlying the different kinds of terminology. Thus, it is of only limited help to opt for a pragmatic solution by asking cooperation partners to provide ex-

planations at least for the most frequently used terms and concepts. Important as this is, it does not offer any protection against the danger of discovering in the course of a given project that you have based your work on one conceptual or theoretical tool but would actually have been much better suited by relying on another one. Nor does it protect us against the kinds of misunderstandings that tend to sneak into the project work due to conceptual ambiguities which may severely influence a project's development or cause us to waste an incredible amount of energy to overcome confusion or even conflict.

What can be done to face this challenge? Again, there is no easy solution in sight here. However, I have come to the conclusion that in order to really be able to advance our efforts here, we have to opt for solutions that may show their effectiveness only in a next generation of intercultural projects. For the time being, I see the necessity to document project experiences of communication problems owed to differing terminologies, methodologies and theoretical concepts. In a next step, such experiences will have to be analyzed and productively met by working out recommendations for avoiding problems and/or adequate coping strategies. Beyond this, we may have to come up with institutional inventions in terms of formalized support structures for intercultural project work carried out with and without the support of EU-funding. We shall return to the issue of different professional "languages" and, indeed, cultures below.

A third aspect directly related to communication has to do with the necessity for cross-national and intercultural projects to rely on mediated forms of cooperation. In this respect, the *ifu* teaches the lesson of the high relevance for actors to get to know each other and of face-to-face interaction. While the issue of mediated communication would actually require a more detailed discussion which cannot be provided here, the *ifu* experience legitimates the suggestion that intercultural projects are well advised to base their design on a mixture of both immediate (face-to-face) and mediated (virtual) forms of interaction. Also, and against the background of an effective investment of financial resources, the specific timing and the various functions of instances of immediate interaction within a project must be carefully planned. In that respect, intercultural research and development projects can draw on experience with virtual learning and, more specifically, on the insight that "blended" forms (i.e. forms that imply a functional mix of immediate and virtual types of communication) seem to be the most promising choice.

Challenge 2: *Intercultural work must have the capability to deal with heterogeneous interests and perspectives as well as with the (frequently denied) power structures that shape a given project.*

Projects are not conceived in a void. Their coming into being endows them with their always particular (and multi-dimensional) historicity. This also means that projects do not provide us with the kind of power-free discursive space aspired to by Habermasian discourse. Thus, actual or suspected positions of privilege or dominance, disprivilege or subordination will make their input felt and, thus, must be faced. If this sounds like a difficult task – it is, indeed. I do not claim that we were quite able to master that challenge in *ifu*. Yet, the lesson to be learned from *ifu* is that we can only profit if we openly try to come to terms with our entanglements in relations of power which, more often than not, are not of our own making.

Ifu was a good place to see what happens when a given project (conceived in a particular locality and for a particular purpose) brings together actors from decisively diverse social and cultural contexts and positions. One of the major dividing lines constructed within this particular context was that between what was conceived of as "white Western mainstream" academic feminism and the perspective attributed to a particular group of participants who defined themselves as "women from the South". These women saw themselves placed by and confronted with a double structure of domination: that of the everyday culture of the German life world surrounding them and the kind of academic culture materialized in *ifu*. In an unpublished collection of small vignettes portraying some of their lived experiences inside and outside of *ifu*, some of these women voiced an alternative, and certainly critical reading of our common experiment in intercultural knowledge production (Madew 2000).

When thinking of health-related intercultural cooperations, and particularly of EU-funded projects, there is good reason to suspect the occurrence of structurally similar or at least comparable characteristics. This is to say that we have to expect major differentiations to be constructed in terms of an East/West divide. Clearly, the *ifu* experience cannot offer solutions for the kinds of problems that may occur in a given health-related EU-based research and development project. But at least it helps to formulate questions which can productively be used for preparing future projects and cooperations:

▪ What strategies can be used for analyzing (at least in a first step) the differing perspectives and expectations that may be attached to the project cooperation?

- What kinds of structural inequalities or hierarchical relations can be suspected to be inscribed into the project which must be expected to make their influence felt?
- What kinds of strategies can be applied in order not to alienate participants who are newcomers to contexts such as EU-based research and development work?
- What is a good way to establish working procedures (along with their underlying rules and conventions) that all actors will feel comfortable with?
- Is there a promising strategy to establish the project's culture of cooperation as something created together instead of being imposed on participants?
- What are promising approaches for coming to terms with the major historical differences between East and West and to bridging the gaps between this major divide?

One problem related to the last question is that those situated in objectively more privileged positions tend to "naturalize"[6] their very privilege (and will not really be happy if reminded of its status as privilege). Therefore, it is difficult for those who initiate or coordinate a project (which both assumes and constructs a privileged position) to analyze their own situation. A promising coping strategy might be to draw on existing networks and seek outside support, e.g. in the form of counselling or even supervising. To my mind, this is a particularly good idea when it comes to analyzing structural discrepancies and tensions between "East" and "West".

Challenge 3: *Research and development devoted to the complex (and context-dependent) issue of health requires multi-professional and inter-disciplinary cooperation. Thus, cross-national projects will be confronted with a multi-faceted interculturality characterized by the intersection and interrelation of various cultural layers and dimensions.*

Recent theoretical discussions have rightly pointed out that the concept of interculturality is not well suited to undo the false notion of culture as something which in itself is homogeneous and fixed. Therefore, we have to start from a concept of culture as process and as marked by heterogeneity and an immense dynamic. Against this background, the notion of interculturality takes on a somewhat different meaning. Most importantly, it suggests that there is much more at stake than a set of differences related to an individual's national identity. Health-related projects conceived within a European framework will have to deal with an immensely broad range of culture-related diversity. As the concept of health implied in the WHO

definition suggests, health-related research and development must be carried out by experts coming from a variety of professions and disciplines. Thus, the kind of interculturality practiced in a European, and possibly EU-funded project context will be of a quite complex, multi-faceted and multi-layered kind. For our purposes here, I will shortly sketch out the most obvious dimensions of such an intercultural venture.

National Differences

To be sure, the most obvious aspect is the situatedness of working partners in different national contexts and the kind of culture which dominates it. In that respect, cross-national cooperation in Europe must face the challenge of our lack of knowledge, our biases and ignorance regarding the histories and realities situated on the respective "other" side of that curtain that is now history. While this certainly holds true for all those who grew up and received their primary education before 1989, I suspect that it will take some time before our educational systems have successfully overcome national biases and historical blind spots so that younger generations will be able to base their cross-national interactions on more and better, less biased information about other regional contexts in Europe (and hopefully beyond).

Therefore, the attempts made in Kassel to familiarize participants with basic social facts and health-related information for at least some of the countries represented in the 2004 workshop "Networking for Women's Health across Regional Diversity in Europe – Experiences, Concepts and Strategies" have been extremely valuable. I think it is no exaggeration to say that such introductions open up horizons. They do make us aware of our non-knowledge and our ignorance. They also may help us to recognize (by comparison) privileged or disprivileged national positions and to strengthen our motivation to find ways to bridge gaps and work together for our common goal.

Accordingly, any health-related cross-national project must familiarize participants with the basic facts concerning the participating countries' histories and actual situations, and more particularly with those facts and kinds of information that – directly or indirectly – relate to issues of health. Therefore, it would be highly desirable to continue the efforts to develop and keep up to date a comprehensive health-related data base designed to support all research and development work devoted to gender-sensitive improvement of health conditions and well-being across Europe.

Social Differences

While national differences will be quite significant and influential at times, we must not expect them to generally provide the source for the most relevant differences between cooperating partners. We also must be sensitive to potential differences between working partners which can be theorized along the lines of social categories such as ethnicity, 'race', class, age, religion and, of course, gender, as well as differences rooted in identity-related issues such as sexual orientation.

It must be left to each concretely given project to sort out the kinds of differences that will decidedly shape the respective interaction processes. Therefore, it does not make much sense to come up with a general recommendation of how to cope with such differences in case they should cause problems. Against the background of my project experiences, and particularly of my experiences in *ifu*, I think it is crucial to communicate about such differences at an early point in the project work. The most promising strategy I see is to ask working partners to formulate their thoughts, their speculations concerning differences and, thus, to lay open existing anticipations of conflict. Not only should such anticipations be discussed, but participants should also be asked to think about strategies for coping with both difference and conflict. Generally speaking, it would be extremely helpful to equip intercultural project work with the function of a neutral moderator or an intercultural supervisor who may be called on to intervene if problems or conflicts should occur.

However, work and communication in any concrete project will also be shaped by compatibilities between participating individuals. Therefore, we can expect considerable numbers of participants to occupy structurally similar positions with regard to social status and educational level. Such similarities will at least to some degree function as a balancing factor providing some shared common ground which is essential to any form of social interaction.[7]

Differences in Actors' Political Situatedness

Project participants cannot help but bring their particular situatedness within their respective national culture to cross-national and intercultural cooperation. In that respect, I would like to point out just two dimensions which will tend to make their influence felt in a given health-related project cooperation. The first one relates to the kind of institutional context in which a person pursues her or his particular professional practices. In that respect, we can expect project participants to be at home either in mainstream institutions or in alternative or even oppositional ones (such as small

NGOs or autonomous women's projects). The second, and interrelated dimension is that of a person's specific position with regard to gender (in)equality and to feminist politics. After all, there is more than one way to pursue the goal of gender equality and the particular position chosen by an individual in no small part depends on her or his particular social and cultural situatedness.

Regarding positions that claim to be gender-sensitive in the context of health-related projects, we should expect an even greater diversity in the future. After all, financial resources for research and development work will tend to remain in short supply on the national levels so that we have to expect considerable competition for EU-funding. Secondly, with the adoption of gender mainstreaming as part of its general policies, it is reasonable to expect institutions and contexts to enter the scene of gender-sensitive health-related research and development which until now have refrained from bothering with issues of gender. While project partners will have agreed on overall project goals and their general approach to questions of gender inequality, it is only in the development of the actual project work that potential differences may come to the surface. To make the matter even more complex, different national backgrounds (due to differing national histories) tend to produce different perspectives on and approaches to issues of gender inequality.

A good way to face such differences and to successfully cope with them is to conceive of the task of sorting them out and trying to theorize them as an integral part of the project work.

Differing Professional Cultures and Orientations

As already pointed out, health-related research and development asks for a cooperation of experts from various professional backgrounds and cultures. One of the major dividing lines which caused considerable problems in *ifu* and which should be expected to challenge health-related cooperation may be stated in terms of a theory/practice gap. However, a more thorough reflection of the *ifu* experience suggests that what actually is at stake here is a major difference between two basic orientations: that between individuals working on the level of more conceptually oriented practices and others whose concerns are shaped by the immediate practices "out there in the field", in the daily routines of down to earth health work. Depending on a given project's particular design, these diverging orientations may cause considerable problems, misunderstandings and even conflict. However, and changing the perspective in the direction of chances, our time calls for

work and cooperations that come up with strategies and good practices for inventing practical combinations of such differing orientations.

Differing Scientific Disciplines and Knowledge Cultures

In a time of highly advanced specialization, science-related work is both highly heterogeneous and always based on a particular set of theoretical assumptions. Moreover, disciplinary knowledge production tends to be shaped by historical developments which in large parts tend to be nationally specific. This confronts us with two major problems. For one thing, scholars tend to be situated in particular knowledge cultures where (among other things) individual work is based on (culture-)specific assumptions and conventions. Yet, the same conventions and routines (e.g. relying on a highly specialized terminology) that enable scholars to directly and unproblematically intervene into the complexities of a particular disciplinary discussion may cause considerable problems or confusion when relied on in inter- or transdisciplinary exchange. Secondly, the challenge takes on an even greater dimension when the category of gender is introduced into the picture. In that regard, the advancement of gender studies has brought about a literal explosion of theoretical and methodological developments in recent years.

To my mind, *ifu* has clearly demonstrated that in spite of decade-long discussions about interdisciplinarity, research and development that moves beyond disciplinary boundaries cannot rely on a successfully established tradition of inter- or transdisciplinary cooperation. It would be most helpful (if not essential) if projects were able to turn to a comprehensive level and seek support, e.g. of an agency specialized in inter- and transdisciplinary research and development work and in issues of both gender- and health-related theories and methodologies. Such an agency could support projects to establish, at a quite early point of the project's development, a shared set of basic theoretical and methodological understandings and to agree on a set of shared gender-related perspectives and approaches.

Challenge 4: *We must learn not only to endure difference, but to successfully cope with it and, where possible, to make difference productive.*

It may have become obvious by now that to my mind, our capability to cope with difference is the number one issue of any attempt to improve understanding and cooperation in our world today. While my conviction is not owed to science-related projects exclusively, *ifu* has played an important role in its formation.

Generally speaking, the societies that I am familiar with maintain a rather strange relationship towards difference. On the one hand, difference and diversity appear to be highly valued – just think of the European Union's mission statement "united in diversity"! Also, valuing difference seems to fit quite well with the focus on the individual and its uniqueness that characterizes the Western liberal and democratic tradition. On the other hand, however, we frequently and systematically find difference to legitimate social discrimination, stigmatization and exclusion (just think, for example, of the stigma attached to a disease such as dementia, or of the discriminating and excluding potential attached to a physical or mental handicap).

Thus, while on the one hand praised and valued, difference is frequently experienced as difficult to deal with in everyday life. And indeed, on the personal and the psychological level, difference definitely is not only fun and games. To be confronted with difference can be not only challenging, but quite upsetting. There is, I am afraid, no other way than facing the sometimes disturbing challenges of experiencing difference. In order to endure differences, and to strife towards making differences productive, it is essential for working partners to agree on a set of agree-upon principles and procedures for dealing with difference.

Returning once again to *ifu*, I would argue that those who were placed in the position of the "other" (i.e. constructed as different) by dominant German culture during the 100 days of the international women's university were confronted with quite mixed, and at times deeply disturbing experiences.[8] Yet, *ifu* also held its share of difficult situations for those placed in the category of sameness who also were (more or less) familiar with the kind of academic culture that hosted this global academic experiment. As part of the hosting party and coordinating function, *ifu* taught me that is is essential for intercultural project work to be sufficiently endowed both with corresponding communication competences and a functional set of formalized support structures. With regard to the former, I fully agree with an *ifu* participant who stated:

It would have been helpful if for the first week of *ifu* all participants underwent some form of intercultural training in communications. How could we have missed this important step?[9]

How could we, indeed?! The somewhat simplified (but nonetheless correct) answer is that the relevance of this issue was underestimated. Learning from *ifu*, I argue that intercultural projects must include a basic communicative training in the project design. The success of the project work in no small part depends on safeguarding a solid interaction basis. Only

such a shared ground allows to establish and keep up good working relationships and productive cooperation. Such a basic training could be integrated into an initial face-to-face session providing an opportunity for all participants to meet in person.

Going over my *ifu* materials, I find that the relevance of this issue had already been pointed out in a workshop of intercultural communication held in February 2000. The workshop was designed to strengthen both sensitivity and competences on the part of *ifu* staff (both administrative/coordinating and teaching). In that context, discussion groups had stressed the relevance of a decided effort to actively include all *ifu* participants (here: students) into the courses (considered as working processes)[10]. Moreover, the workshop documentation points to the importance of discussing and agreeing on guiding principles for the project and the underlying working processes. As for *ifu*, examples for such principles (named in the workshop) included transparency, responsibility, a productive project culture, process-orientation, openness for criticism and the willingness to let go of seeming certainties. Moreover, my experience in other discursive contexts (e.g. participatory technology assessment) suggests that it is productive for participants to agree on a set of practical rules of communicative conduct. Naturally, such rules must be in correspondence to the specific communicative forms (face-to-face, mediated) on which the project work is based. Also, there should be some neutral function participants can turn if they feel that agreed-on rules have been violated.

Finally, I would like to point to three guiding principles foregrounded by Maria del Mar Castro Varela during the *ifu* workshop mentioned above: sensitivity for structures of power and domination, self-reflexivity, and respect. Even though these principles are certainly not specific to science-related contexts, they are extremely important and do provide a productive field for science-related cooperation to establish good practices that other contexts may be able to learn and profit from.

A major task which remains to be accomplished, however, is to work out practical concretions of such guiding principles. For example, while most of us would whole-heartedly agree that respect for the other person is of great importance in communication practices, it is far more difficult to come to terms with concrete manifestations. How exactly is respect expressed and communicated? And certainly as important as that: What kind of communicative strategies are likely to be interpreted as signalling a disrespectful attitude?

While my work since *ifu* has repeatedly confronted me with the utmost relevance of dominance sensitivity, self-reflexivity and respect for my

communication partner, I must leave it to the future to come up with concrete expressions of such conduct and behaviour in intercultural projects which can be used in intercultural training.

I would like to close with a personal note on the relevance of not only coping with difference, but on mastering the challenge to make difference productive. Intercultural work challenges us with the need to grow (develop) and change, to look at ourselves in a new perspective, and also to sometimes give up long-established certainties and self-perceptions. In that respect, the professional and the personal dimension are inextricably interrelated. This is a major reason why intercultural work can be so difficult at times. Both in personal and professional terms, we must make our choice between leaving things as they are or seizing the opportunity for change. We cannot expect all partners to always take the change option and we must also be aware that there are good reasons for some of us to resist change.

In terms of the professional dimension of this, the task is to search for ways of drawing on the kind of diversity found in such working contexts and to make that rich resource productive. This not only requires a fundamental shift in our established ways of thinking; it also calls for innovative theoretical and methodological developments. What are adequate ways to draw on good practices detected in one particular context in order to work out solutions for another one? How can we avoid errors and shortcomings from all too easy abstractions of concrete context and circumstance? This, I think, is the road on which our theorizing efforts must be continued.

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Notes

1 More specifically, it is the deliberate reclamation of a term which, at least in Germany, the journalistic discourse reaching from "Stern" to "Spiegel" and "Die Zeit" and on to the various formats of TV-journalism has chosen as its label for the enlarged European Union. My claiming of the term insists that such an equation is inadmissible and, thus, must decidedly be rejected. In spite of the ongoing enlargement process, the European Union and "Europe" remain non-synonymous and must continue to be considered and treated as certainly interrelated, yet discrete entities.

2 World Health Organization (1948), www.who.int./about/definition/en/print.html.

3 Webster's New Collegiate Dictionary, 1976. In the same dictionary, "to thrive" is defined as "to gain wealth or possessions".

4 FAO (2004). The same report states that the "number of undernourished in the countries in transition has risen from 23 million to 28 million since the break-up of the former Soviet Union, Czechoslovakia and Yugoslavia in 1991 – 1993. Most of the increase and the bulk of undernourished are in the countries of the Commonwealth of Independent States (CIS), where the proportion has increased from 7% to 9%." While the numbers fortunately have decreased in the Baltic States (from ~ 5% to 2 %), they have remained the same (~ about 3%) for Eastern Europe. FAO (2004: 8).

5 It also produces inequalities on the national level since health-related expertise does not automatically correspond to the competence of mastering a second language. Indeed, if your work is focussed on the local and on the immediate level of health-related problems and concerns, and if you work in a small grass roots initiative or NGO, your professional performance has not necessarily required that you can communicate in English. Also, in such a context the notoriously scarce resources for additional qualification will probably not have been invested in staff's second language competences or, if so, it is more likely that staff has acquired competences in a language spoken one of the respective country's major migrant groups or ethnic minorities.

6 By this I mean that once you occupy a privileged position, it becomes "natural" to you. You tend to consider it as a result of your own achievements while its particular social nature is being wiped out.

7 In *ifu*, the work carried out in the curriculum work groups suggests that there is substantial common ground – at least in an all-women context – for scholars from Eastern and Western Europe on which to base their cooperation. It will be interesting to observe whether this also applies to contexts where male and female scholars cooperate.

8   Their experiences have been voiced and documented in a collection of small vignettes and stories compiled by Melinda Madew (2000). I am indebted to Melinda Madew and our cooperation and discussions about interculturality. I have immensely profited from our exchange not the least because we dared to move beyond the level of a merely theoretical discussion.

9   Quoted in Madew (2000).

10 A major *ifu*-specific problem was the particular structure of the working/learning process which many participants found to be much too hierarchical. In their view, the unique situation actually created by *ifu* would have called for a much more symmetrical and dialogical conception of the learning process. Fortunately, work in research and development projects can in principle rely on a symmetrical relational structure.

Listening to the "Other" in Transcultural Therapies. Worldviews, Idiomatic Expressions of Illness and the Use of Cultural Representations in Intercultural Communication

Gesine Sturm

In this article, I would like to discuss the question of understanding in situations of transcultural communication. This article is mainly inspired by the results of my PhD research on transcultural communication in a specific kind of psychotherapy developed in France, the so-called French ethnopsychiatry or ethnopsychoanalysis (Sturm, 2002, 2003, 2005; see also Reichmayr, 2003)[1]. On top of this, my reflections are based on my experience as a clinical psychologist and therapist at the pediatric and transcultural ward for out patients at the Avicenne hospital at Bobigny, a multi-ethnic suburb of Paris. In my practice I work mainly with traumatized patients, many of them being refugees. The techniques we use in the transcultural therapies with refugees (therapies with interpreters, therapies within a multiethnic group of therapists) have been developed mainly on the basis of psychanalytical approaches to trauma-therapy (Garland, 2001), ethnopsychiatric approaches to transcultural therapy (see Baubet et al., 2004; Moro, 2001; Nathan, 1986) and some elements of system therapy.

The following reflections are written from my standpoint as a clinical psychologist, therapist and researcher on the functioning of transcultural communication. Many of the ideas I will present here are inspired by discussions I had with my colleagues at the out patients section of the Avicenne hospital. Others were inspired by the exchanges we had in a group of researchers at the University of Bremen.[2]

Even though transcultural communication in therapies confronts professionals and patients with very specific problems, I believe that this kind of communication can teach us a lot about other situations of communication in the context of mental health. This is why I would like to start my reflections about transcultural communication with a brief discussion of the problems we encounter when working in therapeutic situations with migrants. Then I will discuss the propositions that have been made in the context of French ethnopsychoanalysis in order to overcome the difficulties encountered in transcultural therapies. Finally, I would like to discuss the usefulness of those innovations for other communication situations in the context of mental health with migrants.

Transcultural Communication and Translation

The first topic I would like to discuss is the question of translation in transcultural therapies or other settings of transcultural communication. This issue is of particular interest because in the work with patients with a migration background we often have to introduce an interpreter in order to enhance understanding between patients and professionals. Introducing an interpreter into a conversation is a very delicate issue, and we should be conscious about the difficulties we may encounter in such a setting. I would also like to discuss the issue of translation to some extent here because it seems to me that translation processes (in an extended meaning of this term) are at the heart of all kinds of transcultural communication, even if professionals and clients seem to share one and the same language. When working in transcultural contexts, we often have to "translate" cultural representations and transcultural communication consists very much in building bridges between different symbol systems.

Working with Interpreters

If we need to introduce an interpreter into a setting of conversation between professionals and users of the mental health system, we are confronted with a certain number of questions: Can we find a professional interpreter for the mother tongue of our patient? Does our institution pay this interpreter? And, if we decided to work with an interpreter, which place do we want him or her to take in the therapeutic relationship? And what kind of translation do we ask him or her to provide? A word-for-word translation? A free résumé? A commented text? And, as we do not always have the possibility to find an interpreter – what should we do if we have to work without any interpreter?

Many of the answers we find to these questions will depend on the specific situation we are working in – it will be easier to have professional interpreters if we live in a cosmopolitan city than if we live in the countryside; our possibilities of financing interpreters depend on the institutional context we are working in and even the style of translation we prefer may be tightly linked to our working conditions and the style of dialogue we want to establish. This is why I do not pretend to develop any standards for a good interpretation here (this has been done anyway; see for example for an overview Salman, 2001). I would rather like to propose some reflections on translation that might give an orientation to professionals who want to develop their own criteria for the "best choice" in a specific situation.

Can We Use Family Members as Interpreters?

Let us consider first a worst case scenario, a situation where we can't find any professional interpreter. In those cases we may be tempted to ask family members to take over the role of the interpreter. This "solution" is extremely problematic because it can entail dynamics that make the whole therapeutic enterprise questionable. The person who does not talk the language of the host country becomes completely dependent on a translation he or she is not able to control and has no means to develop his/her own version of the stories that are told. Sometimes it is the husband who translates for his spouse who does not talk the language of the host country because she stays at home with the children. In this case, we may worsen existing dynamics of isolation and dependence. In other cases children may serve as interpreters. Often they are already used to this role because they help out their parents in every day life. Sometimes they even became their parents' personal advisor in the jungle of administration. This constellation, where children become the guide for their parents, is extremely problematic. Parents become dependent and even infantilized, which makes it very difficult to maintain the role of a parent who guides his children when they explore the "outer world". Without this guidance by their parents, children feel insecure, even if they seem to manage the life outside the family with a certain ease. Without any model for the transition between family space and the "outer world" the children are vulnerable and may develop difficulties when they have to face particularly demanding situations. We should absolutely avoid worsening this kind of dynamics by using children as interpreters for their parents. We should also try to become sensitive to dynamics developed by a family in a migration situation – which role do the children take with regards to their parents, which dynamics seem to exist between the parents? Understanding the dynamics in a family helps to develop a better communication with all the family members, if it is in therapy, other situations of health care or still further in other situations (for example if we mediate the contact between parents and teachers etc.).

Integrating Professional Interpreters into a Conversation with Health Care Providers

Let us imagine now that we are in the lucky situation of having a well-functioning interpretation service in our town and that our institution has a budget for translations. Now we have to decide how (and sometimes when) we want to introduce the interpreter into our conversations with the patients. In therapy this question is particularly delicate. The introduction of the interpreter into a therapeutic relationship demands a lot of confidence

and it is not always easy for the therapist to accept this setting because she or he loses some control over the situation. It may also be very difficult for clients to accept the introduction of an interpreter, especially, but not only in therapy. Sometimes patients fear that he or she will not keep professional secrecy, sometimes they feel humiliated because they only talk the language of the host country to some extent. This is why we should discuss very clearly with patients why we would like to work with an interpreter, which role he or she is supposed to take and which are her or his professional obligations (especially the submission to medical secrecy).

There are different ways to use the interpreter in therapy or in other situations of health care. Some professionals try to reduce the bias provoked by translation to a minimum. They may ask the interpreter to translate exactly what the patient said, without reformulating, resuming or commenting on this "text". Others accept the creative character of a translation and ask the interpreter to make this process as transparent as possible (Moro & Revah-Lévy, 1998). In this case, the interpreter may comment on the text she or he is translating, but she or he has to make clear when she/he is translating and when she/he brings in his own comments. Sometimes the interpreter may be even invited to comment a narrative of the patients, explaining customs or indicating connotations of a specific formulation used by the patients. In this case, the interpreter takes over a role of cultural mediator.

Cultural Mediation in Therapy and in Other Situations of Health Care

Situations of transcultural communication often not only demand a common language between clients and professionals, but also an exchange about cultural representations: cultural values, ways of thinking and dealing with sickness and suffering, modes of family organisation that may determine social resources of the patients and last but not least values and norms that are transmitted by religion. Research in medical anthropology showed that cultural representations are of major importance for the subjective experience of suffering. Kleinmann (1980) introduced the distinction between "disease" (the biomedical conception of a health problem) and "illness" (the subjective way of experiencing this health problem) in order to describe the difference between biological mechanisms and processes of construction of meaning. He also insisted on the importance of sociocultural practices (and institutions) that define and deal with health problems ("sickness" in Kleinmann's terminology). Health problems are not only biomedical problems, but they are social and psychological realities at the same time. If we want to establish a satisfying relationship between profes-

sionals and users of the health system, we have to take into account all those aspects. Cultural mediation may be very helpful to do this.

Cultural Mediation in French Ethnopsychiatry

The different authors of French ethnopsychiatry have developed techniques that facilitate the discussion about cultural representations of illness and suffering in therapy (Nathan, 1986, Moro, 1998, 2001). With the help of cultural mediators, they try to find out which kind of representations patients might use in order to think and to discuss their difficulties. Often therapists find out that patients suspended the process of symbolisation and dialogue with their family if they experienced migration as a violent rupture. In those cases the first step in therapy may be that therapists try to re-introduce processes of symbolisation by using cultural representations of different origins. Therapists may introduce images, histories or proverbs coming from cultures that are familiar to the patients, but they can also use "foreign" images in order to introduce different levels of alterity into therapy. During this process, therapists encourage patients to talk about cultural representations that are familiar to them. They are free to use them, to reject or to comment on them. In French ethnopsychiatry, therapists often use their own cultural background in order to engage a discussion about different ways of thinking and dealing with suffering. The idea of this kind of dialogue is not to enhance any kind of "cultural" or "traditional" identity, but to build bridges in between the different universes patients live in. Cultural mediation in this kind of therapy is extremely creative. Therapists engage in a dialogue about different worldviews, cultural representations of distress and strategies that might be used for healing.

Cultural Mediation in Situations of Health Care and Prevention

It may be helpful to introduce an interpreter or cultural mediator into the conversation with the client in order to facilitate the discussion about collective representations that may have an impact on his or her way of experiencing his health problems. Often it is difficult to talk about this kind of representation if the patient can not use his mother tongue, because of linguistic difficulties, but also because he or she may feel that cultural representations dealing with suffering and illness may not be understood or even accepted by professionals. We should understand cultural representations as a language that helps patients to construct "illness narratives" about their suffering (Kleinmann, 1997).

Cultural representations are not only ways of symbolising individual and social suffering, they often also indicate ways of dealing with this suf-

fering. If a person considers, for example, that his or her suffering may be linked to omissions with regards to social or religious duties, he/she may discuss this issue with his/her social or familial environment and try to find out how this omission could be repaired. As Nathan puts it, cultural representations do not provide answers that stop interrogation, but they help us to go further in our reasoning about the sense of a specific situation (Nathan, 1986: 20). Cultural (or religious) representations that may be used in this sense are collective representations that can provoke major changes in the social environment of the sick person in a way that promotes his health. If we discuss those representations in therapy or other situations of health care, this does not mean that we replace our own psychological or biomedical representations. It rather means that we accept that there are different ways of thinking and dealing with problems or suffering. Once we engage in such a discussion, patients may gain confidence into health care providers and experience that medical treatment is not in contradiction with cultural representations that are important for them.

If we introduce a cultural mediator into our conversation (for example an interpreter who agrees to provide some context information), we should be very careful that we do not present this person as an "expert" on the culture of our clients. Patients and interpreters may have quite different cultural positions (due to their social positions, gender differences, individual choices, political or religious convictions etc.). We should keep in mind that cultural representations are not fixed, they are in constant evolution, they may be questioned, re-interpretated and transformed. Sometimes they are used in order to formulate contesting versions about cultural or social practices, sometimes in order to re-interpret historical events in contesting ways (see Das et al., 2000). A cultural mediator is not an expert on a culture, but someone who may facilitate our dialogue with the patients about their conception of their cultural background. We do not integrate him into the conversation in order to find answers to our questions, but in order to generate good questions.

Mediation Between Clients, Institutions and Health Care Providers

Working with migrants, we often are confronted with situations of conflict. Sometimes health care providers (or other professionals) may be disappointed by the attitudes of the families they are working with, not understanding why the families do not always accept or validate the support they wish to provide. On the other hand, patients may feel misunderstood and sometimes even persecuted by institutions of the host country. If we want to understand and overcome those dynamics, we have to reflect on the im-

ages health care providers *and* clients have of the "other" they are working with. Measham, Rousseau and Alain who work with migrant families at the Montreal children's hospital stress the importance of a mediation that discusses not only the images patients may have of the host country, but also the images professionals may have of their clients (Measham et al., 2003). Those images are often linked to institutional dynamics (dynamics of exclusion and defense mechanisms that justify this exclusion, cultural and professional norms and attitudes). They also reflect the political context in which a specific interaction takes place. If we want to overcome those dynamics, we do not only have to open our mind in order to understand cultural representations that may be important for our clients, but we also have to reflect on the cultural representations that forged our own conceptions of health care and about the images we develop when confronted with the "cultural other". Sometimes an exchange with health care providers from different countries may be very helpful for us in order to become more conscious about our own attitudes and the different ways other health care providers may use in order to establish a good relationship with their clients.

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Notes

1   PhD research in a bi–national cooperation between the University of Bremen, Germany and the University Paris XIII in France. The directors of the research are Prof. Dr. Maya Nadig of the cultural studies department in Bremen and Prof. Dr. Marie Rose Moro of the psychological department at Paris XIII.

2   This was at the department of Cultural Studies of the University of Bremen. We had an interpretation group for our field data with Professor Maya Nadig.

Gender and Health: Internet and Network Activities
Vera Lasch

Introduction

For cross-national co-operation on the subject of Gender and Health an overview of the actors and institutions who have developed cross-national competencies is indispensable. In addition the Internet in this area is an important communication medium. It was the occasion for Internet-based research on the availability of the information sources concerned with cross-national aspects on the subject of Gender and Health. The article wishes to give a rough overview of the developments and range, describe the spectrum and, above all, make users familiar with international activities.

Lines of Development

Gender and Health and how they are represented on the Internet, in addition to questions of Internet use, also has a background of women's and gender politics. What are the information resources that, in this professional field of Public Health and Health Politics, represent the interests of women and men? What are the Internet resources that show current discussions, are relevant for a critical discussion of development and express feminist interests in a developing professionalizing field? And which institutions are reference points for the development of transnational problems?

What is generally available on the Internet on the subject of Gender and Health, based on heterogeneous developments that come from various spheres of interest, development traces or political directions, which have contributed to the development of the material available in the internet. Some of the important traces may be mentioned: the women's movement, women's politics and the women's health movement, which in their areas of action always took up the interests of women's health and later the relevance of gender in the area of health and integrated them into their policies and demands. The gradual integration of gender into the political agendas of international organizations and the political strategies of the EU. A research promotion policy that requires gender sensibility and thus produces academic insights.

For the political networks that have made women's health or men's health their subject the question is: which of the groups have developed a transnational focus?

The Internet as an Information Resource

The Internet as an information resource has increased in importance in recent years. It is used more and more. Almost six in 10 (58%) adults searching the Internet for health-related information look often, some (33%) look sometimes (Krane 2005). The Internet has become the everyday tool for those engaged in academic work, research and literature and searches, in order to keep up with new developments and current research work and look for research partners transnationally.

Use statistics of Internet users looking for health information show[1] that the user panel of medical information follows the general evolution: a continued increase in the proportion of female users (Boyer 1998), a diversification of users (away from computer experts and education-related fields) (HON 1998), a growing number also of health-care professionals (of whom 49.2% were women in 2000) and patients using Internet resources (HON 2000). Patients for example look for the following information in particular: disease description, clinical trials, medical literature or support groups.

Internet resources are thus relevant for both experts, self-help initiatives and individuals seeking information. In this paper the accessibility of information and quality for user groups cannot be studied. The spectrum that emerges is of interest together with questions of networking and information possibilities for transnational actor groups.

Methodological Procedure: The material used stems from an Internet search made in 2005[2]. The selection focuses primarily on international and/or transnational and EU-wide institutions. This also, in order to focus above all on cross-national activities and providers oriented to international politics and movement. A search of this nature includes in particular political and organizationally professionalized actor groups. It is an exclusion criterion for shorter-term actors offering or working with other materials at a regional level. To describe the activities and identify the actors the personal information of the Internet appearances have been used. In the following I first give an overview of activity fields before examining the Internet resources.

In addition to these selection criteria it can be generally said that Internet offers on the subject of health, wellness and medicine are booming and the keywords women's and men's health are used repeatedly. The new of-

fers also include offers from health service providers, such as the public health institutions, health insurance companies and doctors' associations. There are also sources of information about practising doctors and clinics, patients' information from the most varied sources, health portals operated by government ministries, the pharmaceutical industry and self-help initiatives, such as portals for tele-medicine with their offers – these to some extent in English and usable transnationally. The first critical voices can be heard about these developments, examining the interests of those seeking information and demanding quality assurance and controls (cf. Klösch-Melliwa 2005). Similarly there are the first attempts to offer a quality guarantee on the information available (see below). It is decidedly worthwhile observing and analysing this development, but is outside the scope of this paper, which is concerned explicitly with describing and discussing Internet resources from the perspective of women's and gender health policy.

International Health Policy and Women's Health

Over the last two decades women's issues have moved rapidly up the policy agenda of international organizations and national governments (Doyal 1998). Some of the important development lines that have brought gender onto the political agenda are:

- The international population and human rights organizations that have been propagating the right of women to reproductive self-determination since the 60s. This gave rise to further concepts on the subject of reproductive rights, non-discrimination in access to health care, information on and access to contraception, a focus on the relevance of violence in health matters for example.
- There is also the World Conference on Women[3], especially the ones in Cairo (1994) and Beijing (1995), which considered the needs of women in health planning[4] and pointed to the need for participation of women in decisions-making processes.
- The integration of Gender Mainstreaming, which originally came into the political strategies of the EU from the development co-operation.[5] With the coming into effect of the Amsterdam Treaty the EU has an obligation to promote the equality of women and men according to art. 2 and art. 3 para. 2 of the EU Treaty, which is to be taken into account in all activities of the EU.
- The establishment of the strategic political principle of Gender Mainstreaming in the general research programmes and policy areas of the EU have ensured that, in research and policy areas, questions once re-

mote from gender are being raised from a gender-criterion point of view, e.g. in the new Public Health Program.

- In addition a growing consensus has emerged on the broader economic and social gains from promoting the health of women. Also, the World Bank (1993, 1995) has argued for investment in women's health, especially in poorer countries.
- Globalization also leads to new constellations in policy regarding the sexes and the women's movement. Between the control systems (Altvater 1996) market, supranational organizations/states and networks various women's networks have emerged as relevant alliances on the transnational levels that are active in various policy areas (e.g. Lenz 2001)

With the increasing integration of principles of Gender Mainstreaming into the partially state areas of policy the corresponding specialist developments have gained in importance. It is becoming important how gender-relevant policies are integrated and implemented in the area of public health discussions about research, policy and care. The quality of integration in partial policies, such as in age, health, health care, and their strategies to establish gender change the focus of gender-political questions. Correspondingly, gender expertise is gaining in importance in knowledge societies and partial areas of the health system.

Doyal (2000) shows that, despite all political efforts to achieve equal opportunities and the integration of Gender Mainstreaming into all the policies of the EU and its member states, the area of public health policies is hardly affected. The situation is thus characterized by the political will to establish gender sensitive public health strategies, and at the same time parallel developments and a juxtaposition of gender-competence and gender-ignorance in certain policy areas. Kuhlmann and Kolip (2005) maintain in their recent book "Gender und Public Health" that the relevance of the category gender in theory and practice have certainly arrived thanks to Gender Mainstreaming, only the implementation is difficult and very complex. It is not always clear what consideration of gender as a social category means. Accordingly, there is a special challenge for the future in the integration of gender knowledge and strategies into practice and in the implementation of this knowledge.

The deficits in public health were summarized by Lesley Doyal at a conference in 2000. The headings of her paper show the main critical points and needs: creating gendered public health information systems in the EU as including sex and gender key variables in routine data collection, recognising diversity in the measurement of Gender and Health status,

measuring health in a broader social context; tackling gender bias in medical research; bringing women into biomedical research, broadening the scope of health research; mainstreaming gender in public health policy programs, putting gender into planning process capacity building for gender sensitivity, intersectoral collaboration for gender equity in health.

The still existing lack of gender-competence in public health also means that players networks from women's and gender research, critical doctors, activists in women's health or gender-conscious public health researchers and women and gender oriented experts, politicians and strategists take on an important role in the discussion. These critical voices, which require and pursue expert integration of gender questions in public health, should be audible in political life.

In the area of women's health there are worldwide many qualified groups of players which tend to act on a regional level, but lack international networking or concentrate on particular topics. As an example one can point to the worldwide women's health centres (Healthy Women Center, Women's Health Center etc.), which offer information and advice, but whose Internet services are available in the local language. A glance at the English-language material shows how broad the advice spectrum is and how seriously they take health self-determination of women. One could cite the example of the Internet services provided by the Women's Health Centre in Graz (Austria), which also keeps available information in English (http://www.fgz.co.at/profil.htm).

Similar structures are also available for the subject of men's health. A first impression may be got from the Homepage "XY". XY is a website focused on men, masculinities, and gender politics. "A space for the exploration of issues of gender and sexuality, the daily issues of men's and women's lives, and practical discussion of personal and social change" (http://www.xyonline.net/index.shtml). There are web resources on men's health (research, policy and promotion), self-care, male sexual health, family planning and reproductive health, males' subjection to violence, critiques of fathers' rights and men's rights.

A parallel development is the Internet presence of very diverse groups that come from the women's movement and the 60s on the subject of women's health. Here a spectrum of groups, networks and organizations have emerged with thematically differentiated and varying range (affecting the regional range, target groups or dependent on financial or personal ressources) Few of these groups come to an international level of networking. Some are partially networked at a trans-state level, e.g. in the German-speaking area of Germany, Austria and Switzerland.

At the EU level those areas are of importance in which a connection of work areas dealing with health and gender topics has developed. This includes lobby groups[6] that have taken up this subject or subject areas (e.g. the European Women's Lobby, recommendations on Gender and Health, capacity building for NGOs). Men's health and the integration of the subject into the Internet appearances of organizations and the activities of NGOs are few and far between.

Some material on the homepage of the European Public Health Alliance[7] makes aspects of the current developments aimed at the political integration of the subject clear. The European Public Health Alliance is one of the large organizations with Internet resources, collecting and disseminating information in the area of public health, but also as an organization launching an EU funded project to boost collaboration with non-governmental organizations based in Central, Eastern and Southern Europe[8] also making available appropriate gender information. For example:

- Equal opportunity aspects. EU wants women and men to be put on an equal pay footing for pensions and *health security*, under plans currently being drawn up in Brussels. According to the German newspaper Handelsblatt, the Commission is considering proposing a regulation in June which will put an end to discrimination against women in private pensions and health security benefits by suggesting 'gender neutral' tariffs. EU Observer on the issue.[9]
- Monitoring in individual social-politically relevant areas: A new Commission report *Gender issues in safety and health* - A review examines gender differences in workplace injury and illness, gaps in knowledge and the implications for improving risk prevention.[10]
- Activity to re-specify and define political goals: The Luxembourg Presidency of the EU organised in early February 2005 a meeting to review the European implementation of goals stated at the Beijing Conference on Women in 1995. The Beijing confrence identified 12 areas as goals for improvement. *Women's health* was one of the priorities.[11] (Source: European Public Health Alliance)

Because there are many references to reports, activities, political request etc. in the most diverse political areas[12], the path via information resources of the EU, WHO, organizations such as EPHA or large women's rights organizations as starting point is a good strategy that provides a relatively good overview of current discussions, policies and materials.

Internet Resources

The overview of existing Internet resources on the subject of Gender and Health is in line with the Internet sites that offer the broadest overview of the variety of material on offer, developed by trans-state perspectives and can show a political development representing the health interests of men or women or both sexes. The lack of trans-state collaboration in many national women's health expert groups shows that these groups, on analysis, are poorly represented.

Material that tries to offer quality-assured information for patients should also be distinguished from them. For Germany these are:

- DISCERN, an instrument or aid developed to help users of patients information to assess the quality of this information and treatment alternatives. The aims are: to support individual patients, deciding about treatment or want to learn more about a treatment used by them; assessment of the quality of written information; as aid to check quality for providers of patient information; as checklist for writers and producers of patient information; as aid for the training of medical experts to improve their abilities in communication and shared decision-making (http://www.discern.de/hintergrund.htm). The material has been prepared by the Medical University of Hanover (Medizinische Hochschule Hannover)[13].

- Patient information from the Doctors' Centre for Quality in Medicine (ÄZQ), a joint institution of the Federal Doctors' Chamber (BÄK) and Federal Association of Medical Insurance Schemes (KBV) based in Berlin. Commissioned by its sponsors, the institute has analysed, initiated and organized projects in promoting and assuring medical quality since 1995. It co-operates internal and external partners. In co-operation with self-help organizations information tested for its methodological quality is available under www.patienten-information.de (http://www. patienten-information.de/content/gesundheitsinfos/).

- The Action Forum Health Information System (afgis) is an amalgamation of associations, business and individuals to promote health information quality afgis has emerged from the project Action Forum Health Information Systems - Development and Testing of the Principles for Quality Assurance Health Information Network on the Internet, supported by the Federal Ministry of Health and Social Security (BMGS) and Feceral Union for Health. (http://www.afgis.de/ueber-afgis_html)

A lot has developed since 1997 in the area of research: the medium-term EU Equal Opportunities Programme, consideration of gender-differentiating questions in the various research programmes and the con-

struction of organizational units with gender reference and expert groups have made at least thematic progress possible.[14] In the area of EU research there are actors and materials such as:

- die Helsinki-Group[15] (group of national representatives established from the European Commission, recognising the need to put the women and science debate on a policy footing, responsible for women and science issues in both European Union Member States),
- the European Technology Assessment Network (ETAN, promote communication and debate at the European level between policy researchers and policy makers on important science and technology policy issues, addressing the gender balance in research policy)[16],
- ENWISE – gender equality in a wider Europe, (now with the Research Directorate General, Directorate Science and Society, Unit "Women and Science". The main responsibility was to produce a report for the new EU countries[17]).

All three groups are represented in the Internet with their reports, political statements and proposals to create equal opportunity in research and to actively recruit and integrat women in research. The materials are an important basis for the discussion in national research committees. Even if health research is not the central focus of the activities of this groups, there are at least experts available for research and research development, whose results can be adduced as a criterion for the development of specific areas of research that need it.

International Organizations

International organizations like WHO and the UN recognized the relevance of Gender and Health some years ago and integrated it into their works, resulting in better political dissemination and establishment of the subject. The following are Internet sites for materials, responsibilities and programmes:

- World Health Organization (WHO)[18]: The Department of Gender, Women and Health (GWH) in the WHO has the following aim:

  "GWH brings attention to the ways in which biological and social differences between women and men affect health and the steps needed to achieve health equity. The main focus of GWH is to promote the inclusion of gender perspectives in the work of the WHO by collaborating with other departments and regional and country offices. It aims to increase knowledge of gender issues by conducting selected research, training and advocacy on how socio-cultural factors and discrimination affect health" (internet information).

Main strategies are: Increase knowledge and evidence on how sex differences and gender inequalities impact upon specific health problems, health services and successful responses; develop tools to promote and expand health sector policies, interventions and programmes at the regional and country level that systematically address gender concerns, including gender-based violence; develop skills and build capacity within and outside of WHO in order to promote policies and programmes that are more responsive to barriers affecting women's and men's ability to lead healthy lives and receive and benefit from health care services; improve public understanding of gender issues by developing advocacy materials and activities; create awareness and provide support to WHO Member States to design and promote gender-sensitive health policies and strategies. Main areas of work are: Gender based violence and gender based aspects on HIV/Aids, Integrating gender into health policies and health programmes.

- Pan American Health Organization (PAHO; WHO). PAHO's Gender, Ethnicity and Health Unit (GH) provides technical co-operation and assistance to PAHO's technical units and Member States to promote gender and ethnic equality and equity in the development of health policies and programmes. GH seeks to identify and reduce the inequities between women and men of all ethnic groups with regard to health status and its determinants, access to and quality of health care, and participation in decision-making regarding policy agendas, definition of priorities, and allocation of resources. Themes are: Gender, Ethnicity and Health; Violence against Women; Gender Equity in Health Sector Reform; Gensalud Information System; Gender Mainstreaming; Mainstreaming Ethnic Equity in Health Policies.

- United Nations Population Fund (UNFPA) has the following analysis of the connection between Gender and Health:

  "Gender inequality and discrimination harm girls' and women's health directly and indirectly, throughout the life cycle; and neglect of their health needs prevents many women from taking a full part in society. Unequal power relations between men and women often limit women's control over sexual activity and their ability to protect themselves against unwanted pregnancy and sexually transmitted diseases including HIV/AIDS; adolescent girls are particularly vulnerable."

- United Nations Develop Fund for Women (UNIFEM) is the women's fund at the United Nations. It provides financial and technical assistance to innovative programmes and strategies to foster women's empowerment and gender equality. Placing the advancement of women's

human rights at the centre of all of its efforts, UNIFEM focuses its activities on four strategic areas: reducing feminized poverty, ending violence against women, reversing the spread of HIV/AIDS among women and girls, and achieving gender equality in democratic governance in times of peace as well as war.

The examples named reflect the activities of globally active organizations and the area of development policy and offer information resources on the worldwide relevance of the subject

Research

In the area of research differentiated developments are visible from an international perspective, in particular large differences between, for example, Europe and America. Sustainable competences in research can be seen in the following selected institutions:

- European Institute of Women's Health (eurohealth.ie). It's a non-governmental organization
  "working to make the health and well being of women a priority for the European Commission and Member States of the European Union. The Institute is a registered charity (…) working to achieve its objective by: Undertaking research at a European level on women's health issues and disseminating results as widely as possible. Promoting gender equity in treatment and care. Making information available to politicians, policy makers, medical/health professionals, NGOs, organizations and individuals with an interest in women's and family health. Presenting specific recommendations to Members of the European Parliament on women's health issues. Raising women's awareness of their own health and of their role in education about healthy lifestyles, by providing information on the prevention of disease, risk factors, early detection and early treatment. Encouraging women to become more involved in deciding policies that affect their benefits. Promoting the teaching of gender health issues in medical and health curricula. Highlighting the need to increase the number of women leadership positions in the health professions to include scientists and researchers".[19]

  The institute includes a broad spectrum of interest groups:
  "Individuals with an interest in women's and family health, medical and health experts, policy makers, MEPs, national governments, representatives, voluntary bodies, women's interest groups, major health organizations, NGOs, patient organizations and corporate bodies world-wide" (ib.).

  On the subject of cancer, Advisory Council for Mid-Life and Older Woman's Health und Gender Equality special information resources are available.

- The research network "Gender Health" is a Swiss national forum to promote intersectoral and interdisciplinary research collaboration founded by the Department of Gender Health of the Federal Swiss Ministry of Health. It sees itself as an open association of researchers and teachers from various health sectors who deal with the relationships between sex and health, sexual relations and sexual equality or research in this area. The goal of the research network is a sustainable Strengthening and Establishment of Gender Health research in Switzerland. Among other things, it makes available the structures for all those interested in networking in this area and co-ordinates their joint activities.[20]

- Reproductive Health Outlook (RHO): The Reproductive Health Outlook (RHO) website provides up-to-date summaries of research findings, program experience, and clinical guidelines related to key reproductive health topics, as well as analyses of policy and program implications. An important objective of RHO is to help users link with quality online resources and collaborate with colleagues around the world. RHO is published by PATH. It follows the World Health Organization (WHO) definition of reproductive health, as defined at the 1994 International Conference on Population and Development in Cairo. Like its companion print publication, "Outlook", RHO presents key research findings and program information related to a variety of reproductive health issues.

- Women's Health Project: The Women's Health Project is an initiative of the National Health Sciences consortium (NHSC), a group of nine top science institutions across the USA, of which the Maryland Science Center is a member and the lead organization for this project. Working together, the consortium used its unique capability to complete the project of developing an educational exhibit, public programming and instructional materials with the goal of making science and research related to women accessible and engaging for the public. The exhibit The Changing Face of Women's Health will wind its way across the country to ten national science centers reaching millions of women, girls and their families.

- The "Global Reproductive Health Forum @ Harvard" (GRHF) is an Internet networking project that aims to encourage the proliferation of critical discussions about reproductive health and gender on the net. GRHF provides interactive electronic forums, global discussions, distributes reproductive health and rights materials from a variety of perspectives through our clearinghouse as well as maintains an extensive, up-to-date research library. Their goal is to reach out to, involve and

meet the needs of under served groups globally, the reproductive health community worldwide, academics and people who are dedicated to women's rights and gender issues. GRHF is a health-focused Internet project which encourages global discussion. To create on-going dialogues, partnerships and strategic planning sessions which take place via the web within countries and across continents is the aim. GRHF is undertaken by the Harvard School of Public Health to provide a space for networking and exchange of perspectives on gender, rights and reproductive health issues. Their analysis was that at present, discussions of reproductive health, especially on the Internet, often fail to encourage innovative approaches and critical analysis of the ideas of reproduction, gender and rights. Even more pressing is the lack of forums for representation and the distribution of these ideas. The GRHF aims to address these concerns. (Internet information)

- But even a traditional university like Yale has a programme to develop Women's Health Research[21]. Research areas at the moment: cardiovascular Health, addictive disorders and statistical modeling.

- Women's International Studies Europe (WISE) is a feminist studies association, constituted in 1990. Aims are:

  "the promotion of women's studies research, teaching and publication in Europe, and the defence of women's studies on a European and international level in all appropriate institutions and organizations". (http://webhost.ua.ac. be/women/wise/# WISE)

  Some of WISE activities are: publication of a newsletter, the European Journal of Women's Studies, collection and dissemination of lists of experts, organization of conferences and expert meetings, developing and supporting national and international initiatives related to women's studies like the preparation of the Worldwide Organization of Women's Studies (WOWS) and the preparation and participation in the UN Women's Conference in Beijing (1995). WISE has divisions, which are networks on specific themes, one of them on "Gender and Health".

- The European Women's Health Network (EWHNET) started[22] europwide a programme of expert exchange among research organizations and practical units in the area of women's health. EWHNET worked within the framework of the medium-term programme of the EU on equal opportunity for women and men (EWHNET), was financed between 1997 and 2001 by this programme and at that time was one of the first projects that attempted in Germany to achieve a Europewide network of women's health activities, identify common themes and initiate trans-state experiences in the area of women's health. At the moment

EWHNET is working selectively on subjects via existing email contacts.

- In the English-speaking /American university and research fields in particular there are some (established) research institutions that have taken up health and medical research, women's health and gender questions into their curricula[23] (other examples: Center for Research on Reproduction and Women's Health, Center for Research on Women with Disabilities, Jacobs-Institute of Women's Health). Here also are the first networks on men's health (Men's Health Network, www.menshealth network.org/goals.htm).

The research traditions on the subject of Gender and Health in Europe and Germany are, by contrast, a lot thinner on the ground. Gender questions in health research or women's health research are offered by the EIWH, otherwise expert opinion is available in specific university locations and the chairs that have found a home in them (For example, Vienna, Ludwig-Bolzmann Gesellschaft[24]; the chair of Women's Health Research at the Westphalian Wilhelms-University of Münster/Medical Faculty[25], a new research chair of the network Women's Research of the State of North-Rhine Westphalia Gynaecological Psychosomatics (Gynäkologische Psychosomatik) in the Medical Faculty of Bonn University). In the European research area, by comparison with the United States, the presence of Gender and Health is relatively scarce. WISE as an European example, is committed to women's research and has integrated the subject of Gender und Health as a working group.

Specialist Organizations and Professional Associations

Similarly there are international amalgamations of organizations, specialist organizations and professional societies which represent the subject and offer Internet possibilities of transnational exchange on an international basis.

For existing deseases worldwide there are activities that have integrated gender questions and women's health. For example for HIV/Aids there is the United Nations Development HIV Program, for breast cancer there is Europa Donna. Some examples:

- The Women's Global Network for Reproductive Rights calls itself an autonomous network of groups and individuals in every continent who aim to achieve and support reproductive rights for women.

  "Reproductive rights are a series of rights that enable all women – without discrimination on the basis of nationality, class, ethnicity, race, age, religion, disability, sexuality or marital status to decide whether or not to have chil-

dren. This includes the right to have access to safe, legal abortion. Reproductive rights are human rights. The Women's Global Network for Reproductive Rights strives for women's right to self-determination in keeping with their freedom, dignity and personally held values. Transforming social, political and economic conditions are part of the reproductive rights agenda so that all women are able to fully enforce reproductive rights". (Internet information)

- EUROPA DONNA: is a European Federation against Breast Cancer base in Milan, founded in 1994 as non-profit organization of women for women and now has so-called national forums and national sections in 28 countries. Europa Donna is not a self-help group, but according to its self-understanding an organization that wishes to help women. The aim is to protect women through broad and current information brokering against later breast cancer, false diagnosis or treatment, to engage actively for breast cancer research, for quality-assured early recognition accordingto European Guidelines and for interdisciplinary breast centres that have to meet clearly defined minimum standard etc. (http://www.europadonna.de/fr_wir.html).

- The Medical Women's International Association (MWIA) is an association of medical women representing women doctors from all five continents. The

   "aims and goals are: To promote the cooperation of Medical Women in different countries and to develop friendship and understanding between Medical Women throughout the world. To actively work against gender related inequalities in the medical profession between female and male doctors including career opportunities and economical aspects. To offer medical women the opportunity to meet so as to confer upon questions concerning the health and well-being of humanity (internet information, compare: http://www.mwia.net/).

   It is a federation of national associations of women doctors in 43 countries (Northern Europe, Central Europe, Southern Europe, North America, Latin America, Near East, Africa, Central Asia, Western Pacific), working together via International Congresses and General Assemblies every 3 years in various countries of the world. International Congresses and General Assemblies are held every 3 years in various countries of the world.

- The association for Women in Psychology (AWP) is an incorporated, non-profit scientific and educational feminist organization

   "devoted to re-evaluating and reformulating the role that psychology and the mental health field generally play within women's lives. It seeks to act responsibly and sensitively with regard to women by challenging the unquestioned assumptions, research traditions, theoretical commitments, clinical and

professional practices, and institutional and societal structures that limit the understanding, treatment, professional attainment, and responsible self-determination of women and men, or that contribute to unwelcome divisions between women based on race, ethnicity, age, social class, sexual orientation or religious affiliation (http://www. awpsych.org/about.htm).

"Its role thus includes education and sensitization of mental health professionals, encouragement and recognition of women's concerns and those who promote them, reconceptualization and expansion of perspectives within psychology, advocacy and critique regarding professional and institutional practices, and the provision of opportunities for creative feminist contributions and the dissemination of feminist ideas" (ib.).

AWP sponsors regional and national conferences on feminist psychology as well as several annual awards. Interesting aims: Developing a feminist model of psychotherapy, Sensitizing the public and the profession to the psychological, social, political, and economic problems of women, Combating the oppression of women of colour etc., (see objectives: http://www.awpsych.org/about.htm#objectives).

- The Association of Women Psychiatrists (AWP), is an organization of women psychiatrists in the United States, and throughout the world. Aim is

"to mobilize women psychiatrists to work together for quality mental health care of all persons, particularly women. AWP promotes inclusive leadership, professional development, networking among women psychiatrists and advocates for women psychiatrists and patients alike, through supporting mental health: research, education, and clinical care, informed by gender." (http://www.womenpsych.org/)

The examples show that Gender and Health has arrived on the political agenda of relevant teams of specialists. This integration is responsible for international further development of the subject and gives it political power. However, only certain specialist organizations are geared to international co-operation. Nationally there are many more different state-specific associations and connections.

Internet Resources with Political and Women's Political Background

The following contains some example for the overlap of women's politics and women's health, from focus points of world politics, (women's) health policy and development policy:

- The Q web Sweden, Women's Empowerment Base. Das Q web Sweden is primarily a political network, but also deals with subjects such as re-

productive rights, abortion, health in Africa. The The exciting range is here extremely politically motivated.

- Protecting Women's Health, Advancing Women's reproductive Rights (IPAS), Ipas has worked for three decades to increase women's ability to exercise their sexual and reproductive rights and to reduce deaths and injuries of women from unsafe abortion. Ipas's global and country programs include training, research, advocacy, distribution of equipment and supplies for reproductive-health care, and information dissemination (Internet information).
- The Center for Health and Gender Equity (CHANGE) is a U.S.-based non-governmental organization focused on the effects of U.S. international policies on the health and rights of women, girls, and other vulnerable populations in Africa, Asia, and Latin America. They believe that every individual has the right to the basic information, technologies, and services needed to enjoy a healthy and safe sexual and reproductive life free from coercion and preventable illness. Their mandate is based on the premise that it is the responsibility of US organizations, connected to US constituencies, to foster accountability of the US government's policies abroad. Our overarching goal therefore is to ensure that U.S. international policies and programs promote sexual and reproductive rights and health through effective, evidence-based approaches to prevention and treatment of critical reproductive and sexual health concerns, and through increased funding for critical programs (internet information). CHANGE is thus one of the US-based NGOs to check national health policy.
- Astra Central and Eastern European Women's Network for Sexual and Reproductive Health and Rights, with information on the situation in individual countries.
- The Network of East-West Women (NEWW) connects women's advocates in more than 30 countries in the region of CEE/NIS/USA. NEWW members represent all strata of society - human rights activists, writers, students, journalists, lawyers, parliamentarians, professors, artists, union organizers, health care workers and feminist activists. Founded in 1991 NEWW is an international communication and resource network supporting dialogue, informational exchange, and activism among those concerned about the status of women in Central and Eastern Europe, the Newly Independent States, and the Russian Federation. NEWW's overarching goal is to support the formation of independent women's movements and to strengthen the capacities of women and women's NGOs to influence policy regarding women's lives (http://www.neww. org.pl/en.php/activites/network/0.html). NEWW is an NGO in Special

Consultative Status with the Economic and Social Council of the United Nations. With members in more than 30 countries NEWW is among the largest and most respected networks in CEE/NIS, and is a trusted source of expertise, resources and information about gender in democratizing societies. Es finden sich Informationen zu Gesundheitsthemen wie: gender perspctives of natural disasters, reproductive health, etc..

- Reproductive Rights Network: AAP is an organization of reproductive rights activists and women's health care providers dedicated to making abortion truly accessible. AAP works on the state and national levels to increase accessible abortion services, increase the number of abortion providers, improve the education of health professional students, and educate the public to see abortion as part of comprehensive reproductive health care. AAP has developed models of activism and training that can be used in other regions across the country. AAP is addressing the crisis of decreasing services with a proactive strategy to: Increase accessible abortion services at hospitals, Increase the number of primary care physicians being trained to perform abortions, Organize Advanced Practice Clinicians (nurse practitioners, physician assistants and nurse-midwives) to become involved in abortion services, Work with medical students and nursing students to integrate abortion into school curriculum, and educate the public to see abortion as health care, not as a stigma.

- The Global Alliance for Women's Health (GAWH)

  "is commited to advancing women's health in all stages of life at all policy levels through health promotion, education, advocacy and program implementation. The GAWH works with coalitions of international, national and non-governmental organizations (NGOs), women's groups, health care professionals, religious organizations, academics and individual citizens from all regions of the world to promote and implement women's health care service improvements and research at the local, national and international levels" (http://www.gawh.org/).

  One of the principles of GAWH is: Partnering among NGOs, governmental organizations, the private sector and academic institutions is necessary in order to provide effective health care and research for women globally. Some of the health issues they provide information on: HIV/Aids, diabetes, Osteoporosis, Ageing, Coronary heart disease, difluctan, smoking, female genital mutilation, depression, trachoma.

- The European Men's Health Forum (EMHF): Aim is

  "to improve men's health across all countries in Europe by promoting collaboration between interested organizations and individuals on the develop-

ment and application of health-related policies, research, education and pre-vention programmes".

EMHF has been initiated by The Men's Health Forum, the leading ad-vocate of men's health in England and Wales. Objectives: Raising the profile of men's health at a Europe-wide level and within individual states. Encouraging Europe-wide, national, regional and local organiza-tions (both governmental and non-governmental) to include men's is-sues in their health policies and practices. Improving the delivery of health services to men, including primary care and health promotion in-formation. Increasing the awareness of health professionals of men's health issues and their ability to work effectively with male patients and men generally. Increasing men's awareness of their own health and their treatment options. Changing men's health-related behaviour, not least in terms of increasing their willingness to access health care and reducing the risks they take with their health. Providing opportunities for organizations and individuals across Europe with an interest in men's health to network and collaborate (http://www.emhf.org/index.cfm/item_id/2/CFID=6860530&CFTOKEN =35940077/).

Some of the groups are associated with one of the central themes of the women's health movement and the women's movement. The right to birth control and abortion and the support for women in these decisions (IPAS, Q Web, AAP, Astra). The GAWH aims to integrate women's interests into programme and policies and links human rights with health policy. Internet resources in the area of men's health appear with the clear aim of influencing European policy/ies – though the EMHF Board shows that organizationally and politically an interesting partnership (research, policy and interest organizations) is integrated.

Discussion and Outlook

The health of women and men was for a long time a neglected area in re-search and the health systems of European states. The subject gradually entered the consciousness of various actors historically as a result of the drive from the women's health movement with its strong focus on health self-determination of women and the women's health groups and centres that emerged from it. This history has a lot to do with the fact expert advice in many countries can be found as a subject in non-professional organiza-tions and has not yet been integrated as a matter of course into research and regulated care.

Men's health has been on the agenda of organizations and political institutions only for a few years, and an important dynamic in the development of this has been the development of Gender Mainstreaming. I have already described some of the organizations that have emerged. An Internet search on the subject quickly produces actor groups in the USA (for example, the Department of Health and Human Services, Centers for Disease Control and Prevention USA with its information material on Women's Health and Men's Health[26]). For Europe, however, the same sort of consistent form of integration of the subject of "Men's Health" e.g. governmental information sources are still relatively rare.

The impetus to devote oneself more intensively to the subject is connected with the EU strategy of Gender Mainstreaming. All institutions are here called upon to devote attention to this subject. This challenge to integrate gender-specific differences and their effects has made it possible to re-anchor the subject of Gender and Health in research institutions and address it in the area of health. In this way women's/men's health experts have been able to establish themselves in research and teaching. For Germany one can say that there are still largely parallel structures, but integration of the subject into certain specialist policies is observable, though the attempts at mainstreaming have still not led to permanent self-evident co-operation or integration. Women's/men's health experts are still seldom in professional positions in which they are able to deal long-term with the subject in a secure and consistent way. Expertise on men's health is similarly hard to find. On the European level the expertise tends to be rather on men's health. On the individual European States level the information situation seems more clearly heretogeneous.

In the analysis of transnational information resources the spectrum of international institutions (EU, WHO, UNO and their corollary NGOs), research initiatives, professional organizations and NGOs seems to be one of interesting information resources. For future activities, both in the area of research, politics and women's/men's policy health attention should be paid to integration and inclusion of experiences (expertise and materials) and competences (e.g. information networking and dissemination) of these actors.

It would also be useful to integrate contacts with the NGOs that have emerged in international politics, women's politics and health political interests into emerging networks. Each of these strands of development has its own experiences and competences. In particular, exchange of experience and development strategy would benefit.

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Notes

1   Source: Boyer et al.: Health On the Net's Fourth Survey on the Use of the Internet for Medical & Health Purposes http://www.hon.ch/Survey/ResumeApr99.html, one of largest Internet survey to date of active health information seekers, Surveys from 1993 to 2005.

2   The search was made in English using the keywords "Gender and Health", "Gender Mainstreaming Public Health", "Women's Health", "Men's Health" via Google. In addition links of organizations, also in the area of women's health, were thoroughly analysed. The links of German-speaking organizations were also taken up here. An example with relatively detailed references is the list of links of the Bundeszentrale für politische Bildung (Federal Centre for Political Education) on the subject of Gender Mainstreaming http://www.bpb.de/popup/popup_druckversion.html?guid=LKI937, 16.01.06.

3   "World Conferences on Women are held regularly by the U.N. They are intended to strengthen the position of women worldwide with respect to the role in legal, economic, social and political contexts. So far four Conferences have taken place: Mexico (1975), Copenhagen (1980), Nairobi (1985) and Peking (1995). Conference decisions are made primarily through declarations. Traditionally the Conferences are accompanied by extensive activities of NGOs." (Prof. Dr. Baer, Lehrstuhl Öffentliches Recht und Geschlechterstudien, http://lms.hu-berlin.de/cgi-bin/glossar_recht.pl?Weltfrauenkonferenzen, 14.09.2005).

4   REPORT OF THE WORLD CONFERENCE ON WOMEN, Beijing, 4.-15. September 1995, see: http://www.un.org/Depts/german/conf/beijing/beij_bericht.html, cf. appendix II Action Platform IV Strategic Goals and Measures, C "Women and Health", 15.10.2005.

5   First equal opportunities issues have received attention, especially in the context of labour market. Gender Mainstreaming was formalised in the Treaty of Amsterdam, with focus on equality between women and man, Later as a more general political principle. With the Gender Mainstreaming strategy the EC is applying a complex of measures, strategies and methods: it is pursuing a double approach, both Gender Mainstreaming and specific measures; it is making efforts to evaluate sex-specific effects and attempts

at equality; mobilization of all Commission posts, the establishment of responsibility, e.g. through training and the creation of problem-consciousness among responsible people; monitoring, benchmarking and breakdown of statistics and data according to sex; establishment in the organization structures, e.g. through the Commissar Group for Equal Opportunity, through the Equalization Group of Representatives of all Commission posts, through the Consultative Committee for Equal Opportunity of Men and Women.

6 For example: European Women's Lobby Response and Recommendations to the European Commission's Paper: "Enabling Good Health for all: A Reflection Process for a new EU Health Strategy", http://ewl.horus.be/site/1abstract.asp?DocID=272&v1ID=&RevID=&namePage=&pageParent=&DocID_sousmenu=&parentCat=19, 15.10.2005.

7 The European Public Health Alliance (EPHA) represents over 100 non-governmental and other not-for-profit organizations working on public health in Europe

8 The goal is to create an extensive and comprehensive online directory of NGOs working on health and environment issues, http://ngo.epha.org/; Gender Information http://www.epha.org/recherche.php3?recherche=gender.

9 Source: http://www.epha.org/a/152.

10 The report by the EU Agency for Safety and Health at Work shows how the design of work, its organization and equipment are often based on the model of the 'average' man, although the principle of matching work to workers is enshrined in EU legislation. In general it can be said that women suffer more from work related stress, infectious diseases, upper limb disorders, skin diseases as well asthma and allergies, while men suffer more from accidents, back pain and hearing loss. Recommendations from the report include the promotion and facilitation of a gender-sensitive approach in research, policy and prevention practices to help ensure effective prevention and avoid gender bias in occupational safety and health (OSH). Coinciding with the release of the report, the Agency has also launched a web feature on gender and occupational safety and health, providing links to a wide variety of resources from sources worldwide. Source: http://osha.eu.int/good_practice/person/gender/, 15.10.2005.

11 Source: http://www.epha.org/m/18 .

12 Also of interest is the Report to the EU Parliament on Gender Discrimination in Health Systems. Similarly the Committee on Women's Rights and Gender Equality held a hearing titled "The impact of gender differences in the matter of public health" on 30 March 2005. Draft report INI/2004/2218, www.europarl.eu.int/search/simple/perform. do?language=de.

13 Dept of Epidemiology, Social Medicine,Health Systems Research, with priority Patients and Consumers (Abteilung Epidemiologie, Sozialmedizin und Gesundheitssystemforschung, Arbeitsschwerpunkt Patienten und Konsumenten).

14 Gleichstellung als Tätigkeitsbereich der EU: http://europa.eu.int/scadplus/leg/de/s 02310.htm.

15 http://www.cordis.lu/improving/women/helsinki.htm, National Policies on Women and Science in Europe.

16 ETAN: http://www.cordis.lu/etan/home.html .

17 "The main task of the Enwise Expert Group was to produce a report, which would set the scene, review the issues and challenges for women in science and in scientific research in the targeted countries; and, building upon the resulting landscape, it would formulate policy recommendations for the different levels of research policy (within

research administrations, public and private research bodies, at regional, national and EU level) and for the scientific communities and the scientists themselves, both male and female". the Commission established the Enwise Expert Group, which worked from October 2002 until December 2003. http://europa.eu.int/comm/research/science-society/women/enwise/index_en.html.

18 Central WHO topics: Gender and Disaster, Women and children are particularly affected by disasters: w3.whosea.org/en/ Section13/Section390_8282.htm/

Gender based Violence in disaster, w3.whosea.org/en/Section13/Section390_8280.htm/ Tuberculosis and gender, www.who.int/tb/dots/gender/en/

Gender, Health and Ethnicity, www.paho.org/genderandhealth/

Gender and natural diseases, www.paho.org/English/DPM/GPP/GH/genderdisasters.pdf Gender and women's mental health. Gender disparities and mental health, www.who.int /mental_health/prevention/ genderwomen/en/

Gender-sensitive interventions, Examining how gender inequalities affect TDR diseases, their control, and access to health care. www.who.int/tdr/topics/social-research /gender.htm/

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Gender and reproductive rights, www.who.int/reproductive-health/gender/ Gender and HIV/ Aids, www.who.int/entity/gender/hiv_aids/en/

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20 http://www.gendercampus.ch/C12/Forschungsnetzwerk%20Gender%20Heal/default. aspx, 15.09.2005.

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22 Subjects treated: Municipal strategies for women's health, Gender and Ageing, Gender based analysis in research, policies and practice, work and motherhood, health promotion and prevention of eating disorders, gendersensitive occupational health. For results see: http://www.gesundheit-nds.de/ewhnet/start.htm.

23 Search keyword: Women's health research.

24 The Federal Austrian Ministry of Health and Women (Das österreichische Bundesministerium für Gesundheit und Frauen) offers under the keyword " an overview of EU-wide organizations: http://www.bmgf.gv.at/cms/site/detail.htm?thema=CH0330&doc= CMS1111669738440 "Forschung, Frauen, Gender und Gesundheit" (Research, Women, Gender and Health).

25 Priorities in Münster: Gender-based medicine, sex-specific differences in health and illness management (geschlechtsspezifische Unterschiede in Gesundheits- und Krankheitsmanagement), applie problems of new diagnoses and therapy procedures (Anwendungsproblematik neuer Diagnose- und Therapieverfahren), evaluation and quality assurance problems (Evaluation und Qualitätssicherungsprobleme), health-related life quality of women in health research in the Third World (Gesundheitsbezogene Lebensqualität von Frauen in der Gesundheitsforschung in der 3. Welt), construction of in-house research reporting (Aufbau einer eigenen Forschungsberichterstattung) (Women's Health Research Series).

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Meeting EU-Conference Participants Interests with the "Open Space" Method – Some Reflection on Process and Results

Walburga Katharina Freitag

> *"In my experience open space is based on the belief that we humans are intelligent, creative, adaptive, meaning- and fun-seeking. It sets the context for such creatures to come together knowing they are going to treat each other well. When this happens there is no limit to what can unfold"* (Alan Stewart, 2005)

Introduction

"*What are the future issues, opportunities and strategies for women's health networking across Regional diversity in Europe*?" has been the central question raised for the Open Space[1] during the conference. With this question we – the conference team – tried to organize a process which supports the main conference task: to lay the foundations for understanding each other. The author of the paper has been member of the conference team and the Open Space facilitator.

Transnational and interdisciplinary networks always face many challenges: the network language very often is not the mother tongue, women's health- and gender-concepts differ from discipline to discipline, country to country, and solutions are often based in specific national health- and social policy-structures and systems. The EU-expansion leads not only to an expansion of languages, meanings, perspectives and policy diversity – perhaps most important – it adds complexity: the new EU-countries undergo rapid and major system changes which lead to severe changes in and access-insecurities to health care services.

The reflective use of a method which supports a basis for mutual understanding seems to be a key-goal for networking, one of the most important challenges for transnational cooperation and at the same time very difficult to achieve. The conference organizer believed that partly conferencing with Open Space could bring the participants a step further to reaching the goal.

In the coming chapters I will explain the Open Space Method and give an insight into the Open Space meeting during the conference. Chapter two shows what you need for a successful Open Space and highlights the participant requirements, chapter three focuses on the underlying methodo-

logical ethics and values which explain why the method is extremely relevant to create network-processes. The necessary framework and the way we organized the process in an Open Space manner are explained in chapter four. Chapter five focuses on the main results, and in the final chapter six I will outline main aspects of the final Open Space discussion and some process-reflections.

Requirements: Whom and what do you need for a successful Open Space?

The most basic requirement is that (nearly) everyone who comes to an Open Space meeting should be passionate about the topic and willing to take some responsibility for creating things out of that passion. On top of this *one or more joint overall issues* are necessary if you start thinking about choosing Open Space. The method can be chosen if change management, conflict resolution, problem solving or strategic planning is necessary. Open Spaces can be realised with a low budgeting and does not need much preparation in advance.

The development of future issues, opportunities and strategies for women's health networking across regional diversity in Europe was, as pointed out already, the conference organizers joint overall task. We were also sure that the conference participants are the *experts* for their countries and specific working fields. So, for a successful Open Space you need active participants, participants who want to influence the formation of the joint task, experienced participants who contribute with diversity of perspectives, participants who are aware of the complexity of structures and, last but not least, participants who want share their knowledge. The conference participants coming to Kassel live in Poland, Latvia, Slovenia, Hungary, Greece, Scotland, England and Germany. Some are grass-roots activists; some are working in NGOs, research institutes, universities, others are part- or full-time employed or doing voluntary work in women's health centres. Most were keen to talk about their home country situation, to identify important questions and to listen to the others.

The *self-directed conference proceeding* is another Open Space characteristic.

> "Open Space conferences have no keynote speakers, no pre-announced schedules of workshops, no panel discussions, no organizational booths. Instead, sitting in a large circle, participants learn in the first hour how they are going to create their own conference. Almost before they realize it, they become each other's teachers and leaders" (Stewart 2005).

The value of this is that everybody very soon has an overview what the participants' *main* fields of interest and questions are plus what type of experience and knowledge they have and want to share. So, if members of an institution are at the beginning of discussing an issue, or if a group is at the beginning of networking processes, in the middle or even advanced: The Open Space process always functions as a mirror. It mirrors interests, experience, knowledge, conflicts and strategies. As an experienced open space facilitator puts it:

> "Groups large and small (5-1000+) demonstrate their capacity to rapidly create effective meeting agendas and deal with highly conflicted issues" (Stewart 2005).[2]

Ethic and Values: Growth from within

As cited above, the participants learn during the first hour how they are going to create their own meeting, workshop or conference. Knowledge about the so called Open Space *principles* is most important. Four principles are the 'heart' of the Open Space Method.

First principle: Whoever comes is the right person

The principle, whoever comes is the right person, "reminds people, particularly conveners of the groups, that it is not how many people come, or even who comes – in the sense of status or position – that counts, rather it is the quality of the interaction and conversation that make the difference" (Owen, 2001: 96). It even may be that nobody will come to a particular theme. There are several possibilities why this may happen: it may be a good theme but the wrong time, it may be great idea but not good to start with.

Second principle: Whatever happens is the only thing that could have

This principle is a reminder that real growing and real progress will only take place when we all move beyond our original agendas and expectations, which very often are closely bound by conventions. It is, as with Owen's experience, precisely in the moment of surprise, when something unexpected happens, that we grow. The philosophy is to cherish such moments and realize *that whatever happens is the only thing that could have*.

Third principle: Whenever it starts is the right time.

The real impact of this principle is to serve important notice about the nature of creativity and spirit. Both are essential and don't pay much attention

to the clock. So, even when a meeting is scheduled for 2 pm, there is no guarantee that anything will take place at that moment. *Whenever it starts is the right time*.

Last principle: When it's over, it's over.

This principle reminds us that we can be creative using our time. If there is nothing left to say, it is over and allows us to move on.

The Law of two feet

The so called 'one law' is the law of the two feet. This says that if during the sessions, "any person finds him or herself in a situation where they are neither learning nor contributing, they must use their two feet and go to some more productive place" (Owen 2001: 98). The law has four useful effects.

First, it is the death to egoists or *"Curbing Egos"*, as Owen puts it. People who are sure that they alone possess the truth or think that they have a mission regardless of anyone else's feelings or desires rapidly get a feed back when half the participants leave the room. *"Defining responsibility"*: The second effect is connected with the first: The law places responsibility for the quality of each person's learning and/ or contribution directly where it belongs - with that person. If somebody decides to stay in a session, the decision to do so is her or his responsibility. The law of the two feet places the responsibility for our actions directly on our own shoulders. There is nobody else to blame if the sessions turn out differently than expected or if we are in a situation which is miserable and non-productive.

The third and fourth effect is that participants can act like *Bumblebees* and *Butterflies*.

Bumblebees take the freedom of the law very seriously and use their two feet. They are constantly flitting from session to session. The contribution to the session is large and direct.

> "Like their counterparts in nature, they pollinate and cross-pollinate, lending richness and variety to the discussions" (Owen 2001: 100).

Butterflies act in an opposite way. These conference participants often never get into any session. They may be found at the café, the conference lobby or even at the hotel bar. Some might wonder why they even bothered to come. The truth – according to Owen – is that they do very little but in this lays their contribution. They create centres of non-action, where silence may be enjoyed or some new, unexplored topic of conversation en-

gaged. The philosophy behind this way of action is that *significance may emerge because nobody is looking for it*.

Facilitation and Getting Started

The *facilitator* is required to 'hold the space' and manage the information systems: rooms, time, equipment and the way the open space process is organized. We had one full day for the Open Space, beginning in the evening of the second conference day and ending in the afternoon of the third day.

Participants were invited to come to the middle of the circle where they could pick up a marker and large sheet of paper on which to write their topic and name. Anyone who wanted to initiate a discussion then stood up and announced it to the group. The procedure is as follows.

They post their proposed issue on a wall. When everyone who wanted has announced and posted their initial topics, it's time for what Owen calls "the village marketplace": Participants mill around the wall, putting together their personal topics and clustering those which have a great deal of similarity. After having finished the clustering it's time to select one of the many pre-established times and places. For this purpose participants go over to the wall where a "space/time matrix" has been taped to the wall. They take a post-it note (that tells at what time and where their particular topic will be discussed) and attach it to their sheet of paper. They then tape the quarter sheet on an open wall space adjacent to the space/time matrix.

The people who come forward and prepare the matrix are so called *"conveners"* of a topic. They are not necessarily experts on the topic. But they should have passion about the topic, want to discuss it with anyone who also cares about the topic, and should be willing to take responsibility for developing the process (for further details in organising the available time see Cox 2005). The first meetings can begin immediately.

Market place – The Agenda – The Results

Let us now go back to our Open Space activities. After having introduced the method, many participants took over the initiative. The following nine thematic clusters are the result of the initial invitation to announce topics. The participants who had contributed to a cluster were responsible for the discussion and result, under which headline the topic will be announced for the main bulletin board. So, don't be surprised, if not all personal topics are fully represented under the clustered topic.

(01) How to assess gender bias in health care?
Role of self-help and gender in health care/ identifying differences in Europe

(02) Strategies to encourage colleagues to become involved in Women's Health Movement
Empowerment of women to get used to exercising women's health rights

(03) and (04) Women's occupational health
Health promotion in occupations regarding paid and unpaid 'activities'
Working conditions and women's occupational safety and health
Opportunity for networking on defining what a healthy working life should mean to women
Reproductive rights in occupation and gender
Breast feeding in the workplace
Single parents and occupational health

(05) and (06) Primary prevention on neural tube defects
Effects on SES (socio-economic-situation) – disparities on women's health
Cardiovascular disease among women – strategies for activities across Europe
Strategies to cut down caesarean-sections epidemic (in Europe) – Grassroots and NGOs
Reproductive health and rights
Breast cancer
New technologies designed by women engineers, suitable for women's health

(07) Sexual diseases, mental disturbances of immigrant women, victims of trafficking in Europe
Women's health across regional diversities - women's diversities to cross/bridge regional diversity in life/ health/ work/ love
Inside out and outside in: opening the doors of academic realms for outsiders to participate (and pay them, because those suffering are very often very poor).

(08) NGOs possibilities to participate in EU women's health networks
Building women's health networks where they are not existent
Looking for funding opportunities for women's health networks

(09) Ageing, health and gender – Research and cooperation for this topic
Care and gender – models for a coming future
Autonomy of women in health care
Gender and ageing/ old age – problems and solutions

The Final Agenda

Within 15 minutes the participants created an agenda of five one and a half hour sessions, focusing on the following topics:

1. Expansion of Women's Health Networks in the EU
2. Empowerment of Women
3. Women's Occupational Health
4. Gender, Health and Ageing
5. Access to Health Care for Excluded Women (with a special focus on immigrant women/ victims of trafficking/ women with sexual diseases and mental disturbance)
    (For the detailed results please see attachments.)

The announced topics as well as the clustered topics represent very specific issues with which the participants are familiar and which they want to put forward in the European community. Sometimes the strategic dimension and question of how to process strategies on a European level were more at the center.

The group discussing the 'Expansion of Women's Health Networks in the EU' (see attachment 1) developed strategies to build up women's health networks in Central and Eastern European countries and to get access to EWHNET. The group articulated an explicit order towards EWHNET to make clear the network aims, to talk about definitions and to make visible the scope of interest it has with the new member countries. On top of this the new members find it necessary that EWHNET defines the issues covered by the network. Another important aspect is related to the countries women's health networks: A mentoring system, according to the groups ideas, could assist the new countries to build up their own networks.

The group discussing the 'Empowerment of Women' (see attachment 2) developed ideas to start analysing the gender relations and power relations in the health care system. The basic idea is to develop a reflexive knowledge about gender inequalities in health care systems and to strengthen women within the professions as well as women as clients to take over responsibility and to demand the rights and empower themselves.

The third group focussed on the issue "healthy working life for women" and developed the strategy to produce a Powerpoint-Presentation for wider distribution, which should be put on the EWHNET-Website.

The fourth group on Gender, Health and Ageing decided to identify research topics, and at the same time to develop strategic aims how to promote the topic in an European Network. They decided on a meeting, which has been realised meanwhile[3].

'Excluded women in Europe' was the central topic, the fifth group discussed. The group developed the vision to realize free access to medical care for immigrant women, for Victims of trafficking and victims of forced prostitution. Terre des hommes, Amnesty international, the University of Osnabrück / Equal and marginal groups were identified as groups to collaborate with.

The final discussion was around future activities and the status of EWHNET. Whereas former EWHNET cooperation partners see EWHNET as a transnational cooperation project which is without funding at the moment, the participants coming from East Europe hoped that EWHNET would and could serve as a basis for further networking on women's health issues in an expanded Europe.

Open Space Discussion and Some Process Reflections – Unfinished

If I – as the facilitator – look back to the process, I have to remark that Open Space was the right method. The participants were extremely passionate to participate and used the groups for discussion and exchange. The Open Space has produced an important insight into what the future issues, opportunities and strategies for women's health networking across regional diversity in Europe from the participant's perspective are.

Two aspects could be enhanced in future. The first aspect has to do with the organisation of the whole conference and the time management: Introduction into the method and setting up the agenda was terminated at the end of the second conference day. Not everybody who set up the agenda participated in the process of day three. The main Open Space day was the day of departure. Some had to leave around noon, so that not everybody who participated in sessions participated in the final group discussion. What can be learned? It is necessary to have full one *and* a half day as a minimum for an Open Space and necessarily everybody who contributes to the agenda has to participate in the sessions. Otherwise problems arise which mainly have to do with a result-documentation and distribution which do not meet the participants' expectations.

The second aspect has to do with expectations. As mentioned above, the final discussion was around EWHNET and its activities. For the participants coming from the new European countries it was difficult to understand what the status of the network was or still is, and perhaps this point has not been communicated clearly enough by organisers and the old EWHNET-members. Transnational cooperation projects differ in their goals from networks, but projects as well as networks depending on project

money tend to be unstable. Having had the money to fund the conference did not mean to have the funding to continually extend the existing EWHNET-structures. In the plenum's discussion the coordinator of EWHNET explained, that EWHNET at present is without any funding. For this reason the communication structure is limited: With an email-list members are informed about news. For meetings to build up further network structures funding has to be raised.

A country which wants advice about networking etc. can receive support via email or by former EWHNET-members. Countries interested in a joint theme and collaborating together have to apply for funding themselves. The major aim of this workshop in Kassel has been to link interested women for common future work in the field of women and health. To foster new structures it will be necessary to communicate this important aspect.

So far, some groups have reached the defined aim of further cooperation. Cooperation between conference participants is reported and the group around the topic "Gender Health and Ageing" succeeded in fund application for a workshop which was held in April 2005. On this basis they could discuss the developed questions and publish ideas and results. On top of this, the group succeeded in organizing three research applications for further funding and cooperation.

The Open Space was helpful to create a foundation for understanding each other and could build up trust. But the expansion of European women's health networking and any further cooperation depends on a minimum of funding for communication and travelling. Hopefully soon a group of activists will have the power and money to continue the promising *Women's health networking across Regional diversity in Europe.*

Report Group 1
Expansion of Women's Health Networks in the EU

Date and Time:	October 10th, 2004, 11.15 a.m.
Topic:	**Expansion of Women's Health Networks in the EU**
Convener:	Csilla Csoboth, Hungary
Participants:	Marlena Skorupka, Małgorzata Kamińska, Elisabeth Geisel, Gabriele Kreutzner, Katja Reimann, Solvita Olsena
Discussion:	• What defines a network: giving information. • Possibilities on mentoring. Mainly between those who are experienced in networking and those who are not, for example the new EU countries. Institutions with experience could volunteer knowledge to the inexperienced. • Poland and Hungary do not have networks in women's health and would need assistance in building networks. This also may be true for other CEE [4] countries. • New countries need more information on how a network works, what the tasks of a network is, what a network can achieve. • The experience of ENCA [5] was discussed. How to initiate networking: starting with a launching congress, meeting persons by chance, finding a contact person for the issue in each country. • New countries should look at the legal background of a network in their own country. • The definition of a network needs to be clear, who's working on what issue, with what means. • Finding common interests through a structured network is important, especially in the new countries. • Roles of NGOs [6] in a network. NGOs can be part of a network and participate in projects. How should an NGO approach politicians in the decision making process. How can the decision be made to decide on the path of the way to go: methods and tips for lobbying.

	• Case example: Purpose of GFG[7] - working group for women's health, small organizations working together. They have a reputation for giving information and opinion. • Time is needed for networks to acheive their goals. • What are the possibilities for NGOs in the CEE region to enter Europe. • What are the possiblilities for different networks to work together. • Coordinating functions of the network, collect knowledge of NGOs regarding women's health and include this knowledge into the networks. • Poland has many NGOs, but not an NGO that works with general women's health. • Important to coordinate local networks and to meet at conferences. • What influence can CEE countries have on EU policy making in regard to women's health.
Suggestions:	• A database should be established- including contacts and optimizing flow of information. The network should structure the abundance of information and knowledge, have a central database, find resources for building the network. This would need central coordination with national contacts. • State future steps of the network. Define the needs of the network and give clear definitions on its goals. • A mentoring program should be established. • Build trust between individual persons and organization within the network, enhance personal contacts. • Enhance the role of NGOs as transferring body. • Develop a network that links different actors. • Spread information, proposals, grants, connect interests. • Develop a plan on how to optimize funding and spread this knowledge to members.

| | The network should enable its members to find the right partners for NGOs in other countries. EWHNET should define the aims, definitions, scope of interest it has with the new member countries. Define the issues covered in the network. Develop a plan on how CEE countries can participate in policy making. The network should be structured thematically and regionally. The network should join efforts of academics and NGOs. Tasks of the network should include: influencing politicians, enhance collaboration between researchers and NGOs, define activities and develop working groups. Joint application for funding, developing EU programs that include NGOs. The network should find projects which are supported by means other than the EU, for more independence from EU funding. |

Report Group 2
Empowerment of Women

Date and Time:	October 10th, 2004, 9.30-11.00 am
Topic:	**Empowerment of Women**
Convener:	Solvita Olsena, Latvia
Participants:	Margaret Reid, Daina Biezaite, Elisabeth Geisel, Marlena Skorupka, Małgorzata Kamińska, Katja Reimann, Solvita Olsena, Irena Fazarinc, Evi Batra, Fotini Sterigiopoulou, Maria Koutsogianni
Discussion and central recommendations:	To look for possibilities to introduce research projects which improve the quality of women's health and health care. To look for possibilities to organize further discussion on following issues: • Who are decision makers (male/female) in Health Care in the EU countries and in EU-institutions? • How to improve education about health knowledge: in school; in work place; education of educators; education of health care professionals; • How to increase awareness-raising among women about their bodies: from mother to daughter; using childbirth as an example/time to repeat importance of health; using ourselves as example; put this topic into curriculum of medical profession about understanding needs and rights of clients. • How to motivate women's groups to take decisions in their health • How to influence women/worker in health and how women can become policy makers. • How to empower health care professionals to put attention to their own health. • Education of educators is the field of empowerment of women. • Male and female – we are equal but not similar.

Report Group 3
Women's occupational health

Date and Time:	October 10th, 2004, 11.00 a.m.
Topic:	Women's occupational health
Convener:	Evi Batra, Greece
Participants:	Norma Greenwood, Birgit Babitsch, Birgit Pichler, Daina Biezaite, Vera Lasch, Csilla Csoboth
Discussion and central recommendations:	The group discussed main issues for a "healthy working life for women" as it is known today. Strategy: Produce a powerpoint presentation for wider distribution The products should be put on the EWHNET-Website

Report Group 4
Gender, Health and Ageing

Date and Time:	October 10th, 2004, 09.15 a.m.
Topic:	Gender, Health and Ageing
Convener:	Dr Vera Lasch, Germany
Participants:	Norma Greenwood, Csilla Csoboth, Birgit Babitsch, Gabriele Keutzner, Daina Biezaite, Angelika Wibbeler
Discussion and central recommendations:	The group discussed the focus of cooperation in the field of "gender, health and ageing" - Lifelong strategies to deal with age and lifelong strategies of combing resources and constrains are to be focused on - Role of pension systems, social networks strategies of generations and especially younger women's strategies in the filed of occupation and security in old age are to be mentioned. - The role and change in selfhelp-networks, their chance for quality aspects in older age is important

	- To focus on research in the different countries; it is important to face the differences. As there are between rich and poor countries, between rural and city areas, between men and women, between "social environments" and society systems. - The main focus should be on life course and quality of life - Change of view from old age as "problematic age" to "best time of life" - Thinking about changing concepts of age, capacities of different groups (like well political organized groups) - Role of spiritual "well being" - Quality of life dimensions should be identified - Defining and clarifying the points of interest at the beginning of research cooperation: clarification of population ... (what is old age), data basis relevant, meaning of health, differences in health regulations, future developments, relevance of women's working status und working periods. - Perhaps shaping and writing a book on these definitions and findings - Highlighting and clarifying the working basis for the group in defining
Points of interest	- The focus on life long strategies for quality of life and the "social environments" helping or taking strategies under risk - Promising strategies to enable persons to manage life in old age - The role of gender and gender relations in the field of interest
Strategic aim	- Exchange of promising strategies - Building new positions how to shape - Exchanging political strategies (and finding them) Meeting spring next year, partners will be organised in the meantime

Report Group 5
Excluded women

Date and Time:	October 10th, 2004, 11.15 a.m.
Topic:	Excluded women - special focus on immigrant women / victims of trafficking/ sexual diseases and mental disturbance
Convener:	Angelika Wibbler, Germany
Participants:	Fotini Sterigiopoulou, Maria Koutsogianni, Katja Reimann
Discussion and central recommendations:	The group discussed the situation in Greece. Visions: Free access to medical care for • Immigrant women • Victims of trafficking • Victims of forced prostitution Realms to collaborate with: • Terre des hommes • amnesty international • University of Osnabrueck / EQUAL-Project • marginal groups

References:

Cox, David W. (2005): Using Open Space Technology for School Improvement. http://www.clt.astate.edu/dwcox/ost_article_2.htm, Access Date: 7th of June 2005.

Stewart, Alan (2005): Open Space Technology. In: http://www.co-intelligence.org/P-Openspace.html, Access Date: 7th of June 2005.

Stewart, Alan (2005): Open Space Technology for conferences, meetings and workshops. http://www.openspaceworld.org/tmnfiles/OStewart.htm, Access Date: 7th of June 2005.

Witthaus, Udo (Ed.) (2000): Open Space: eine Methode zur Selbststeuerung von Lernprozessen in Großgruppen. Bielefeld, Bertelsmann.

Notes

1 The Open Space Technology (OST) is closely associated with the name Harrison Owen. But Owen himself rejects that it is *his* product and instead stresses the fact, "that the creation of OST has been a collaborative project involving perhaps thousands of people on four continents over a period of twelve years (Owen, 2001: preface). In Germany the use of the term 'Open Space Method' is preferred, since the term technology has quite a different meaning in German language. Whenever I refer to the *process* initiated through and structured by the Open Space Method I simply speak about *Open Space* or *Open Space meeting*.

2 Despite the fact that the method itself is the result of more than 20 years experience, following book gives an inside into the ways, institutions handle open space results, see: Witthaus (2000) or search the world wide web.

3 Workshop "Gender, Health and Ageing", 29.-30. April University of Kassel, Germany. Documentation: www.uni-kassel.de/iag-fg; Publication: Gertrud Backes, Vera Lasch and Katja Reimann (Ed.) (2006): Gender, Health and Ageing. European Perspectives on Life Course, Health Issues and Social Challenges, Wiesbaden: VS.

4 Central and Eastern European countries

5 ENCA: European Network of Childbirth Association

6 Non Government Organisation

7 GFG: Gesellschaft für Geburtsvorbereitung, Familienbildung und Frauengesundheit e.V.

Identifying and Applying Gender Aspects in Health

Gender-Based Analysis: Concepts and Importance

Judith Fuchs & Birgit Babitsch

It is evident that sex and gender play an important role for health and health behavior. A large body of scientific results demonstrates differences between women and men regarding living conditions and their contribution to health, the onset and development of diseases as well as health care utilization. Nevertheless, there are plenty of aspects still not sufficiently explored and gender-neutral research – which mostly means male-oriented research – can often be found. That is one reason why Gender-Based Analysis (GBA) is relevant not only today but also in the future.

What is Gender-Based Analysis?

The aim of Gender-Based Analysis is to support and improve gender equality. There are different approaches within this concept. One string focuses mainly on government policy and programs and has its roots in the discussions on "women/gender and development". This approach is also called Gender Mainstreaming. Since the Fourth World Conference on Women in Peking all member states have the obligation to implement Gender Mainstreaming as a political strategy in their countries. The number of activities and their effect on maintaining consolidating gender equality differ among countries – but it can be stated that progress has been made, although gender equity has not yet been achieved.

Figure 1 shows the steps which the Canadian Gender-Based Analysis guide (Status of Women Canada, 1998) suggests should be done to get gender into policy. This guide proposes eight steps that can be followed sequentially, and/or revisited with the emergence of new information or perspectives:

Figure 1. The policy/analysis circle

1. Identifying the Issue

2. Defining Outcomes

3. Defining Inputs

8. Assessing Quality

7. Communication

4. Research

5. Developing Options

6. Recommending,
Seeking Decisions
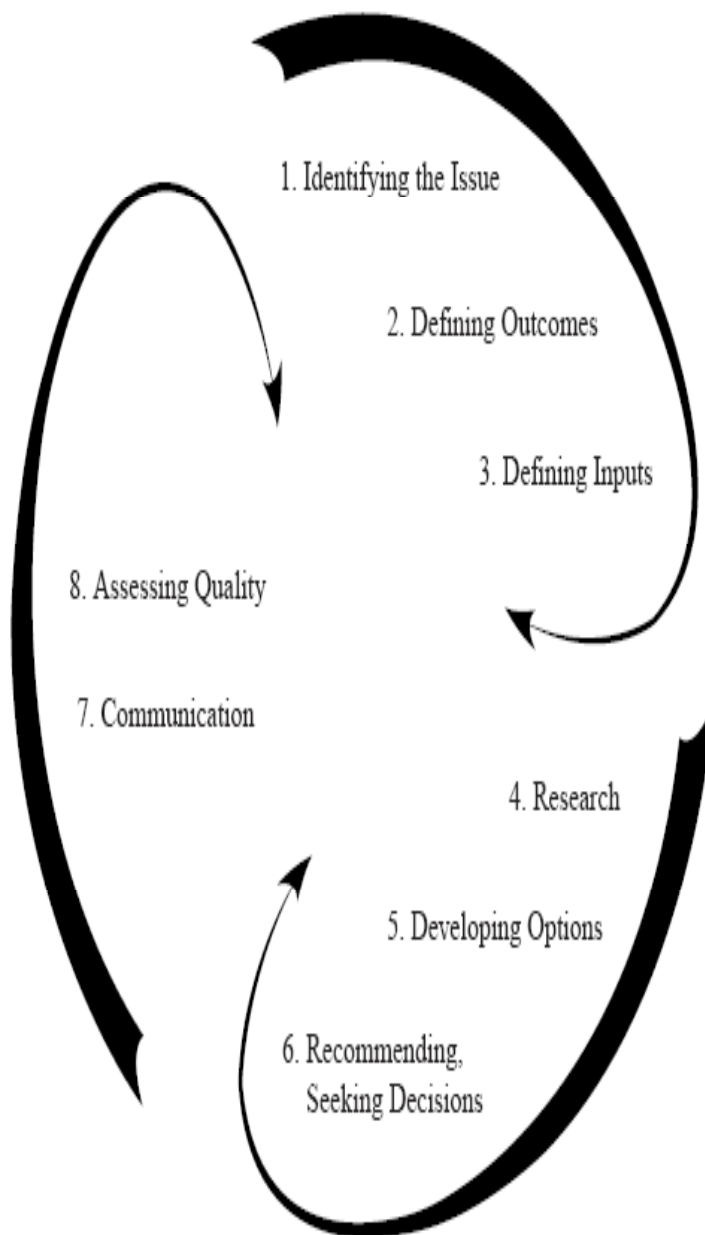
Source: Status of Women Canada (1998): 8

The other string describes GBA more in the meaning of a "gender tool" with which gender analysis of research activities and practice can be performed. In this definition, it is only a part of the broader concept which helps to detect gender bias and to establish gender-sensitive research or practice.

Both concepts aim to maintain gender equity and to assess the (possible) different impacts of the reviewed policy, programs or research on women and men. Therefore, it is necessary to integrate the gender perspective systematically in all phases of the policy, practice or research process. A gender-neutral position should only be adopted when it has been proved that no gender differences exist. If this is not the case, the more or less simple task is to differentiate between women and men and to ask questions with respect to possible gender effects, such as 'Does this program affect women or men predominantly?' or 'Does it promote or prevent gender equality?'. We know that this job is in reality one of the most difficult and there is a high reluctance to do it.

The exclusion of sex and gender as variables in any type of health research is a serious omission that leads to problems of validity and generalizability, weaker clinical practice and less appropriate health care delivery (Greaves et al., 1999).

Health Canada started in the early nineties to develop a practical guide how to avoid gender bias in research and policy, based on the work of Eichler (1991).

The following chapter focuses on the second interpretation on GBA as an analytical tool which provides the basis to identify and clarify differences between women and men and their consequences for health (Source: http://www.hc-sc.gc.ca/hl-vs/women-femmes/gender-sexe/index_e.html). A primarily science-focused approach of GBA was given by Eichler (1991, Eichler et al. 1999). On the basis of an intense discussion of the feminist methodology Eichler developed a non-sexist research method. She clarified the concepts of sexism and discovered different types of gender bias:

- "androcentricity": the adoption of a male perspective. Forms are the exclusion or underrepresentation of females, overgeneralisation or taking males as the norm against which females are assessed.
- "gender insensitivity": ignoring sex and gender as a socially important factor.
- "double standard": treating or evaluating substantively identical situations differently on the basis of sex.

The aim of this non-sexist research method is to overcome existing gender bias (sexism) and to perform gender-sensitive research. Gender-sensitivity is an important aspect not only to enhance scientific quality but also to reduce gender biases in policy development and program planning. The exclusion of sex and gender as variables in any type of health research is a serious omission that leads to problems of validity and generalizability,

weaker clinical practice and less appropriate health care delivery (Greaves et al., 1999 in: Women's Health Bureau 2003). If research/researchers ignore/s gender differences, the results may suffer from significant shortcomings as well as perpetuate gender biases.

The different forms of gender bias can be found in all phases of the research process. On the basis of a questionnaire it is possible to detect gender bias in each stage of the research process (see table 1).

Table 1: Questionnaire to detect gender bias in the research process

Formulate Research Questions	Does the research question exclude one sex when the conclusions are meant to be applicable to both sexes? If yes, reformulate the question so that it is applicable to both sexes or so that it is applicable to only one sex.
	Does the research question exclude one sex in areas that are usually seen as particularly relevant to the other, such as family and reproductive issues in research about men or paid work in research about women? If yes, give attention to the role of the other sex.
	Does the research question take the male as the norm for both sexes, thereby restricting the range of possible answers? If yes, reformulate the question to allow for the theoretically possible range.
	Does the research question take the family or household as the basic analytical unit when different consequences for women and men within the family or household can be anticipated? If yes, change the question so that the unit of analysis corresponds to the level at which observations are made.
	Is the research question different for the two sexes though their circumstances are equivalent? If yes, reformulate the question.
	Does the research question assume that men and women are homogeneous groups when the impact of the health issues being studied may be different for different groups of men and women? If yes, explore differences among the men and among the women, not just those between the men and the women.
	Does the research question construct men as actors and women as acted upon? If yes, explore the role of women as actors and of men as acted upon.

Literature Review	Does the phenomenon under consideration affect both sexes? If so, does the literature give adequate attention to each sex? If no, note the under-represented or excluded sex.
	Have studies concerning family roles and reproduction given adequate attention to the role of men? In all other studies in the literature being reviewed, has the role of women been given adequate attention? Are different types of families taken into account? If no, compensatory studies on the under-represented or excluded sex may be necessary before drawing conclusions.
	Does the literature address issues of diversity among women and men? If no, note the exclusions and limits of the literature.
Research Design	If the phenomenon under investigation affects both sexes, does the research design adequately represent both sexes? If no, include the under-represented or excluded sex. If the balance of previous research has largely excluded one sex, a one-sex study may be highly appropriate.
	Of the major variables examined in the study, are they equally relevant to men and women? To women and men from a variety of diverse groups? Is the diversity within subgroups identified and analyzed? If no, correct the imbalances by including variables that affect the under-represented group.
	Does the study take into account the potentially different life situations of men and women? If no, explore the context in a gender-sensitive manner.
	When dealing with issues that affect families or household, is it possible that the event, issue, attribute, behaviour, experience or trait may be different for different family members. If yes, identify and study separately individual actors with a view for potential gender differences. This may involve a drastic revision of the research design.
	Is the same research focus, method or approach used for both females and males? If not, is the different focus, method or approach justified? If no, provide a detailed rationale.
	Is the sex of all participants in the study, including researchers and research staff, reported and controlled for? If no, report and control where possible and necessary. Where not possible, acknowledge and discuss the potential distorting effects of the sex of the various research participants.

Research Methods and Data Gathering	Has the research instrument been validated on diverse groups of both sexes? If different instruments are used without compelling reasons, develop an instrument that is applicable to both sexes and to diverse groups of both sexes. If different instruments are necessary, justify their use in detail.
	Does the research instrument take one sex (race, class, etc.) as the norm for both sexes and thus restrict the range of possible answers? If yes, reformulate the instrument to allow for the theoretically possible range.
	Are opinions asked of one sex about the other treated as fact rather than opinion? If yes, reinterpret other-sex opinions as statements of opinion and no more.
	Are the same coding procedures used for males and females? If no, make coding procedures identical.
Data Analysis and Interpretation	If only one sex is being considered, are conclusions nevertheless drawn in general terms? If yes, make conclusions sexspecific where only one sex is considered, or change the research design and consider both sexes.
	Are data interpreted by taking males as the norm? If yes, take females as the norm and compare the two.
	Are practices that abuse or subjugate women or negate their human rights presented as culturally appropriate or justified in the name of a supposedly higher value? If yes, describe and analyze such practices but do not excuse or justify them.
	Does the analysis pathologize normal female biological processes or normalize male biological processes? If yes, create alternative accounts.
	Have the potentially different implications for the two sexes of the particular situation, condition or event under investigation been made explicit? If not, make them explicit.
	Are gender roles or identities presented in absolute terms? Are stereotypes perpetuated? If yes, acknowledge gender roles and identities as socially important and historically grown, but make it clear that they are neither necessary, natural nor normatively desirable.
	When both sexes are included, is equal attention given to female and male responses? If no, create the appropriate balance.
Language of Research Reporting and Research Proposals	When both sexes are mentioned together in a phrase, does one sex consistently precede the other? If yes, alternate in some manner.
	Are any gender-specific terms used for generic purposes? If yes, use generic terms when referring to both sexes.
	Are any generic terms used for genderspecific situations? If yes, use sex-specific terms when referring to one sex.

Visual Representations	Are men and women appropriately represented, given their relative importance with respect to the topic under study (e.g. significance of the problem for each sex, proportion of the population of each affected by the problem)? If no, correct the imbalance by fairly representing the excluded or under-represented sex.
	Are females and males depicted in stereotypical ways? If yes, eliminate the stereotypical representation and replace with a more realistic one.
	Are men and women depicted in ways that represent their diversity (e.g. images of visible minorities, of people with disabilities, of gay and lesbian couples)? If no, incorporate these and other facets of diversity into the images.

Source: Women's Health Bureau, Health Canada, June 2003

The questions listed above can be helpful to detect gender bias in each step of the research process, but they should not be used as a 'cooking recipe', as not all points fit to all research or policy. It gives a very precise overview what problems may emerge by excluding gender and hereby supports research of good quality and validity.

We used these questions in teaching and lectures. The reactions were always very positive; it seems that only going through the questions and demonstrating examples lead to a higher sensitivity for gender issues. It can be used as a tool for own research as well as for analyzing other results and policy strategies.

Studies about GBA

Different studies examined whether gender bias exists in medicine and public health. All results indicate that women and men are not equally treated in research and all forms of sexism can be found in the phases of the research process. Studies regarding allergies and social inequality and health show that gender bias is a very common feature in these fields (Bolte, 2000; Babitsch, 2005). The results show that a sex stratification of the results is very common but the integration of gender is still missing.

A systematic analysis using GBA tools was conducted for the public health field in Germany within the research project Gender Bias – Gender Research, sponsored by the Germany Ministry for Education and Research (Maschewsky-Schneider & Fuchs, 2003).

Aims of the project were the evaluation of the status of research on gender and health in Germany in order to identify gaps in research and knowledge and to reflect and discuss recent research in view to the im-

provement of prevention, health promotion, and health care for women and to develop guidelines for gender-sensitive public health research.

Within the project, we sent a questionnaire to the leaders of current and terminated public health projects (N = 317) in Germany asking for the inclusion of gender issues into research. The analysis focused on what the projects did and what they think should be done concerning the inclusion of gender issues in Public Health research. The results show that the participants of this survey (N= 186) are interested in doing gender-sensitive research and show a rising awareness of seeing the importance of including gender in Public Health research in general. Women and men are both willing to carry out gender-sensitive research, but women included in this survey show more sensitivity for gender issues than men. In the participants' opinion special efforts should be made with respect to research questions, design, and conclusions.

Figure 2: Percentage of articles including gender in selected elements of the publication
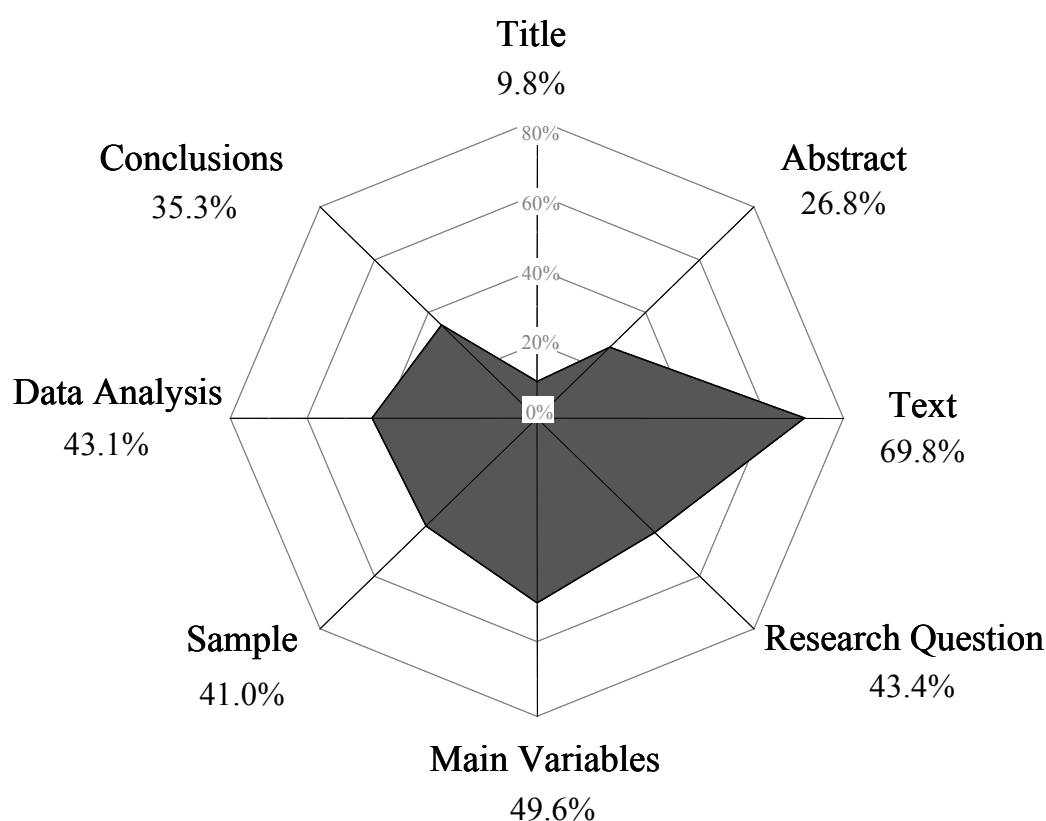
Source: Results of the review of German-Language Public Health Journals (Fuchs & Maschewsky-Schneider, 2002)

In a second part of the project, a standardized rating form for a review regarding the consideration of Gender based on Eichler's work was developed. The data basis for the review was 516 articles in German-language public health-journals of the years 1990, 1995, and 1999. With this rating form we were able to describe the percentage of articles which included sex and gender in different elements of the publications (see figure 2). All in all, the main part of the reviewed articles included both sexes, but did not make it obvious neither in title nor in the abstract. In the articles dealing with both sexes in the research question, in the majority gender issues were not mentioned. Only half of the authors considered different life conditions of women and men in the main/key variables. The following figure shows the main results and demonstrates the level of gender awareness in publications.

As a result of both survey and review we specified three different areas, where gender bias might occur: on the formal, the methodological and the substantial area (see figure 3). Depending on the area different strategies to avoid gender bias are necessary.

- **Formal area**: Here it seems easy to include gender: Guidelines from journals could demand the nomination of gender in title or abstract, otherwise articles can not be published. By this means researchers are obliged to include this information and recipients are able to decide whether a publication could be helpful for own work or not.
- **Methodological area**: this is a longer and more complicated way but based on a tool like GBA scientific associations should include these issues in their guidelines for good scientific practice.
- **Substantial area**: researchers can develop a long-term sense of gender based on published gender-sensitive results and on demands of good quality of research, supported by handbooks and advanced training which leads to the overall inclusion of gender issues.

As a result of the work in the Gender Bias project a couple of recommendations were published in different journals and discussed in workshops and congresses. Central recommendations of our work are more consideration of gender from the German granting agencies careful attention of gender in work and publications by the researchers themselves checking the inclusions of gender issues in all reports and publications by the recipients of research.

Figure 3. Different areas where gender bias might occur

Substantial area

- formulation of hypotheses
- discussion of literature
- interpretation of results
- conclusions

Methodological area
- drawing of the sample
- description of the sample
- data analysis

Formal area: Language in
- title
- abstract
- text
- diagrams, etc.
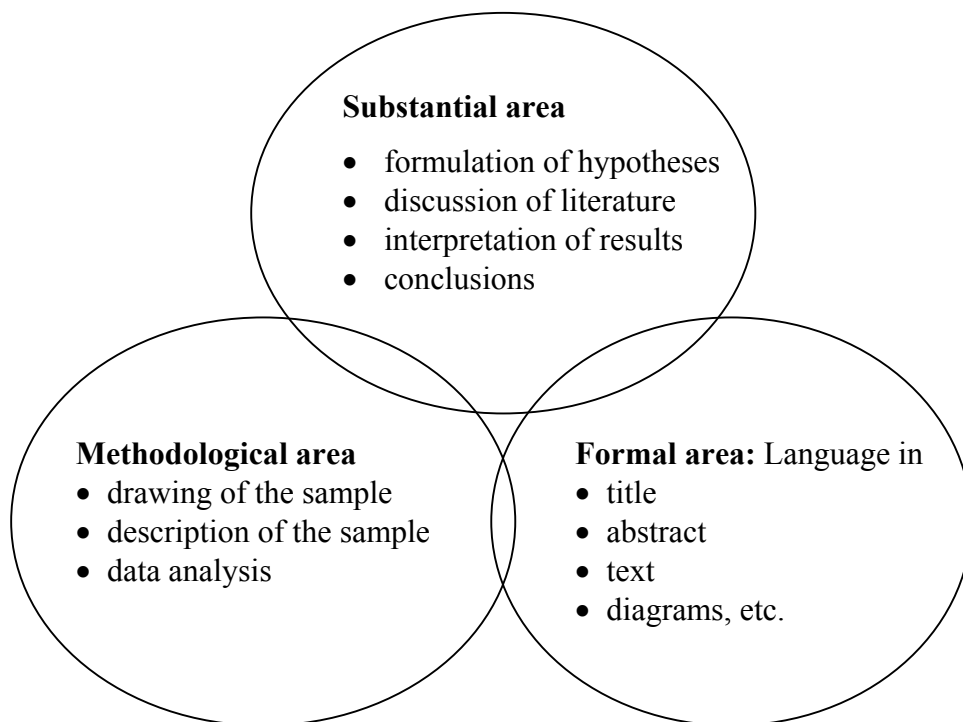
Results of the survey and the review of literature were presented and discussed in international contexts 2001 at the international workshop 'Gender Based Analysis (GBA) in Public Health Research, Policy and Practice' in Berlin and 2002 on the workshop 'Women in Science' held by the German-Israeli Co-operation in Science and Technology in Bonn and on the expert-group workshop 'Gender Exclusions from Medical Research' in London. All experts appreciated these results as a basic principle for the inclusion of gender issues in policy and research.

Perspectives

Gender-Based Analysis is an important tool to assess gender sensitivity of projects and research. Study results show for Germany and other countries that in medicine and public health a wide range of gender-blindness as well as gender bias exist. The studies also show that on the scientific level further developments are needed to improve the methodological approaches of GBA.

The results of GBA make strikingly visible how important it is to differentiate between women and men and what will happen if it is not made. GBA guarantees that sex and gender are key variables in the research process, gender is not regarded as an exclusive variable but rather as a complex

construct which influences and is influenced by other social differentiations, contextual information will be integrated, research results becomes more exact owing to the awareness of the reference groups, and gender-blindness and gender bias can be recognized and eliminated.

The reduction of gender bias is an inherent goal of research and an important precondition for gender equality. Only research results which are gender appropriate guarantee the quality which we need in science and in practice. The first steps have been taken, but there is a lot to do in the future to ensure that sex and gender are key variables in all fields of activity.

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A Healthy Balance: Applied Research on Women's Paid Work and Unpaid Caregiving in Nova Scotia, Canada

Brigitte Neumann

The Healthy Balance Research Program (HBRP) has the goal of improving our understanding of the relationships between women's paid work and unpaid caregiving, empowerment and health status for the purpose of improving both policy and programs to support caregivers. The program is funded by the Canadian Institutes for Health Research, as a "Community Alliance for Health Research" (CAHR). The goal of the latter is to bring together community, government and researchers in order to ensure that research is well informed by community perspectives and capable of "translation" into practical application.

This paper will describe the partnerships within which the research is conducted; that is, the collaborative relationships between academic, government and community partners within which this CAHR operates. The research projects conducted to date will be described, and the potential policy impacts various avenues for dissemination to policy audiences discussed. These policy audiences include officials responsible for the design and administration of health programs related to caregiving, elected officials at both provincial and federal levels of government, community advocates for caregivers and women's groups.

Location of the Program

The research program is located in the province of Nova Scotia, Canada. Nova Scotia is one of Canada's smaller provinces, both geographically and in terms of population. Located on the Atlantic coast, the province has a population of about 938,000.

Halifax is the largest centre, with a population of 380,000, followed by Cape Breton Regional Municipality at 106,000. About half the population, then, lives in small towns, villages and rural areas of the province. This translates into differences in the context in which health and social services are delivered. The relatively high proportion of rural population requires appropriate modifications of health and social service delivery to address the realities of rural life. Among the challenges faced are those related to transportation of either care provider or care recipient; reduced availability of specialized health and community services; difficulties in keeping those

in need of care in their communities; and, sometimes, few resources in the community itself.

Nova Scotia has an aging population, with 12.3% of men and 15.8% of women aged over 65. Among persons aged 85 years and older, 71% are women. Fertility rates have undergone a long-term decline, from 4.1 at the height of the baby boom in 1961, to approximately 1.48 in 2003. The province of Nova Scotia also has a higher proportion of persons with disabilities than Canada as a whole: 20.1% of Nova Scotians reported a disability compared to 14.6% at the national level (Nova Scotia Department of Finance Economics and Statistics Division 2005).

The Paid and Unpaid Work of Women: An Overview

McFadyen (2004) reports available statistics on women's paid and unpaid work in the province of Nova Scotia, and Coleman (2003) discusses the total workload of women in the paid labour force in the Atlantic region. An overview of women's work and workload is available in the above publications, primarily based on Statistics Canada sources. Some basic facts about women's work in Nova Scotia follow.

The paid labour force participation of women has increased dramatically in the past generation, from 35,9% in 1976 to 53,2% in 2003. In 2003, women made up 47,3% of the labour force of the province. The dual-earner family has become the norm, with only 16% of couple families having the male partner as the sole provider.

Mothers with children under 3 years of age have shown the steepest increases in employment rates: currently, 66% of women with children under 3 are employed, compared to only 25% in 1976. At the same time, the availability and affordability of licensed child care spaces remains a problem for many families, who rely on other family members or informal, unlicensed arrangements for the care of the children.

As the population ages, it can be expected that the family caregiving responsibilities for frail seniors will also increase. McFadyen (2004: 44) illustrates that about 1 in 5 Nova Scotian women provide some unpaid care to seniors and 15% of men do so. Of the female caregivers, 22% spend more than 10 hours per week in this activity, while 15% of men do so. Beyond these very elementary data, however, we had very little more detail. We did not know, before undertaking this project, how many of the caregivers for elders also had children to look after, and how this interacted with work responsibilities. Recognizing the positive aspects of both paid work and unpaid caregiving, we asked ourselves at what point the total

hours of work became difficult for various categories of caregivers: were women more or less stressed when they had child care and paid work? How does elder care affect stress levels? How does paid employment combined with elder care make an impact? These are questions still being addressed by the ongoing research program, and some of the results will be discussed later in this paper. Gaining a better understanding of the prevalence, intensity and duration of various caregiving activities was a driving force behind the Healthy Balance Research Program.

"Total work hours" include work in the paid labour force plus the work of caring for children, housework and care for adults requiring assistance because of age or disability. The latter group is, of course, growing quickly as the population ages, as noted above. Canada has a number of data sources to measure total work hours. Since 1996, the Canadian Census asks 3 questions about unpaid work: unpaid hours spent in childcare, unpaid hours spent on housework and unpaid hours spent in elder care. Time use surveys are also conducted periodically. While these yield more comprehensive data, their use for small provinces such as Nova Scotia is limited because sample sizes are too small to allow detailed analysis. Nevertheless, Coleman (2003: 66) notes that the time use survey for 1998 yielded an average of 50 total work hours for women in Nova Scotia, compared to 47 total work hours for men. These averages would, of course, vary considerably for women and men with child care responsibilities and for those who care for disabled or frail adults, perhaps in addition to child care.

During the 90s, the data show an increase in total work hours for women, and a concomitant increase in various forms of stress. Coleman (2003: 24-25) notes that employed single mothers in particular experience high time-stress, averaging 75 working hours per week. He raises the question of whether the income gain due to paid work, which would be expected to increase positive health outcomes, is not counterbalanced by the high stress level involved in increasing women's paid work hours.

It is of great importance to gain a better understanding of the health impacts of caregiving work, work traditionally performed by women. The demands for such work are increasing as our population ages, and effective policy and program interventions should be based on a clearer understanding of the prevalence and impacts of this work. It is to this end that the Healthy Balance Research Program was established – not to suggest that women face an either/or choice between the work of caring and paid work, but to find better policy and program initiatives to enable a balance between the two work arenas.

The Healthy Balance Partnerships

The Healthy Balance Research Program (HBRP) was designed to provide a more comprehensive picture of women's caregiving roles in Nova Scotia. Originally, two organizations, the Advisory Council on the Status of Women (NSACSW), a provincial government agency, and the Atlantic Centre of Excellence on Women's Health (ACEWH) at Dalhousie University joined forces to propose a multifaceted research program to address the topic. With funding from the Canadian Institutes for Health Research, the partnership was elaborated to include some 20 researchers. One of the program co-directors has since taken on a new role as Chair of Women's Health Research at the University of Ottawa, building an ongoing relationship with the Women's Health Research Unit at that University.

> "The NSACSW was established by legislation, namely, the Advisory Council on the Status of Women Act. That Act specifies the agency's mandate: it is to advise government and to bring forward the concerns of women. Established in 1977, the Council consists of 12 women appointed by the provincial Minister responsible for the Status of Women, with a staff complement of 8 full-time equivalents. The mission of the Council is to advance equality, fairness and dignity for all women. Strategic goals of the Council are as follows: inclusion and participation of women in the decisions that affect them, with particular attention to historically disadvantaged groups; economic equality; personal safety and freedom from violence; and improved health and well-being. The core functions of the agency include policy and research, information and education, and community liaison and outreach." (NSACSW 2005)

The Atlantic Centre of Excellence for Women's Health is one of four such Centres in Canada. The goal of the Atlantic Centre is to support research, influence policy and promote action on the social factors that affect women's health and well-being over their lifespan. The Centre's fundamental values include respect for women's perspectives and experiences and the research programs seek out and listen to the voices of women not typically heard in health research or health systems. (ACEWH 2005) For example, the Centre has undertaken research to foster social inclusion of women marginalized through factors such as poverty and racism. Their current work includes a focus on single mothers, on women and HIV/AIDS, and, of course, the situation of caregivers.

Affiliated with Dalhousie University, the Atlantic Centre of Excellence for Women's Health is able to bring academic strength to the project, as does the Women's Health Research Unit at the University of Ottawa. The Advisory Council on the Status of Women brings its own research capac-

ity, linkages to diverse communities, and policy contacts, particularly in the provincial jurisdiction.

Through the Women's Health Research Chair at the University of Ottawa, new relationships with stakeholders in the federal jurisdiction, such as Social Development Canada, can be developed. Because many policy sectors relevant to caregiving, such as tax policy, health policy, and labour standards have areas of either or both provincial and federal jurisdiction, it is important to develop knowledge translation strategies for both orders of government in order to maximize the likelihood that the research will in fact be useful in informing the relevant policy debates.

Shared values on the importance of women's health from the perspective of diversity and inclusion underlie the partnership. With this principle of inclusion and participation in mind, the Healthy Balance Research Program includes groups of women from aboriginal, immigrant, disability and African Nova Scotian communities. These so-called Equity Reference Groups and their functions are described below.

Equity Reference Groups

The purpose of the HBRP was practical from its inception: all participants wanted to conduct "research that makes a difference", that would link readily to the world of policy makers, and that would include community as well. Because much research overlooks marginalized populations, four Equity Reference Groups (ERGs) were developed to advise on all aspects of the research, to ensure the cultural appropriateness of the work, and to take part in eventual dissemination of the work. The groups involved were women from the African Nova Scotian community, Aboriginal community, immigrants and women with disabilities.

Nova Scotians of African ancestry have a long history in the province, arriving among the earliest settlers. Their history is distinguished by the survival of vibrant communities, traditionally centred on the church, in spite of the scourge of racism and historical exclusion from educational and economic opportunity in particular.

The First Nations people of Nova Scotia, the Mi'kmaq, too have a long history of oppression and exclusion. Furthermore, access to services of all kinds is conditioned by the complex jurisdictional arrangements brought about by the Indian Act.

Nova Scotia has proportionally fewer newcomers than many other provinces and the large urban centres of Toronto, Montreal and Vancouver. Within the past year, however, Nova Scotia has begun implementation of

an immigration strategy, to attract and retain more immigrants to the province. Immigrant women can find themselves isolated and poorly informed about service options of all kinds, particularly in caregiving roles, experiencing difficulty in access to services due to language and cultural differences.

Finally, women with disabilities face a very high vulnerability to poverty. Their roles as mothers and as caregivers to other family members are often not considered, and this research program intended from its inception to include their perspectives.

Since the program's inception, ERGs have met about twice a year, initially to advise on the research agenda, and then to hear about progress. As more results become available, the ERGs will be engaged in helping to bring information back to their communities, and to make their own contacts with policy and decision-makers about needs for caregiver support in their communities. The ERGs have been and continue to be integral to the research, having enriched the process throughout—they helped to structure the research questions, to interpret results of both qualitative and quantitative work, to identify shortcomings of existing approaches and to identify dissemination opportunities in the future.

Other Partnerships

A National Reference Group was established, with the intention of meeting annually to review progress, make recommendations for further work and to communicate results. While sessions held were positively received, this has been less successful, primarily because the time frame over which the research was conducted was lengthy. Nevertheless, as a stream of research results is now becoming available, it will be useful to reconvene the group for information exchange and feedback, future direction and discussion of knowledge translation opportunities.

Finally, the Healthy Balance Research Program has the goal of building research capacity, and thus has supported a number of graduate students and one post-doctoral fellow in their work. Students have completed theses on a variety of topics, including caregiving for persons with Alzheimer's disease; case histories of policy change in home care; children's experiences of caring for parents with multiple sclerosis; self-managed care; and utilization of the home care system.

The Research Projects and Research Teams

The successful research proposal was designed with the following questions in mind:

- What is the prevalence of different kinds of unpaid caregiving in Nova Scotia? How are different kinds of caregiving shared between women and men?
- What unpaid caregiving situations, on their own or combined with paid work, are associated with positive or negative health status? How does empowerment act as an intervening variable?
- How do social determinants of health interact with paid work, caregiving, unpaid work and health status? Race, culture and ethnicity; rural and urban location; income; age of the caregiver; type of occupation and employment status; family composition and status; formal and informal assistance and support were of concern.
- How helpful are current policies and programs that address paid work and family life? How could they be improved?

The proposal recognized that both qualitative and quantitative research projects were needed to address these questions. Qualitative research is essential to provide an in-depth understanding of the realities of caregivers' lives. Quantitative research is needed to answer questions about the prevalence, intensity and duration of caregiving in the population as a whole. By considering the findings of quantitative and qualitative approaches jointly, better interpretation of survey and secondary data analyses can occur, with higher relevance to policy and program design. Tashakkori and Teddlie (2003) provide in-depth discussion of such approaches.

A first step in the research process was to develop some common approaches to the research questions. To this end, leading theorists on care, Pat and Hugh Armstrong (2001) were engaged to prepare a synthesis paper on the issues related to women's caregiving work.

Armstrong and Armstrong (2001) produced "Thinking It Through: Women, Work and Caring in the New Millennium" as an analysis of the Canadian and international literature to extract guidelines for understanding women's caring roles.

The authors affirmed the need to look not only at the common factors affecting women in caregiving roles, but also the importance of looking at the socially structured differences among women: the intersections of gender with race, class, income and ability, *inter alia.* Secondly, the authors emphasized the critical role of the state in determining private and public responsibilities, the need for careful scrutiny of market mechanisms in rela-

tion to women's caring roles, and the effect of state action on communities. Both time and money are involved in the costs of caring and both need to be addressed in formulating caregiver policy. Power, in the sense of access to resources, should be explored, to find ways of enhancing the control that women have in providing and receiving care. Of critical importance is the position that we should recognize care as a social objective, not as a social problem. Care must be understood as a relationship, not just a series of tasks.

Interestingly, there are a variety of definitions and perspectives on caregiving among the researchers participating in this program. Some, like the Armstrongs, operate in the feminist tradition of Marilyn Waring's (1988, 1999) analysis of women's unpaid work, and define unpaid caregiving as all work that involves helping someone else who is unable to perform the task in question herself or himself. Thus, childcare would, for example, be included in the definition of caregiving. Others, especially those with a background in gerontology, prefer to think of caregiving as work being done for elderly people or people with chronic disabilities. After extensive discussion, and review of focus group results, the consensus was reached to focus our work on unpaid caregiving of persons of any age with disabilities, and on unpaid caregiving of seniors. At the same time, to provide the wider context, analysis of secondary data included attention to the effects of parenting on both mothers and fathers. Furthermore, in order to arrive at a deepened understanding of caregiving based on the voices of caregivers themselves, the decision was reached to do extensive qualitative work, using both focus group and ethnographic approaches. The results of this work are described later in this paper.

A second commissioned paper, Shillington (2004) presents an examination of the tax and transfer systems in place in Canada's federal jurisdiction. Numerous tax measures, the pension system and social support programs are inventoried, with costs identified. This work was undertaken in response to the fourth of the research questions; namely, what existing measures were in place, how well they function in meeting the needs of caregivers, at what cost to the public treasury.

Shillington identifies three policy paradigms operating within the tax and transfer system, with different assumptions about beneficiaries and entitlements: the social support paradigm; the social insurance paradigm; and the taxation paradigm.

The social support system refers to assistance provided through direct government spending. It aims to assist those "most in need", necessitating bureaucratic structures to determine eligibility through means tests and on-

going monitoring of income and assets. An important Canadian example is the Old Age Security System, which provides up to $5,757.58 per annum to persons aged 65 years and older. For those whose total annual income is very low, less than $10,000, the Guaranteed Income Supplement (GIS) is available to raise incomes to a maximum of $13,704 per year. Interestingly, Poon (2005) demonstrates that in 2000, only 50% of eligible 66-69 year old seniors applied for the Guaranteed Income Supplement, and only 24% eligible in the 80+ age category did so. Shillington noted an additional problem arising from the fact that reduction rates of the benefit are high, and that benefits related to receipt of the GIS disappear rapidly with income increases. This matter is important to caregivers who, because they frequently have very limited income because they cannot work in the paid labour force, may be over-represented in the population eligible for GIS. Unlike certain European countries and Australia, for example, there is no allowance for caregivers in Canada at this time, and family caregivers are not eligible for payments that would be made to professional care providers.

The second paradigm Shillington identifies refers to social insurance, where the underlying principle is that people get payouts depending on contributions in the form of premiums paid. Canada's social insurance system has two main programs: Employment Insurance and the Canada Pension Plan. Both programs depend on contributions made during employment. Employment Insurance is the system used to provide maternity and parental benefits, with almost half of Canadian mothers not eligible because they have not worked sufficient hours to qualify, or because they are self-employed and thus not eligible for Employment Insurance. The Canada Pension Plan allows for a "child-rearing dropout" enabling a more favourable calculation of benefits. Nevertheless, Shillington demonstrates the disadvantaged situation of women: in 2003, the average monthly retirement benefit paid to men was $519, with women receiving $312, about 60% of that paid to men.

The third policy paradigm Shillington describes occurs within the tax system, where there are numerous and complex measures that can support caregiving. The assumption underlying tax concessions is that these are a matter of entitlement and fairness, in sharp contrast to the social support paradigm, which has implicit notions of charity as an underpinning. A major problem is that many tax credits available to support caregivers are nonrefundable. That is, if the person's taxable income is low, the credit is of no benefit to them. One consequence of non-refundability of the existing Caregiver Tax Credit is that only 39% of claimants were female, although we know that caregiving is a predominantly female activity. As Shillington

(2004:59) notes, "ultimately, about 50.000 males receive full value for this credit compared to 32.000 females; a biased sample of those caring for relatives".

Both papers commissioned by the HBRP provide a point of departure for further work. The positions proposed by Armstrong and Armstrong (2001) have provided guidance throughout the research, ensuring a common stance toward caregiving among all research teams, in particular fostering the position that caregiving is not just the performance of tasks, but the maintenance of a relationship. Shillington's work provides some of the basic information needed for the policy component of the program: recommendations for caregiver compensation and support will have a financial component and an understanding of present measures, their benefits and their shortcomings is essential.

In addition to commissioning papers, the program developed four research teams to conduct the four projects initially envisaged.

First, a team to conduct focus groups with caregivers throughout the province was established, under the leadership of Dr. Jacqueline Gahagan of Dalhousie University. The purpose of this qualitative research was to enhance understanding of what participants understand by "caregiving"; and how caregiving affects paid work, family responsibilities, and health and well-being.

A second team, led by Professor Shelley Phipps of Dalhousie's Department of Economics, was recruited to undertake secondary analysis of existing data. Review of available data sources for Nova Scotia had very limited results. Because of the small population size, surveys done at a national level usually do not include sufficient sample size for analysis of a small jurisdiction. However, the General Social Survey carried out by Statistics Canada was used to investigate the prevalence of different types of caregiving at the national level, differences between women and men in the time devoted to caregiving, and what impact this had on self-reported stress.

The third research team was charged with conducting detailed case studies of individual caregiving situations, to construct what was originally called "family portraits". Dr. Brenda Beagan of Dalhousie University was charged with the leadership of this project.

Finally, a survey team was developed with the intention of using results of focus group information to ask representative samples of Nova Scotians about their participation in caregiving and the health consequences thereof. Professor Janice Keefe, Canada Research Chair in Aging and Caregiving at

Mount Saint Vincent University, leads the survey team. The planned survey would remedy the problem of limited sample size for the province of Nova Scotia in national surveys.

Qualitative Research: The Focus Groups

Gahagan et al. (2004) report the results of 18 focus group sessions held with 107 participants. Respondents were evenly divided among urban, small-town and rural environments. The mean age was 45.6 years, with a range from 17 to 85. Ethnicity included 16 persons of African descent, 15 Aboriginal persons, 13 immigrants, 49 persons of European descent, and 14 "other". Twenty-three participants reported that they themselves lived with a disability. The length of time participants reported being caregivers ranged from less than one year to 71 years, with a mean of 10.7 years. The modal family income was under $20,000, for 49% of participants, with 14% reporting incomes of $40,000 or more. Only 27% of respondents worked full-time outside the home, 19% worked part-time and 54% were not employed. The family situations of these caregivers were very varied: some were single mothers caring for children with or without disabilities; some were spouses of care recipients; some were adult children caring for a parent; some were grandparents caring for a child, and some were grandchildren caring for a grandparent.

Respondents generously shared their experiences as caregivers, the problems this entailed, as well as the rewards they gained. The relational nature of caregiving was richly illustrated, with reference not only to the relationship with the care receiver, but also with other family members, with friends and with care providers and professionals in the formal health and social services system. In other words, caregiving is not only a series of tasks, but, expanding on the point made by Armstrong and Armstrong (2001), caregiving entails the development and maintenance of a web of relationships not only with the care recipient, but also with many significant others in their social world.

Being female was an important factor in taking on the caregiving role for many respondents, in particular if womanhood was combined with any training as a health care provider. In the latter case, women reported that their previous training whether as a nurse or as a personal care worker, while providing them with necessary skills, also resulted in higher expectations from other family members and the care recipient. As well, the professional boundaries that characterize the professional relationship are absent when the care recipient is a family member. As one respondent put it,

"(…) the more attached you are to the person, the more you tend to devote or commit. You can't seem to walk away the same way as a volunteer or a professional care provider (…)" (Participant quoted in Gahagan et al 2004: 7)

Caregivers emphasized their personal qualities as essential to being able to do the work. For example, proving personal strength, being able to fulfill the role expected of a woman, being able to forgive oneself for frustration and ability to maintain the dignity of the care recipient - these were among the qualities caregivers valued. Caregivers spoke of the importance of caring for family, the need for high energy and inner strength, the effect of the low value placed on caregiving in society at large. Women of African descent and Mi'kmaq women talked about the cultural importance of caring for elders in their communities, a traditional part of female identity and lifestyle.

An important part of the caregiver role entails advocacy on behalf of the care recipient with various health and helping agencies. For example, persons with chronic health problems are assessed by case managers in the Home Care System to determine their eligibility for various health and support services, including light housework and respite care. For some caregivers, needing and accepting "outside help" was very difficult because of strong feelings that they should be able to care for their family member themselves. Furthermore, the breakdown between public and private domains when professional helpers visit the home can be a source of anxiety, and some respondents noted the difficulties of having "strangers" in the home. In rural areas and small towns, concern with a loss of privacy and confidentiality was expressed. Rapid turnover of professional helpers exacerbates the situation, in part because the caregiver frequently has to assist the professional – for example, to find supplies in the home, to teach the professional specific needs for skin and hair care products in African Nova Scotian clients, to update on new health developments.

Caregivers are also in the role of teachers to other family members, to friends and, indeed, sometimes to strangers. They explain the symptoms, the causes, the remedies of the care recipient's problem, and inevitably spend considerable time and effort to educate themselves and other family members.

Health, work and leisure are affected by the caregiving role. As the workload of caregiving increased, caregivers found themselves increasingly isolated, unable to maintain social contacts and friendships of the past because of the time commitments of caregiving on the one hand, and the energy required to maintain social activities on the other.

Sleep deprivation and fatigue were common problems. Fatigue was of particular importance to women with disabilities, who expend more energy to do the work of caregiving than if they were able-bodied. Sleep deprivation in turn increased social isolation, and even had an impact on the caregiver's nutrition:

> "(…) [Caregiving] was the only thing. Unless someone brought me a sandwich I wasn't stopping to think, 'Oh, I'm hungry'. I don't know if I even got hungry." (Participant quoted in Gahagan et al. 2004: 18)

Not surprisingly, some caregivers commented on their stress, loneliness and depression. Many cited kinship networks and friends as being critical supports for themselves, giving empathy, recognition, appreciation and commiseration, as well as practical support.

The physical challenge of caregiving work, particularly that of lifting the care recipient emerged as a problem for some caregivers. Given the risk of injury associated with repeated heavy lifting, this would seem to be a particular area for intervention, both through appropriate training and the provision of technical and equipment support.

Caregivers did make use of a wide variety of community supports and home care, generally speaking well of these services. At the same time, utilization and coordination of services can itself be a source of stress. Gahagan et al. (2004: 37) write

> "caregivers often walked an interpersonal tightrope of diplomacy held together with a healthy measure of humility in order to secure resources (…)"

The focus group research presents a rich source of insights into the daily lives of caregivers. The data set is now being used for further analysis, with a paper in preparation on the self-efficacy of caregivers in relation to wellbeing. The research will also be useful in the interpretation of findings from the survey described below.

Secondary Data: Analyzing the Relationship between Caregiving and Stress

MacDonald, Phipps and Lethbridge (2005 a) used General Social Survey (GSS) data collected by Statistics Canada from February 1998 through January 1999 to examine the impact of paid and unpaid work on women and men aged 25-54. The survey is representative of Canadians, and includes 3304 women and 2947 men.

Respondents were asked whether they felt themselves to be "constantly under stress, trying to accomplish more than you can handle?" They were

also asked about their satisfaction or dissatisfaction with the balance between their job and their home life. These became the dependent variables for further investigations.

The survey also asked respondents about their "usual weekly" hours of total work. Women, it turns out, do about 10 hours more work each week than men: 75.4 hours compared to 65.0 hours. While men do more paid work than women, women do over twice as much unpaid work as men do. The "sandwich generation" of women who do both childcare and eldercare includes 14.5% of women, compared to 11% of men. Despite greater participation by fathers in childcare than in the past, women still put in twice as many hours as men on those tasks. Interestingly, among the 24.7% of women who did eldercare and 21% of men who did so, the time spent by women and men respectively was much closer, at 7.8 hours per week and 6.2 hours per week respectively.

Probit analysis was used to address the question of how paid and unpaid work are associated with time stress; what the role of the spouse is in married couples; and the extent to which various features of paid work help or exacerbate stress. The analysis controlled a wide range of socio-economic variables, immigrant status, activity limitation, presence and number of children and presence of elderly parents.

MacDonald, Phipps and Lethbridge (2005a) found that stress was heightened for women with additional workload, particularly in paid hours. Stress for women was not heightened to the same degree when childcare was present, but was greatly increased through eldercare. Housework, on the other hand, raised the stress levels of men, but childcare and eldercare did not. These findings are of interest in light of survey findings that for many women paid employment is rewarding, and can mitigate stressors that exist when only unpaid work is performed in the home. It would appear that the "double work load" of paid and unpaid work is particularly stressful for women when paid work, child care and elder care demands occur simultaneously. The policy question then is not whether women should restrict their activities to care work, but rather, what better balance between government policies, employer policy, and community support is needed to enable families to care for their members.

Interestingly, flexibility in start and stop time of work did not affect satisfaction with work-home balance and neither did irregular shifts. Multiple job holding and self-employment were helpful to women in increasing satisfaction with work-home balance. Multiple job holding usually occurs when individuals work part-time on an occasional basis for different employers. In all likelihood, this gives the individual a high degree of flexibil-

ity in choosing or rejecting particular work shifts, although the available data did not allow testing of this possible explanation. Self-employment basically means having one's own business, without being anyone else's employee. Self-employment among women has grown rapidly in Canada, and while businesswomen face long hours and many entrepreneurial challenges, they also achieve much more control over the work that they undertake, particularly the time when it needs to be performed and the location where it can be performed. There are numerous examples of women who have left the high-pressure corporate world, for example, to start their own businesses precisely because it allows them more freedom to balance their work and family responsibilities.

Further analysis of the GSS data focused on Atlantic Canadian women; that is, women in the four provinces of Nova Scotia, New Brunswick, Prince Edward Island and Newfoundland (MacDonald, Phipps, and Lethbridge, 2005b). Although sample sizes from each of these provinces separately precluded analysis, the four provinces together yielded a sufficient sample to undertake analyses comparing Atlantic Canadian women to Canada as a whole. The result of that analysis is intriguing: Atlantic Canadian women do more unpaid work than women in other parts of the country. However, the reason for this finding is remains unknown: controlling for the wide array of social and economic variables available did not yield any explanation, but it is important to keep the higher workload of women in this region in mind when planning policy and program interventions.

Qualitative Research: Caregiver Portraits

Beagan et al. (2005) conducted in-depth qualitative research with 14 women caregivers. Four were of European descent, two rural and two urban. Two women had disabilities. Two women were of African descent, one living in the city and one, in the country. Two women were selected because they are lesbian, and one additional caregiver subsequently identified herself as lesbian as well. Of the two First Nations women, one lived on a reservation and one did not. Two women were immigrants.

The ethnographic approach followed in this research program involved repeated interviews and visits, at different times of the day, by research assistants in the role of participant observers. Each participant had a total of at least 24 hours of contact time, and the research assistants kept detailed field notes about their observations. The participants were also given disposable cameras, for use throughout their day, to take photos that would illustrate their caregiving experience.

The first report coming from these incredibly rich data highlights the experiences, both positive and negative, of the caregivers who took part in this work. Varied and diverse in background, the women's generous participation in the research not only deepens our insight into caregiving, but also is a rich source of ideas for policy and program improvements that take the diversity of women and their families into account.

The caregiver portraits were based on the stories of 14 women. Four women were of European descent, two urban and two rural. Two women identified themselves as lesbian. Two women identified themselves as having disabilities, including cognitive and physical conditions. One African Nova-Scotian woman lived in the city, one lived in a rural area. Two participants were of aboriginal origin, one living on a reservation, the other, elsewhere. Two women were immigrants to Nova Scotia from different countries and having lived here for different time periods.

For all the women, their caregiving was the top priority in their lives, even though all engage in a variety of other activities, including employment or self-employment. Their relationships to the care recipient also varied: children, husbands, fathers, a granddaughter, a mother-in-law and a former mother-in-law were included. The reasons for needing care included serious physical disabilities such as spina bifida or cognitive conditions such as Alzheimer's disease.

It is beyond the scope of this paper to re-tell each of the dramatic stories which unfolded during the research process with these 14 women. Some highlights however emerged:

- Amara is a 60-year-old immigrant woman from Lebanon. She has cared for her developmentally challenged daughter for the past 39 years, and when her husband contracted Lewy body dementia and Parkinson's disease seven years ago, her work intensified. She reports numerous frustrating experiences with homecare services, experiences so frustrating that she decided to undertake all the work herself. The frustrations stemmed from the rushed service and constant rotation of workers. Amara also notes the lost connection to her husband as his disease progressed:

"You're not looking after your husband any more, you're looking after a child (…) you don't expect your husband to get old and sick.

It takes time, I'm reaching 60 years of age and I don't have the energy like before. What I used to do for an hour, now it takes me two or three hours to do. Especially with a special child, and dealing with a sick husband who needs care 24 hours a day, so it's very tiring for 60 years. You know some-

times I reach a point where I can't walk, I can't do anything." (Participant quoted in Beagan et al. 2005: 4-5)

- Carol is a 60-year-old woman of European descent, with nine siblings. She is self-employed and cares for her 87-year-old mother who has Alzheimer's disease. As the disease progresses, Carol is more isolated in her home, and experiences more sleep disruption. She coordinates her mother's professional care, but is frustrated by the constant change of care providers sent through the home care system, each of whom requires orientation to the home and to the care recipient's needs. Carol feels that she works hard to care for her mother, and also feels she should get some compensation for her work. Carol gets some assistance from her siblings, for example with home maintenance and she also benefits from the appreciation the other family members express for her work. She maintains a loving relationship with her mother, and is glad to care for her mother as her mother cared for her in earlier times.

- Julia and her common-law partner Michael care for his ninety-year-old mother, Charlotte. Charlotte requires help with eating, bathing, dressing, medication and colostomy care. She needs attention on a 24-hour basis, resulting in sleep deprivation for both caregivers. Julia makes constant efforts to show Charlotte loving attention even in the face of intense fatigue:

  "Well you know, I don't regret it for a minute. But there are times when I feel I am just going through the motions, because I am so tired and that makes me feel guilty, because I am not doing the care with love (…) Then I think: 'Oh my goodness, I hope she doesn't notice.' And of course I would never know if she noticed or not, I notice it (…)." (Participant quoted in Beagan et al. 2005: 25-26)

  Julia comments on the overworked and understaffed health care system, and recommends better training for family caregivers. She also expresses concern for her relationship with Michael:

  "That's a concern of mine. That Michael's and my relationship, I find that this is one of the reasons, with the sleep deprivation we are having words with each other, and sometimes I think that when this is all over if we continue to look after his Mum the way we've been doing, we may not have a relationship (…)." (Participant quoted in Beagan et al. 2005: 24)

These abbreviated examples illustrate the kind of information collected. In summary, over all the case studies, the researchers found that time pressures reduced time for self-care, increased social isolation, disrupted balanced living, affected income, work and educational opportunities, affected

relationships with the care recipient and others, could produce ill-health through exhaustion and created emotional impacts including depression. At the same time, the caregivers experienced positive impacts in satisfying deep human relational and ethical needs. As one respondent concluded:

> "What could be more satisfying, or more meaningful, or more dutiful than looking after your own mother?"

The caregivers also produced a wide range of suggestions for practical improvements in support services, from more consistency in services through provision of payment from public sources for family caregivers. These suggestions will provide the basis for further analysis of practical and possible approaches to improving support for caregivers.

The research team, through thematic analysis across the case studies is preparing papers addressing, among other things, the moral tensions caregivers experience, the stereotypes about caregivers that tend to reduce the effectiveness of policies and programs, and the faulty and often tacit assumptions that underlie policy and program development in relation to caregiving. Some examples of the latter include what Stadnyk and Beagan (2005) have called "familism" and "residualism". Familism concerns the assumption that it is "natural" for families, and more specifically women in families, to provide care. Residualism refers to the assumption that publicly funded supports for caregiving should only be available after a family has exhausted all its own resources. Both sets of assumptions should be questioned and alternative scenarios developed.

Quantitative Research: Survey of Caregiving in Nova Scotia

Janice Keefe, Canada Research Chair on Aging at Mount Saint Vincent University, leads the team of researchers collaborating on the survey. She and her colleagues have just completed data collection and preliminary analysis of a survey of Nova Scotians to determine overall patterns of caregiving in this province, and then to probe more deeply into the relationships between paid and unpaid work, empowerment and health status among respondents.

Since the data files have only recently been received, no results can be shared at this time. Needless to say, the team looks forward to analyzing the 1988 screening interviews and the 465 in-depth interviews. These will provide estimates of the prevalence, duration and intensity of caregiving and enhance our understanding of its relationship to health and well-being among both women and men in rural and urban areas of the province.

The publication plan for the survey results reflects the questions the survey was designed to address. The first monograph will describe the population of caregivers in Nova Scotia in terms of demographic and socio-economic variables. The monograph will describe the profile of caregivers and caregiving experiences, analyse the gender differences in caregivers and caregiving, and describe the health situation of caregivers.

A second monograph will examine the employment characteristics of Nova Scotia caregivers, including an examination of those working for other people (employees) and those working for themselves (self-employed persons). The financial and job-related costs of caregiving will be analyzed in light of available workplace benefits, such as flexibility in work hours and presence or absence of family leave.

The third monograph will more closely examine the health situation of caregivers, expanding on the work of the secondary data analysis described earlier in this paper. Health issues such as stress, smoking and other drug use, nutritional status, emotional health, sleep deprivation and medication use will be examined in relation to the intensity and duration of caregiving and paid work. The "health monograph" will also look at the health care utilization of caregivers, the level of chronic illness and disability among caregivers and the level of participation in positive health behaviours such as exercise and positive leisure activities. Finally, the monograph will address the central question underlying this research program: how is unpaid caregiving and paid work related to health status, and how is that relationship mediated by variables related to resiliency and empowerment of women? It is through the answer to such questions that one returns to our metaphor of "healthy balance". Since the 1960s, women in Nova Scotia have dramatically increased their educational levels and their participation in the paid work force. At one time, women struggled for the choice to be in the paid work force. As those commitments increased, by the late 80s, there was increased concern about the need to balance work and family life, and the need to rebalance the relative contributions of women, other family members, employers, governments and community organizations to overall individual and social well-being. The findings of the HBRP will help to formulate new policy and program recommendations to support caregivers and their families, and to further women's equality in paid work as well.

Next Steps: Informing the Policy Process

Through ongoing communication and linkages, the Healthy Balance Research Program is well positioned to take its findings to a wide range of interested stakeholders and audiences. Among these audiences are elected

and appointed officials at provincial and federal levels of government with responsibility for caregiving policy and programs; professional associations; employer associations and labour unions; women's equality-seeking groups; and the equity communities that have contributed so much to this research.

Our university-based researchers will continue to work to produce articles for the academic media. Just as importantly, we will continue to prepare a variety of presentations and articles that meet the needs of officials and other professionals that make and influence the policies and programs that can improve the lives of caregivers and care recipients throughout Nova Scotia.

A consistent theme from every one of the projects undertaken is that caregivers need access to information about support services in their communities and about government programs designed to assist them in user-friendly formats. They want and need education and training to improve their knowledge and skills to meet the physical, emotional and social needs of their care recipient. Such education and training must be highly individualized, reflecting the wide range of problems care recipients experience, and the wide range of corresponding needs that caregivers have. We must work to build support services in communities both in terms of improved access to transportation and professional services, but also in terms of social support for caregivers through voluntary organizations. A community's capacity to support caregivers can be improved through financial support for organizations such as Caregivers Nova Scotia, which provides counselling, referral, self-help and social support to caregivers, and acts as an advocate for caregivers within the political realm. The design of health promotion programs that address the needs of caregivers is another opportunity for improvement. Changes in the taxation regime, the social insurance programs and the social support programs need to be developed with financial sustainability kept in mind. Armstrong and Armstrong (2001:2) stated at the outset of our work:

> "Care work is women's work. Paid and unpaid, located at home, in voluntary organizations or in the labour force, the overwhelming majority of care is provided by women. It is often invisible, usually accorded little value and only sometimes recognized as skilled."

Improved recognition, accommodation and compensation of caregiving are fundamental to achieving equality for women. The Healthy Balance Program will continue to pursue that goal through forums and conferences, through participation in government consultations, through providing well-substantiated advice to government at both federal and provincial levels

and through nurturing the partnerships with community groups, service delivery organizations and government departments that can act to help and support caregivers in a manner that is consistent with the economic equality of women. In other words, we will seek to develop sustainable policies and programs that enable caregivers to maintain their participation in the paid workforce as well as providing their family members with the loving care they need.

Conclusion

The Healthy Balance Research Program has been a challenging enterprise, not only from the academic perspective but also from the perspective of an agency like the Advisory Council on the Status of Women, whose central purpose is the development of policy advice that reflects the needs and interests of equality-seeking women. Four years into the research process, we have succeeded in assembling an impressive array of data. Those data now need analysis and integration, along the lines suggested by the summaries presented above. The combination of qualitative with quantitative findings creates the possibility of synergy between the two types of research. The quantitative findings allow us to estimate the scope and cost of policy interventions. The qualitative findings allow for evidence-based interpretation of survey results.

The development of a policy framework within which to situate the research findings is a next step in our work. We plan to bring together our equity reference groups, our researchers and stakeholders in government and community in a forum to be held in May 2006, to develop the common principles for policy development and to define the key sectors within which policy recommendations will be formulated. From the forum, additional working groups can be structured to develop and circulate the policy recommendations themselves, and to develop advocacy strategies to foster their acceptance. Such strategies will include communications plans for media coverage to inform the general public, presentations to professional associations of key groups such as the nursing profession, and smaller briefing meetings with officials in ministries such the federal level.

The Healthy Balance Research Program set out to "make a difference" for caregivers and care recipients in Nova Scotia. With active participation from a wide variety of stakeholders, both lay and professional, the preconditions for positive change are in place, in pursuit of the larger goal of creating a caring society.

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Database Women's Health and Health Promotion as a Means to Understanding and Networking

Birgit Heidtke

Since November 2003, the Database Women's Health and Health Promotion has been online in Germany. This database is provided by the *German Federal Centre for Health Education, Bundeszentrale für gesundheitliche Aufklärung* (BZgA).

SoFFI K., a social science women's research institute, has been involved in the development of the database and has taken an active part in its conception, composition and edition. The database *Frauengesundheit und Gesundheitsförderung* (Women's Health and Health Promotion) is hosted on the BZgA's website: www.bzga.de/frauengesundheit.

First I would like to give some information about the background and conceptual design of the database before presenting its range of information and features. And I will try to conclude with an outlook on the chances and benefits of a European database for women's health.

Background and Objectives

The Federal Centre for Health Education (BZgA) as agency of the Federal Ministry of Health and Social Security has been engaged in the field of women's health for many years.

The background of the idea to establish a database for women's health is the implementation of a women and gender specific approach to health and health promotion on an international and national level that brought issues of women's health into research, practice and policy. Specific living conditions, circumstances and health needs of women require specific strategies to promote women's health. Meanwhile there exists a wide spectrum of institutions and networks, of projects and experts in this field: just to name some examples as the WHO's *Department of Gender and Women's Health*, the *European Institute of Women's Health* or last not least the *European Women's Health Net*. Knowledge and resources of information have grown significantly on a national, European and international level and standards to develop and enhance gender related quality in research and practice have been established. Thus there is a clear need for networking and exchange of knowledge between experts, organisations and political initiatives.

The idea of the database was to establish an information pool addressed to experts in the field of women's health, to give access to specific and up to date resources of information. Many disciplines are relevant in the field of women's health – among others medicine, psychology and sociology. The database wants to interlink these single information pools and to provide resources that are not always easily available, like information of the women's health movement, reports of workshops and meetings, statements of smaller organisations.

The database sees its objective as contributing to the development of a knowledge pool that links together sources of information in the field of women's health and gender mainstreaming. Compared to print media an online database has the opportunity to be open for a current updating. Therefore it can grow continuously and quickly can follow up new developments.

The work on the database started in 2000. In the beginning the database hosted quite a lot of publications that only were available in print and informed about working groups and smaller organisations that provided no online information. Actually the database more and more turns out to be a gateway to online information and online resources in the field of women's health: This development shows how fast the changes in health information are. The database has to meet these changes and is to be seen as a product that will undergo a continuous process of adapting new topics and needs for information.

In 2004 it was decided to open the database for end users just as well. In the future it also will provide information resources that are addressed to people with an interest and to those with a personal concern for topics of women's health.

As gateway to online health information it is a major objective to provide access to relevant and reliable information. Therefore a concept of quality has been developed for the database that refers to international standards of quality for health related online information like for example the code of conduct of the *Health on the Net Foundation* (HON-Code). The concept reflects for example quality criteria for how to select information that is hosted by the database. It will be a future task to lay open these criteria in order to get a concern for quality over to users of the database and to encourage them to take an active part in the improvement of quality for online health information – not only in regard to the database. Quality for health related online information also was a major topic of workshops organised by the BZgA to support an exchange of experts in the field of Women's Health and E-Health (see below).

Conceptual Design

In its conception the database refers to:

- the findings of research in the field of women's health
- the index of health indicators proposed by the WHO for Women's Health Reports.

Women's health research has established paradigms for research and practice in regard of women's health that provide strategies to implement a sensitive approach for gender differences and specific women's needs in Public Health. To name some of them:

- An understanding of health that has a concern for the conditions of living and circumstances of women. This understanding also has an interest for how women actively contribute (or do not) to healthy living.
- To realise – beyond gender differences – social, ethnical and demographical differences among women and to recognise the strong relation between the social status and the health status of women. In health promotion programmes this requires for example sensitivity for subliminal exclusions and discrimination.
- To focus not only on the medical but also on the psychosocial aspects of health which are often neglected, especially in the field of reproductive health.

This understanding of health was considered on the whole for the conceptual design of the database. It was followed by the decision about which topical fields and single topics should be taken up and it went into the ideas of what kind and range of information should be accounted for. Therefore the database provides for example the topical section *social conditions* with its sub-topics*, migration, social disadvantage, violence, women with handicaps.* And it takes an effort to provide access to publications and activities that are rather tacked away, beyond the scientific and public mainstream.

The choice of topical sections and issues provided in the database also follows the index of health indicators that was developed by the WHO in the framework of the campaign *Women's Health Counts* for Women's Health Reports. This index of health indicators was modified for the intentions of the database. Decisions for the selection and provision of indicators were led by:

- The epidemiological relevance of a topic: In Germany among women breast cancer for example is the most prevalent cause of death among cancer diseases
- The gender specific relevance of a topic and the consideration of a higher prevalence of women: as for example in eating disorders.

- The importance of a topic in view of health prevention and health promotion.

Target Groups and Intentions

The database is designed for every one with an interest in women's health. It wants to provide information resources to end-users that have a special concern for certain topics, for example out of a personal health problem or because they support someone else nearby. At the same time it wants to support people who work, lecture, publish and counsel in the field of women's health and/or gender equity.

- The database wants to be a gateway to reliable information of quality.
- It wants to support end-users in their search for health information and to impart knowledge of and awareness for quality criteria of health related online information.
- It wants to give a survey of organisations and institutions that offer information, counsel and support.
- It wants to give a *review* of current literature, statistical and epidemiological data and of relevant institutions, organisations and networks.
- It wants to give *access to results* of research and good practice and to provide documents related to political interventions and developments.
- It wants to *facilitate co-operation*, communication and networking between people working in the field.
- It wants to *establish standards of quality and gender sensitivity* for health related online information.
- And last but not least it wants to be a *gateway to an international information pool concerning gender specific health information*. This international dimension of the database is realised in its European and Global Section.

User Experience and Feedback

The database relies on feedback of users as well as experts for its advancement, in regard of content and usability in navigation and search. It therefore invites users to feedback via a button on the welcome page that is responded rather frequently.

This feedback is vital for to get an idea of who uses the database, of why and how it is used. Most users give feedback out of a certain interest in a topic, some propose issues that should also be included or give hints for missing resources. Above that we receive information, hints and review from experts, in particular from members of a working committee that was

set up to accompany and counsel the database's further development. This exchange provides a basis for a continuous amelioration and widening of the database.

The International Dimension

The database has its main focus on German resources but in addition provides international links and documents of European, global or for example American relevance. Most documents in this section are in English, short abstracts are written in German. We would like to invite EWHNET's knots to take part in the advancement of the European section of the database: by sending information of organisations and publications that are relevant in women's health matters in their country. But again a basic requirement to include it in the database is that information is available in English.

To enhance the international dimension of the database the *Federal Centre for Health Education* has hosted several transnational workshops to offer space for an exchange and to interlink experience of projects either in the field of Women's Health or/and E-Health. Issues here were for example how to anticipate and modify quality standards for health related information concerning women's health. One workshop focussed on the information needs and chances of health promotion via internet for the group of elder women. The results of these meetings will be published by the BZgA in 2006.

Reference

www.bzga.de/frauengesundheit

Gender-relevant Issues and Debates

Neo-liberal Challenges for the Health: Gender Sensitive Reflections on GATS and the EU-Directive on Services

Arnd Hofmeister

Introduction

The neo-liberal transformation of societies all over the world is still an on-going, however contested, process. Keywords of this process are liberalisation, privatisation, structural adjustments, and deregulation just to name a few of them. In this paper I will outline the global context of this transformation especially the GATS (General Agreement on Trade in Services) of the WTO (World Trade Organisation). In more detail then I will analyze specifically the discussions on the EU-Directive on Services. Thereby I will focus on the implications for population health and the health care sector by taking a gender sensitive approach. Analytically I distinguish between a comprehensive understanding of health which includes all social determinants of health on the one hand and a selective understanding of health concentrating mostly on the health care sector on the other. My general theses are: Firstly the privatisation of services threatens the health of the population worldwide and worsens the situation specifically for women, especially when they are in charge of reproduction[1] and care for those in need. Secondly, criticism focusing on the exclusion of the health care sector from these liberalisation processes (especially the EU-Directive) undermine with their narrow concept of health in the long run the health of the population. Thirdly, privatisation in general threatens working and living conditions, especially of those women who work predominantly in service areas which are privatised and outsourced first. Fourthly, the promises of the creation of new jobs by privatisation processes need to be questioned in regard to what kind of jobs are created and whether privatisation improves the service and health care provision for everybody. Fifthly, privatisation of health care and the search for profits will reinforce the divide between "productive" and "reproductive" elements of health care by privileging the former and thereby worsening the situation of those working on the reproductive side. Sixthly, only a comprehensive understanding of health makes it possible to avoid the pitfalls of neoliberal ideologies. Finally, healthy public policy has to include everybody or it is not healthy.

The General Agreement of Trades and Services (GATS)

The foundation of the WTO in 1994 marks a fundamental change in global policy since it subjects at once almost all human activities to its rule, which has to be qualified as neo-liberal. Within the WTO there are more than two dozens agreements on specific areas such as the "Agreement on Agriculture (AgA)", the "Trade Related Aspects of Intellectual Property Rights (TRIPS)" or the "General Agreement on Trades in Services (GATS)". All of them follow the same principles: trading conditions of the most favoured nation apply to all, equal treatment of all enterprises, no public subventions for services, liberalisation of trade by the opening of borders and reduction of obstacles and the application of the market principle and free competition in all areas (Neuschwander 2000: 546ff). GATS has high implications for health not only because it deregulates health care and the social services sector but almost any service provided like education, environment, communication, finances, tourism, leisure time, culture, sport and transport among others. The health impact of these sectors is widely known.

The GATS distinguishes four different modes of supply of services: the first mode includes cross border trade (a delivery of a service from the territory of one country directed to another country e.g. e-health counselling), the second mode addresses the consumption abroad (one country offers services to consumers of another country e.g. surgeries in another country), the third mode covers commercial presence (services provided by a service supplier of one country in the territory of another country e.g. foreign care provider offer services), and the fourth mode concerns presence of natural persons (a service supplier of one country offers services by persons of its own country in another one e.g. foreign nurses provide care). Especially modes three and four are the most disputed ones. The main criticism concerns processes of outsourcing (to reduce staff costs and circumvent wage agreements) and brain-drain (emigration of highly qualified and highly needed staff from the countries of the South to the North). WTO summarizes these developments in a 'Background Paper on Health and Social Services': "the most significant benefits from trade are unlikely to arise from the construction and operation of hospitals etc., but their staffing with more skilled, more efficient and/or less costly personnel than might be available on the domestic labour market" (WTO 1998; 18).

However, GATS does not ask for the privatisation of public services, but is just one mechanism to liberalise public services and services in general. In Art I, 3, b and c of GATS it explains that "services" include any service in any sector except services supplied in the exercise of governmental authority; (c) 'a service supplied in the exercise of governmental author-

ity' means any service which is supplied neither on a commercial basis nor in competition with one or more service suppliers. This foundational article seems to ease the consequences especially for public services like health care and social services at least in those countries that already have developed public services. Still it remains an open question of jurisdiction and of political debates how this article is interpreted. According to one position, it might be argued that if any aspect of the service of a public institution being provided is operating commercially and/or in competition with another provider, the GATS rules could apply e.g. public hospitals offering private services. This means consequently for those hospitals no subventions, same conditions for every provider etc. However, according to another position, it can also be argued that the overall aim of public services overrules cases in which public services operate partly commercially or in competition with other providers.

Although there are no decisions about such cases yet and health care and social services as public services are not significantly affected by GATS, it would be short-sighted to think that it has no impact on the health of the people. Using a comprehensive concept of health which includes social and environmental determinants it is evident that the impact is huge, whether we think about water and sanitation, transport and education or culture and sport. If access to these services is more and more privatised and thereby limited to those who can afford them, the possibilities for 'healthy' decisions are limited.

GATS marks the global context of neo-liberal policies which hit the public services in different parts of the world differently. For countries of the South, which are often mistakably characterised in a neo-colonial discourse as developing countries, its effects are immense in that not only that public services cannot be developed, but also the structural adjustment policies of the International Monetary Fund (IMF) and Worldbank force these countries to adjust their public services to the neo-liberal regime which means to privatise even the most basic public structures. For countries of the North with a developed social security system the situation differs and its consequences will emerge in some years. However, with the EU directive on services in the "internal market" first steps are already undertaken.

The EU-Directive on Services in the Internal Market

The first communication from the EU Commission about an 'Internal Market strategy for Services' was published in the year 2000 (COM 2000, 888 final, 29.12.2000). It is the first step to the Lisbon-Agenda, the intensely

discussed EU strategy to make the EU "the world's most dynamic and competitive economy" by 2010. The proposal of the commission for this directive was published in 2004 (COM 2004, 2, 03) and is at the moment (September 2005) discussed following the procedures of EU legislation by the EU Parliament and the European Council. Working papers of the council with clarifications (Council of the European Union; General Secretariat of the Council 2005) and reports and suggestions by the European Parliament (2004) have been issued as follows.

Basically, the service directive proposes fundamental changes in the EU service market. The proposal consists of three main principles:

The first refers to the 'freedom of establishment'. Any individual or company of a EU member state should be able to provide any service in any country with few or any legal or administrative restrictions.

The second component is the 'country of origin principle'. This means that on a temporary basis individuals or companies can test other markets without being established in the country before and to provide services to consumers in another Member State on the basis of the laws of their country of origin and without registering in the host member state. It is the member state of origin which is responsible for supervising the provider and its services, including those provided in another member state.

The third component finally asks Member States to promote mutual assistance and harmonisation measures which are supposed to respect consumer protection and quality standards.

Strong criticism against this directive was articulated from governments as well as from NGOs and civil society. Critics warn that the directive will lead to competition between workers in different parts of the EU with a downward spiral in income levels. It might also lead to social dumping by eroding workers rights and protection and might damage the supply of essential services. Furthermore the burden of proof will shift from the liberalisers to the regulators with the consequence that any existing legislation must be justified on the grounds that it is not-discriminatory, necessary and proportional (socialplatform 2004).

In this debate the claim for the exemption of health services from the directive has been very prominent. Critics argued that the directive will certainly affect the ability of member states to plan, regulate and organise their health care system. They hold that the health sector cannot be treated like any market-based sector (e.g. including financing systems in health care not being based on supply and demand and the complex model of cooperation involved in health care systems etc.). Furthermore, the banning of a

number of authorisation requirements and licensing requirements will be highly problematic for this sector. Especially the country of origin principle has been criticised (ibid. 2004).

The rapporteur of the EU-Parliament E. Gebhardt from the socialist party suggests in her draft from April 2005 excluding health care and social security from the directive and proposes the replacement of the country of origin principle by the mutual recognition principle, which hands the control over to the service to the country of destination and should guarantee social standards in the country of destination (European Parliament 2004). The conservative party pleads to keep health services in the directive but to exclude them from the country of origin principle which they themselves seek to replace by the internal market principle. Their argument is mainly that the growing market of private health services should be included in the liberalisation process.

In these political debates one can observe again a selective conceptualisation of health and a simplistic understanding of health care services. This is all the more astonishing since according to the 'Treaty of Nice' health itself is supposed to be a cross-cutting issue and "a high level of human health protection" (Treaty of Nice, Art. 152) is the aim of European (health) policies. It is remarkable that the discussion about the general health impact of other policies like transportation, environment etc. is beyond the scope of most arguments. It seems to be unimaginable that the access to health care in a literal sense might be impossible, if there is no public transportation in rural areas, which e.g. would enable old and poor people to see a general practitioner (GP). The link between privatised and expensive swimming-pools on the one hand and the difficulty for obese children and adolescents (who are currently target group number one) to participate in appropriate physical activities on the other hand is not seen and discussed A properly carried out Health Impact Assessment would clearly show the huge impact of privatisation policies of other services on health and might shift the whole discourse.

It is interesting to observe that there is more or less 'no' European health policy except in the field of public health. Most national health politicians and stakeholders of the health care sector are very careful that there should be no European influence on national health policies. With such a narrow understanding health politicians miss the huge impact of other social, economical and environmental policies which strongly influence the health of the population (see Busse 2001). They think that by excluding the health care sector from the scope of the directive the threats for the health

of the population are prevented. This false feeling of safety undermines in the long run the possibilities of healthy public policies.

Gender sensitive Reflections

Until now the discussion of GATS and the EU Directive on Services seem to be genderless. The consequences of privatisation policies seem to have affected 'the people' differently only along social class lines. Privatisation privileges the rich and makes life more difficult for the poor. However, if we now analyse these policies following a gender sensitive approach more consequences and implications become evident. Thereby the focus is on gender, the division of labour and employment.

Such an approach is supposedly integral to policy making in the EU since gender mainstreaming principles following the 'Programme of Action for the Mainstreaming of Gender Equality' of the EU Commission (COM 2001, 295 final) are introduced. If the more advanced strategy of an integrated 'Impact Assessment' (COM 2002, 276 final) was in place which is supposed to reflect economic, social and environmental impacts at once, the privatisation policies especially in health services would be regarded as much more problematic.

A gender sensitive approach asks in its analyses whether and, if so, how women are differently affected by a specific policy compared to men. It means to inquire and assess:

1. under- and over-representation of women in affected groups;
2. possible differences in regard to living and working conditions, needs and interests of women and men,
3. possible differences in usage of main resources such as money, education, advanced training, transport facilities;
4. differences in granting funds to women and men and their use by women and men;
5. standards and values influencing the roles of genders e.g. gender-specific division of labour etc.

For such gender sensitive analyses the (statistical) representation of women in the health (care) sector is the first priority step. In a second step ongoing liberalisation strategies in the health care sector need to be described and their gender impact assessed. Finally transformations of the health markets in European countries have to be reflected following gender mainstreaming criteria.

In Germany around 4.2 million people work in the health sector (10% of all employed people of which around 70% are women). However, in the

top jobs (GPs, dentists and pharmacists) only 40% of all employed are women while in the other health professions (nurses, physiotherapists etc.) 87% of all employed are women (Statistisches Bundesamt 2004). To complement this picture we have to add the number of 1.4 million people in need for care for whom this care is provided at home (Statistisches Bundesamt, Pflegestatistik 2003). For nearly one million people home care, supported by the statuary care insurance, is delivered by relatives who are predominantly women. Finally, one has to keep in mind that all those who care for their relatives without (financial) support in any form are invisible to these statistics. This overview reflects the gendered division of labour. The productive, high paying side is dominated by men while women are in charge of the reproductive low paying side. Consequently, changes in health care services will affect mostly women. This situation is similar for all countries of the North.

This situation is met by different liberalisation strategies. A complete privatisation of health care at the moment seems to be not enforceable on a societal level in most European countries. However, there are several strategies in place, which, step by step, transform the whole system. Most strategies resemble the structural adjustment programmes for the countries of the South. One strategy is outsourcing of services linked to health care e.g. cleaning, laundry, laboratory analyses etc. It is mostly women who work in these services and the consequences of outsourcing are well known. To reduce costs, working conditions and payment of these low paying jobs are worsening. Another strategy is the introduction of internal markets between different providers of health care, which forces them to increase their efficiency. Furthermore commercial accounting systems are introduced in all areas of health care services. This leads in home care for example to a complete modularisation or taylorisation of working processes in which every measure or intervention is calculated in time and money from insulin injections to dressing support etc. Finally an economisation of health care in form of Disease Related Groups (DRG) or concepts of Managed Care (Baumberger 2001) is introduced in Western health care systems. That means e.g. in Germany that the statutory health insurance pays a fixed amount of money for a specific intervention and then it depends on the health care providers to calculate interventions. In order to make benefits patients need to be sent home as quickly as possible and necessary care needs to be externalised. Again, it is predominantly women who care for relatives at home. These policies are accompanied by a general discourse about the inefficiency of publicly organised health care, thereby suggesting and legitimising their replacement by private enterprises.

The common characteristic of these different strategies is the 'principle of efficiency' which contravenes the 'principle of care' (Wichterich 2001, 2003). While the 'principle of efficiency' favours the medico-technocratic approach to health and its complete commodification, the 'principle of care' prioritises social and caring aspects. The aim of the former is to make profits, thereby focusing on the individual patient's health risks, the latter aims for the patient's well-being and it orients actions towards population's health needs. The combination of 'the principle of efficiency' with the medico-technical approach (including the real benefits, which are made by private enterprises) leads to a different valorisation of both principles. While the former is regarded as promising and constant investments are made, the latter is devalued and funding is reduced.

When we rearticulate these two principles in the framework of gender mainstreaming it becomes evident that "productive" labour is privileged compared to "reproductive" labour. Productive aspects of labour are structurally and empirically linked to Western concepts of masculinity and men, while reproductive aspects of labour are linked structurally and empirically to Western concepts of femininity and women (Bourdieu 2001, Gottschall 1995). Thus, in concrete terms women carry predominantly the burden of liberalisation processes while men predominantly make the profits.

The Development of Health Markets

The commodification and liberalisation of the health care sector can be observed in many European countries despite their different form. Although the UK is proud of its National Health System (NHS), most of these strategies have been put into place long before GATS. Contracting out of services, implementing internal markets between GPs and hospitals, introducing user charges and private insurances are some of the measures being taken. Even hospital buildings are separated from the services and run by the private sector (Sexton 2003).

In France with its national and compulsory health insurance system intensive care is provided by either public or private hospitals. Although the choice between both is free and refunded by the health insurance funds e.g. the regional hospitalisation agency (ARH) is sending, by emphasizing the efficiency, patients with 'lucrative' interventions (surgeries, radiological examinations etc.) into private hospitals while public hospitals have to care for infectious and chronic diseases, geriatric problems etc. (Pouliquen 2002). In consequence the care provided by public hospitals due to increasing costs by lower refunds is worsening, while the shares of private hospital trusts are increasing.

As soon as a private profit system is introduced into health care systems the proclaimed aim of health policies, to increase the health of the population, is threatened. Private providers are structurally interested in their shares and not in general health not to speak of the population. Whether countries have a national health system or a national health insurance scheme the neoliberal strategies are similar. To reduce costs providers shorten 'expensive staff' in the care and reproductive part in favour of new medical doctors or technological apparatuses. While costs for care are either socialised or transferred to the voluntary sector the profits are privatised. The gendered effects have been discussed before. It is the irony of history that this private sector is growing mostly in those countries where it is profiting from public spending.

The 'health market' is seen as one of the fastest growing sectors in western societies. Investments here seem to promise new jobs. The phantasm of 'technical feasibility' dominates investment strategies and thereby covers its societal costs. It is again investments in the medico-technological or pharmaceutical complex and not the reproductive or primary health care sector which dominates. These decisions are partly due to the shift of the hegemonic ideology or dominant discourse. With the neo-liberal transformation of Western societies a change of perspectives from political economy to business administration economy has taken place. The political economy of the welfare state founded on societal solidarity and argued that a healthy population is a necessary precondition for a productive workforce and developed its strategies according to this basic assumption prioritising the population health. However, this system was characterised by a paternalistic state and traditional gendered division of labour. In its most advanced forms it based on a comprehensive understanding of health which included all economic, social and environmental aspects. In contrast a business administration approach founded on the idea that "Every man is the architect of his own fortune"[2], trusts in the organisational competences of open markets and presupposes a selective understanding of health as a technologically feasible state. In consequence, newly created jobs lie in the area of health care management and health technology development where the "patient becomes a consumer" (Wulf 2001) and the patient is only of interest as such. Those who are not able to consume health services are those 'bad risks' for whom finally the public sector might care. The reproductive and caring part of health is reduced to a minimum of ta(y)ilored[3] care modules and transferred into private responsibility or ill-equipped public hospitals and foster homes.

Conclusion – The Global Context

Analysing the consequences of the neoliberal transformations for the health of the people highlights the analytical dimensions necessary to understand these processes. Looking at GATS and its implications it is necessary to differentiate between the countries of the South and the North. While the former have very few opportunities to create a public (health) system[4] and the provision of health is mostly the task of caring mothers and women, the latter try to keep their health systems out of GATS and instead privatise most other public services. This development is especially observable in the discussion about the EU-Directive on services. The consequences of privatisation policies, with a public health system still in place, threaten the population health since access to a healthy and good living is only possible for wealthier people. Privatisation affects differently along class and geographical lines. However it was one part here to highlight the differential gender effects (though primarily focused on employment). What privatisation means in the future for the health of the population is not only analysed for the countries of the North and the South and for the rich and the poor but also according to their gendered effects. Here the implicit gendered bias of neo-liberal ideology has becomes apparent. Its focus on productivity, growth and markets dethematises the reproductive aspect of health and caring. Jobs in the reproductive care sector predominantly held by women are devalued, outsourced, reduced or transferred in familial responsibility which mostly is again the task of women. Managerial strategies to increase the efficiency and the profits of health care support these developments. Proper care for old people or those in need becomes more and more only affordable for rich people. Here the dialectics of globalisation creates a bitter ironic synthesis. In the 'Global Care Chain' it is the low paid nurses and the medical staff from the countries of the South who deliver individual care for the rich. It is in this complexity that neo-liberal challenges for the health (care) sector have to be met. When we struggle for 'health for all' we should keep in mind that: the highest attainable standard of health is a human right; health is a common good and not a commodity; the highest standard of health is an entitlement, not a granted charity; in health there is no us and them, there is only us and the highest standard of health requires global solidarity.

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Notes

1   In this context reproduction includes not only the process of generating offspring but also aspects of domestic work and caring, mostly labour that does not produce surplus value.

2   It is not surprising that the gender in this proverb is male.

3   Although Taylorism as a scientific management concept of the early 20th century is highly criticised it has been introduced in the reform of the payment and organisation of care with all its already known bad impacts.

4   "Sierra Leone is the only country to have listed all its health service categories as covered by GATS – and yet US hospital chains or insurance companies do not seem to be dashing there" (Sexton 2003).

Violence Against Women – A Public Health Concern and a Pandemic Human Rights Violation

Verena Kaselitz

The link is evident: Violence is undoubtedly a serious threat to women's health; it impairs women's physical and emotional well-being in the short- and long-term. Violence ranks as one of the leading causes of injury and death for women. Besides self-inflicted and collective violence, which of course also affect men, it is predominately interpersonal violence which can certainly not be discussed without the gender perspective; interpersonal violence[1] has a clear gender-bias. The WHO's 2002 Report on Violence and Health – otherwise gender-neutral – reserves the section on 'Violence by Intimate Partners' solely to violence against women perpetrated by men.

> "Intimate partner violence occurs in all countries, irrespective of social, economic, religious or cultural group. Although women can be violent in relationships with men, and violence is also sometimes found in same-sex partnerships, the overwhelming burden of partner violence is borne by women at the hands of men." (WHO 2002: 89).

Estimates by women's organisations and women's rights advocates have been proven in recent prevalence studies on (intimate partner) violence against women. The WHO refers to 48 population-based surveys from around the world which show that between 10% and 69% of women have been physically assaulted by an intimate male partner at some point in their lives (WHO 2002: 89). However, violence is not limited to physical assault. Perpetrators not only hit, punch, push, but they also use other forms of violence. Women usually experience psychological, sexual abuse and/or economic violence at the same time.[2]

The list of consequences of such acts of violence is long: they go from bruises and cuts, from fractures to lasting disabilities, they range from somatic and psychosomatic complaints such as eating disorders and nausea to psychological consequences such as sleeping problems and panic attacks (see e.g. Hellbernd et al. 2003). Violence can be a traumatic experience as Judith L. Herman so profoundly revealed in "Trauma and Recovery" (Herman 1992). Consequences are profound and increase the risk of future ill health. Even when the violence has stopped the (health) consequences can still persist. When looking at the biographies of abused women researchers found out that some of them had already experienced physical or

sexual violence in their childhood. In addition, the impact of different types of violence at different stages in life appears to be cumulative.

The seriousness of the extent and the consequences of intimate partner violence and the ubiquity and pervasiveness of it make it seem obvious that the WHO calls it an "important public health problem" (WHO 2002: 89).

A Health or a Human Rights Issue?

Despite the clear consequences for the well-being of women the women's movement, feminist researchers and women working with abused women have rather been opposed to seeing violence against women as a health issue. In 1999 when the EU introduced the Daphne Programme to combat violence against women, children and young people and enhanced its status from an annual funding initiative to a 4-year (and better funded) programme there was considerable reservation about it being legitimated by Art. 152 of the Treaty (establishing the European Community), the article on 'Public Health'. From the very beginning in the early/ mid 1970s the focus of the new women's movement was on combating violence against women because it was (one of) the major human rights violations worldwide, resulting from the historically unequal power relations between men and women – a definition that 20 years later was taken on by the United Nations (UN 1995).[3]

In its recent documents and publications the WHO never fails to stress both concerns, the human rights and the public health concern. The fear expressed by women's activists that seeing violence against women, especially intimate partner violence, as a health issue and thus turning it into an individual problem, is clearly rejected by the WHO when defining that "public health is not about individual patients" and that "it aims to provide the maximum benefit for the largest number of people" (WHO 2002: 3).

Other forms of violence against women apart from intimate partner violence are often easier perceived as a societal problem. To name just the most widespread ones: trafficking in women, violence against women in military conflicts and female genital mutilation (FGM).

Three Decades Dedicated to Combating Violence Against Women

Despite the occasional drawback violence against women – and intimate partner violence against women in particular – has become an issue of public debate and has gradually been put on the political agenda over the last three decades. Women's groups set up a network of services to help and

support women victims of violence, and helping abused women has only been one of their concerns. Most of the – especially early – initiatives clearly saw their activities as immanently political. They not only gave women practical and emotional support, they tried to strengthen their resources, to make them aware of their rights – and publicly, to demand these rights for all women. To both the abused women and the public they tried to convey that violence was not an individual but a social problem, a severe human rights violation. It was probably their major achievement to turn violence against women from a private problem to a human rights violation and a clear indicator for the inequality between women and men.

Almost parallel to the efforts of the women's movement feminist researchers began to study the roots, impacts and consequences of violence against women. Since the late 1970s researchers have monitored and evaluated projects and measures initiated to support and help women victims of (intimate partner) violence. Research made it evident that violence against women had to be understood in the context of a patriarchal and hierarchically structured society which is prone to perpetuate gender inequality. Thus, violence against women fundamentally touches disciplines like sociology and political science but it has not yet become an integral part of research in these areas as e.g. Regina-Maria Dackweiler and Reinhild Schäfer pointed out still in 2002. They also referred to British-American researchers Rebecca and Russell Dobash who noted an increasing interest of a great variety of disciplines like medicine, psychology, law and criminology but remarked on the virtual absence of political science.

Given the many involved disciplines and the rather large number of feminist researchers, often with a personal experience of having worked in support services like refuges or counselling centres, the studies conducted so far have explored a great variety of issues. However, as Carol Hagemann-White pointed out, the mainstream in social sciences has largely neglected the gender perspective of violence, despite devoting considerable attention to the alarming level of violence in society. As a result this research has focused on the perpetrators whereas feminist researchers, among them also a few men, have concentrated on the victims (Hagemann-White 2002).

To learn more about the roots, impacts and consequences of violence a lot of qualitative research has been carried out. These days we know about the dynamics of violence, the risk factors, we know the impact on the children, we know that women are mainly raped by men familiar to them, etc. Many women's projects have also been evaluated by researchers, which not only helped to answer the why and how: why women become victims of

(intimate partner) violence and how it had happened/how can they be best helped. It also helped to demonstrate the need for these support services. In addition, being scientifically evaluated makes it easier for women's services to justify their relevance, the proficiency of their work and thus gain more public and financial support. With the gradual dismantling of the welfare state the latter has – unfortunately – again gained in importance. Although nobody (publicly) disputes the need for such services, the reluctance to fund them is growing.

Although combating violence against women was one of the main aims of the women's rights movement, the focus differed from country to country. While e.g. German, British and Dutch women campaigned against domestic violence, stressing physical abuse, the French and Swedish activists largely focused on sexual violence and rape (see Hagemann-White 2004). This is however not immediately reflected in the development of support services. All of the countries mentioned nowadays have quite a large number of women's refuges whereas help is often not so easily found for victims of rape and sexual violence. Still in 1996 France had neither a specialised crisis centre nor a helpline. Finland has just one rape crisis centre; Germany, Ireland, Switzerland and the UK have networks of support services (see Kelly and Regan 2001).

The provision of support services differs largely, mainly along a North-West and South-East divide. In a survey (Appelt and Kaselitz 2002) conducted in 2002 the number of women's refuge places was established. Following the 1986 recommendation by the European Parliament's Committee on Women's Rights and Equal Opportunities only two countries fulfilled the recommended number of one family place per 10,000 of the population – Luxembourg and the Netherlands. Most of the Western, Northern and Western Central European EU countries reach a percentage between approx. 30 and 80 per cent while almost all countries in the South and East of the continent have hardly any refuges (e.g. one refuge in Bulgaria and Hungary, three in the Czech Republic, four in Portugal and Romania). On the other hand, the existing women's refuges largely meet many or most of the other recommended standards as put forward by the European Parliament Committee, especially when run by feminist NGOs. Staff is female, they aim at empowering women, maximum safety for the residents is paramount and there is no fixed time limit for staying in the refuge (although they try to find a solution for the woman's future as soon as possible).

Although many of the early support services were initiatives by local (feminist) women's groups, once they had succeeded in putting violence

against women on the public agenda, state and Church run institutions followed. Many of the independent, non-profit (and feminist) women's groups have formed national networks. These days in almost all of the EU-15 countries anti-violence networks exist, although with different structures and purposes. Usually, they network specific kinds of services like the refuges, the counselling or rape crisis centres. This again applies primarily to the countries in Western, Central Western and Northern Europe, whereas in Southern and Eastern Europe networks are just emerging.

Even though national anti-violence and women's refuge networks had existed for a long time there was no European-wide coalition as late as 1993 when women's groups from around the globe came together to lobby for the international recognition of violence against women as a human rights violation during the UN World Conference on Human Rights in Vienna. While women's groups from other continents were quite well networked and prepared, many of the European women met for the first time. It took another two years until the WAVE (Women Against Violence Europe) network was officially launched at the 4th UN World Conference on Women in Beijing in 1995. Like in many other areas as well, unity does not come so easily to Europeans, also not to women's rights advocates, anti-violence activists, feminists etc. Although sharing vital common goals (exchange of experience, mutual support) and agreeing on basic principles (violence against women as a human rights violation) WAVE – ten years after its founding – is still an informal network, lacking a legal basis and statutes.

Focus for the Future

In 2005 the UN women's rights advocates and feminists world-wide celebrated the 30th anniversary of the 1st World Conference on Women in Mexico City in 1975. Many achievements have been made since then. But even when speaking from a European perspective differences are significant. While in some countries, like in Germany or Sweden, a rather dense net of support services exists, comprising refuges, counselling centres and helplines, many countries in the South and East of the continent can offer very little to abused women. In these countries most women's organisations and independent, non-governmental service providers receive very little or no financial support by the authorities, be it on the local, regional or national level.

A crucial role is played by the health sector. Because of the health consequences of violence it is quite likely that an abused woman will consult her family doctor/ general practitioner or her gynaecologist at some stage.

As research in Berlin has shown as many as 67% of the women in the survey regard doctors as suitable persons to contact in case of abuse (Hellbernd et al. 2003: 34). However, women seldom start speaking about violence themselves, but they would like to be asked, as this survey – like others before – found out. Unfortunately, there is a lack of knowledge about intimate partner violence, its causes and impacts. Medical professionals also feel that they cannot cope with the problem, both professionally as well as emotionally. It is therefore still common that instead of talking about violence and supporting the patient, sedatives and painkillers are prescribed. Training and sensitising of health care professionals is vital and certainly a must for the future. Pilot projects already exist in some regions like in lower Austria where training for health care professionals has been carried out since 2000. Effective support for women victims of partner violence would also require a closer co-operation between the health sector and women's services. Knowing about the positive responses by women it would also be necessary to do systematic screening for violence. Although this poses an additional task on the health care professionals when time pressure is a constant problem, it can prevent severer health consequences or even prevent further violence.

In recent years some countries (or regions) have introduced so-called protection from violence laws aiming at giving more effective protection to the victims, placing responsibility on the perpetrator and making violence against women a criminal instead of a civil offence. To really be able to give effective protection to victims of violence it is essential that the authorities work together with help providers, with the women's support organisations.

However, laws are just one piece in a comprehensive strategy that is necessary to successfully combat violence against women. Co-operation among the institutions involved and an interventionist strategy are vital.

What has to be admitted, however, is that we are far from celebrating the eradication of violence against women. Despite improved laws and networks of support services in many countries we are faced with a constant level of violence. Despite laws that expel perpetrators from their homes, women's refuges receive about the same number of victims every year, in some cases even more. The number of police interventions is on the increase. It is generally believed that we are not witnessing an increase in violence – although some experts helping abused women have voiced their doubts already as to a 'stable' level of violence.

After many years of qualitative research on violence against women it was only in the 1990s that the first representative surveys on the prevalence

of (intimate partner) violence were conducted. In short, they confirmed the estimates made before (by experts and activists). As quoted above the figures worldwide range from 10 to 69%. In Europe the figures are around 20 to 25% on average. Due to different methodological approaches comparisons are very difficult to make. This is not only a matter of using different interview settings (postal questionnaire, telephone interview, face-to-face interview) and a different definition of violent acts/experiences of violence, it is also necessary to reflect on different perceptions, on diverging cultural attitudes towards corporeality and sexuality. Especially when it comes to sexual violence the figures have to be treated very carefully. In the Dutch survey (Römkens 1997), e.g., 7,4% of women said that they had been raped by their partner but 21% of women said that they had been forced to have sexual intercourse.

So far most studies have focused on physical violence although there is not even an empirically verified measurement for the severity of the violent act. But when looking at the categories used and answers given by women it becomes clear that violence is only partly about physical harm; the damage to a woman's well-being, the mid- and long-term consequences, should be our main concern.

Leaving methodological problems behind we are nevertheless faced with a considerable level of violence in general and violence against women in particular. Violence against women occurs at the background of a long (European) tradition in which military strength and a competitive market economy paid off: a certain level of aggressiveness has not only been tolerated but paved the way to success, both on the individual as well as on the state level. At the same time there is a significant absence of strategies to deal with everyday aggression, anger, frustration, etc. As Hagemann-White (2004) argues it is therefore problematic

> "jede körperliche Äußerung von Aggression als 'Gewalt' zu inkriminieren, aber andererseits sehr schwierig, ergänzend dazu die sicherlich oft verheerende 'psychologische Gewalt' zu definieren oder empirisch zu erfassen" ('to criminalize each physical expression of aggression as violence but on the other hand it is difficult additionally to define or empirically establish the often devastating 'psychological violence'). (Hagemann-White 2004)

Primary Prevention

One of the lessons learned from the WHO World Report on Violence and Health clearly was that special attention should now be given to the primary prevention of interpersonal violence.

"Although support and care services for victims are important in mitigating the physical and psychological consequences of interpersonal violence and reducing individual vulnerability, considerable attention needs to be given to preventing the development and perpetration of violent behaviour in the first place." (WHO 2004)

In the pure meaning of the verb 'prevent' simply denotes "to stop something from happening" (Swift 1985: 413, quoted in Godenzi 1996: 320). As a research field, prevention came into being only very recently, having evolved out of medical practice. In 1964 Paul Caplan developed a 3-level model of prevention for use as a prophylactic strategy in the context of psychiatry. Researchers and experts like Godenzi, Taskinen and Heiliger have adapted it to the needs of a systematic approach to dealing with violence. The three levels concerned relate primarily to the time sequence within which the various courses of action are adopted: primary prevention relates to actions to obviate violence before it occurs, secondary prevention relates to action to detect violence in time or to terminate it at the earliest possible juncture and tertiary prevention describes actions to prevent renewed outbreak of violence or to soften the impact of violence.

The focus of both research and activity has so far clearly been on secondary prevention arising from the overwhelming need to help and support victims of violence. Thanks to these efforts we have an efficient system of services, well-founded intervention strategies and reasonably good protection of victims, at least in many regions and countries in Europe. In recent years great emphasis was put on tertiary prevention, specifically on working with the perpetrators, basically abusive men.

Although the majority of researchers is unanimous that, in the long term, only primary prevention will eradicate violence it is so far the least tackled. According to Godenzi it calls into question the very foundations of our society:

"(…) after all, it raises such fundamental issues as the organisational basis and the style of modern societies" (Godenzi 1996: 327).

Optimistically speaking, the changes in family life (single-parent families, more families with a non-biological parent, greater variety in "family substitutes", increasing number of working mothers, etc.) can have positive effects on the frequency and kind of violence since these new family structures supersede the isolation and the traditionally patriarchal structure of nuclear families and thus reduce the pressure on individual families. Pessimistically speaking however, according to Bart and O'Brien (1985: 120 quoted in Godenzi 1996: 327), it would be necessary to end male domi-

nance in society, but "we do not know how to bring such a revolution about (...)".

Based on the Anglo-American debate on prevention Godenzi derives five preventive strategies: elimination of the gender-based imbalance of power, zero tolerance for physical and psychological violence, correction of economic shortcomings, reinforcement of the social network and information and education.

Although primary prevention is considered to be targeting society at large it is worth separating different target groups within in order to avoid remaining on a rather superficial level. Anita Heiliger's model of prevention distinguishes three levels of primary prevention: general primary prevention intended at implementing changes in social structures such abolishing gender-based hierarchies and thus establishing gender equality, primary perpetrator prevention dealing with changing the male self-image implicit in gender-based hierarchies, notably the notion of male supremacy over women, proprietary rights and authority over women and children, and the exercise of power and thirdly, primary victim prevention which is about strengthening the victims' self-esteem and resistance, (…) reinforcing and anchoring their autonomous social and emotional situation (…) (see Heiliger 2000: 168-169). Heiliger's suggestions relate to the sexual abuse of girls but her classification holds good for the entire field of prevention.

The WHO calls for a systematic approach in promoting primary prevention, following six steps (see WHO 2004 : 43-46): mapping existing primary prevention programmes, supporting and evaluating demonstration programmes, disseminating country-specific prevention experiences, advocating primary prevention, integrating primary prevention into routine local and national government work and building sustainability mechanisms. As the mention of evaluation clearly indicates, the research field is called upon to help to identify measures which have long term effects, which support a social change. Even if we see the willingness for promoting and advocating such a change we have to be wary so that all other forms of prevention are not becoming endangered, especially by the withdrawal of financial resources. We still live – and will be living for quite a while – in a society in which at least every fifth woman experiences violence in a relationship.

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Notes

1 Violence against women takes many forms. Although they are often treated separately, both in the practical as well as theoretical field, it is important to regard them as one problem which demands a diversity of action and activity to be taken. Although this essay primarily deals with intimate partner violence (IPV) all other forms of violence against women are as serious as IPV. Intimate partner violence is also often called domestic violence, both belonging to interpersonal violence. However, none of these terms indicates the sex of victim and perpetrators. That is why many feminist advocates and researchers tend to use the term male violence against women (in relationships).

2   In the 1993 Declaration on the Elimination of Violence Against Women (United Nations 1993) Article 2 gives the following definition: Violence against women shall be understood to encompass, but not be limited to, the following:

(a) Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation;

(b) Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution;

(c) Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs.

3   In the Beijing Declaration and Platform for Action, the outcome document of the 4th UN World Conference on Women, it says: Violence against women is a manifestation of the historically unequal power relations between men and women, which have led to domination over and discrimination against women by men and to the prevention of women's full advancement. Violence against women throughout the life cycle derives essentially from cultural patterns, in particular the harmful effects of certain traditional or customary practices and all acts of extremism linked to race, sex, language or religion that perpetuate the lower status accorded to women in the family, the workplace, the community and society.

"Our Bodies, Ourselves" – A Polish Edition as a Way to Reclaim Women's Bodies and Promote Choice In Poland?

Malgorzata Tarasiewicz

Summary

In 2004 a few Polish women's organizations published a Polish translation and adaptation of an internationally famous feminist book "Our Bodies, Ourselves"[1]. The book has turned out to be especially important in Poland. Why this you may ask? Our answer: A traditional and stereotypical approach to women supported by the Catholic Church and right wing parties resulted in a huge lack of information about body issues, sexuality and health care problems specific to women.

The article shows the situation of Polish women with a special focus on reproductive rights and the consequences of illegality of abortion. It shows the ways in which publication of "Our Bodies, Ourselves" in Polish works to empower Polish women and change their situation by giving them access to practical information.

> *"Within these pages, you will find the voice of a wome"s health movement that is based on shared experience. Listen to it – and add your own."*
> *(Gloria Steinem, 1998)*

What makes "Our Bodies, Ourselves" special?

" 'Our Bodies, Ourselves' reflects the health concerns of women of diverse ages, ethnic and racial backgrounds and sexual orientations. It is a source of new information, references (including Internet resources) and personal support for the decisions that will shape women's health and women's lives. Its topics explore a range of issues from living a healthy life, to relationships, sexuality, childbearing, and growing older, to dealing with the medical system and organizing for change. This is a book for women of all generations to use and to share with others. It attempts to raise awareness within society about the health, sexuality and reproductive rights, distributes practical and usable knowledge, gives individual advice, and makes recommendations for change. It also attempts to encourage women to speak openly about their experiences and induce change. It aims at helping women with respect to their treatment by state institutions such as maternity wards and prosecutor offices where they report domestic violence cases. The publication attempts to encourage women to speak openly about their experiences and induce change as well as promote a pro-choice attitude to women's stereotypical roles and

make them familiar with their reproductive rights, provide them with self-help and self-care tools."[2]

Why Women's Organizations Decided to Publish the Book in Polish in 2004?

The idea of the publication of the book in Poland has been in the air for many years, beginning in the early nineties right after the fall of communism. Unfortunately, women's groups which wanted to undertake the publication had not enough funds to print the book. They were promised funds by the government when left wing parties were in power but, with the right wing winning, the election the promises withered away.

Again, the idea to publish the book reappeared ten years later in 2002 and was taken up by three women's groups, one dealing with reproductive rights, the other group concerned with care for women giving birth and the third one which coordinated the project dealing with women's rights in general. This time the publication was successful and the book appeared in the book stores in November 2004 after two years of intense work of many women's groups and individual women. It has around 800 pages and is sold for the price that covers the costs of production and is given for free to libraries and women's groups. The book is not a mere translation from English but it is an adaptation of the book to the Polish conditions and needs. It is illustrated by pictures of Polish women and letters and stories of Poles. Also the bibliography and contact addresses which can be found at the end of each chapter were changed. Some chapters were written anew – like a chapter on the health system in Poland.

The book seems particularly relevant for Polish women. The idea behind the book was to initiate a public debate and draw attention to the issues of women's health and public health care. The reasons why such a book and debate are needed lie in the fact that the health care sector in Poland is in the process of constant reform. The result is that there is a lack of clarity and the atmosphere of confusion in the general population regarding the public and private health-care services. This lack of clarity often translates into a lack of knowledge about health care, illness prevention, and treatment. It also results in a lack of trust in the medical system. Patients seek reliable information and the book aims at offering this kind of information to them.

Women in Poland do not have a large repertoire of information about body issues, sexuality, and health care problems specific to women and especially about reproductive health including contraception. From our per-

spective, issues connected to abortion (which is illegal in Poland) need to be discussed more openly – like abortion availability or procedures. At the same time due to the positions taken by some political parties and Catholic Church, sex education is not generally available in schools. Our position is that solid factual information is needed to counteract popular myths and stereotypes.

In Poland, because of conservative attitudes in society resulting from strong influences of the Catholic Church, issues connected to women's body are treated as a taboo. There is a strong tradition of shame associated with disclosure of "internal" family problems. The scopes of these problems range from women's reproductivity to domestic violence. Due to stereotypes about traditional roles of women and men, domestic violence is not recognized as a serious social problem. Its cases are often not reported because of a strong tradition of shame associated with its disclosure. Domestic violence in many communities is often accepted as inevitable. "Our Bodies, Ourselves" speaks about violence against women and gives advice to women, victims of this type of violence.

A Need for Information and Knowledge Which Supports Change

The publication of the book aims to initiate a public debate about the treatment of women by state institutions, starting with maternity wards and ending with a prosecutor office where they report the domestic violence case. The authors of the Polish edition of the book want women to speak openly about their experiences and induce change as well as promote a change to women's stereotypical roles and make them familiar with their reproductive rights.

The Polish edition came at the most appropriate time. The recent reform of health care seems not to serve the population well. Not only patients but also medical professionals are disoriented and confused about the rules of the new system. Moreover market economy brought about new threats. Powerful pharmaceutical companies encourage physicians to prescribe pricey drugs, not always to the benefit of the patients. There are numerous new private clinics, which charge a lot for their services whose quality may be pathetically low. At the same time it is difficult to be well informed about the rules on how to use the public sector of health care. The public sector often provides only very basic services. It takes months of waiting to get some tests prescribed by specialists. There are women's organizations supporting women who had to undergo mastectomy or for breast-feeding mothers, but they are all based in big cities. Thus they are not accessible to masses of women. Circulation of information and exchange of experience

are limited to a minority of women only, others have no chance to participate in support groups as there is no such thing in their towns or villages. Information or advice on the phone, legal or psychological assistance are not always readily available either.

That is why the value of the book is immense. It is of vital importance for Polish women to know where and how to get help in case they are sick, what questions they should ask when talking to a physician, what rights they have as patients. Women need to be aware of their health situation and this will help them choose what seems best for them.

The selection of information and texts is deliberate and it aims at strengthening the position of women in their contacts with health care professionals. The book tells them explicitly they have the RIGHT to demand the information they need. It is also important to point to the readers that their active participation in the treatment is necessary.

In the US the feminist movement initiated changes in the health care system back in the 70s. It was then when women started to talk loud about the lack of appropriate information, abuses in medical procedures, lack of safe contraceptives. They rejected treating natural phenomena like pregnancy, birth, confinement after childbirth and menopause as diseases.

There is no social movement in Poland working to improve health care and probably it will not get started any time soon. You can easily count organizations or support groups for women on the fingers of one hand. "Our Bodies, Ourselves" can fill the gap and inspire changes.

No Respect for Reproductive Rights[3]

Even though the government is leftist now, and though its members made extensive promises to women in the pre-election period about introducing legislative changes which would support pro-choice legislation, Polish current laws and practice do not guarantee respect of sexual and reproductive rights (The Anti-Abortion Law in Poland 2000).

Of all contraceptives only condoms and spermicides are easily available in stores. They are inexpensive and can be purchased by anonymous buyers. The drawback is however that there are no vending machines in places where they are most needed, like campuses, pubs and clubs.

Other contraceptives are not sold over the counter and are more expensive. Family doctors or doctors in public health centers are those whom patients contact first and those doctors usually are not willing to prescribe contraceptives as it means more work for them for which they are not re-

imbursed. So gynecologists are usually the ones who have to deal with those issues. Since they can only see a limited number of patients a day, the waiting period to get a prescription extends to a few weeks.

Another obstacle is the so called "conscience clause". Basically it gives a reason to a doctor to refuse to perform or help perform an abortion, but sometimes it is also used as the reason to refuse the prescription of contraceptives, including hormonal drugs. It is based on the teachings of the Catholic Church and a pronatalistic policy, which favors a family model with many children. The only contraceptive acceptable and recommended by the Church is the ovulation rhythm. Other methods are thought to be equivalent to abortion and prescribing them is considered as a support for the "civilization of death". This perception of contraception is also presented in schools.

There is pressure on physicians too. For example, *Gazeta Lekarska (Medical Journal)*, the official monthly magazine for doctors, does not publish texts which would not be in keeping with a Catholic point of view. At the same time it does publish texts written by the chaplain of the health service workers which are strictly religious, presents photographs from official catholic ceremonies, and prints invitations to religious celebrations and events. It supports an impression of the omnipresence of the Catholic Church and makes it difficult for a physician to oppose if they want to be part of the professional circles. It is difficult to find a doctor with a pro-choice attitude or somebody who is willing to prescribe contraceptives since no institution has a list of them.

The "morning after" pill is also very difficult to purchase. Prescription is required. It is expensive and frequently sold out. Waiting period is 2-3 days, which contradicts the very sense of using it.

Surgical procedure causing infertility is never performed on men. It can only be performed on women if pregnancy is not recommended for medical reasons. It is decided by physicians, not by women. Otherwise sterilization is punishable by up to 10 years in jail for the doctor.

Abortion can only be performed by a physician if:

1. pregnancy threatens health or life of a woman (no terms)
2. prenatal examinations indicate high probability that the embryo is abnormal, has defects or a grave disease (before the embryo is capable of independent living)
3. pregnancy is the effect of a rape (up to 12 weeks)

For many years the number of official abortions in Poland – a country of 38 million – is around 140 per year. It is hard to estimate the real number – it

probably approaches 80 thousand or even more, as some women's groups claim.

Women who decide to have an illegal abortion can do it quite easily in Poland (in the so called "abortion underground") and the same doctors who refuse an abortion at the public health clinics do it for money in their private practice. In many newspapers there are 'hidden' advertisements which say "bringing back your menstruation" or "safe and discreet gynecological procedures". The major problem is the cost of an illegal abortion which may be as high as 800-1000 US dollars, which is a lot taking the average Polish income into account.

From time to time there is news in the media about an arrest of a doctor who performed an illegal abortion and the abortion ends in bad health consequences for a woman. Some women choose to go abroad (it is called "abortion tourism"), to former Soviet Union states like Ukraine or Russia (Kaliningrad) if they want to have the abortion cheaper (the cost of abortion there is rather low – 200 US dollars – but the sanitary conditions are often very bad), or to Western Europe if they can afford it. Usually they choose Holland, Germany, Belgium and Austria. There are special agencies that organize "abortion tours".

Illegal abortions bring grave health consequences for women or even end in death, like a woman whose story was told by Shana Penn (2001) in her article "Breaking the Silence: How Poland's Abortion Law Jeopardizes Women's Health and Rights"

> "Kasia was the mother of a one-year-old child, when she became pregnant a second time. She decided, with her husband's support, to have a 'private' abortion. Although her pregnancy was in an advanced stage, she found a doctor who agreed to do the costly abortion in a private clinic. Complications arose during the operation, which required emergency medical attention, such as only hospital facilities provide. Rather than bring his patient to a hospital emergency room just 500 meters from his clinic, the doctor transported Kasia to a hospital 20 kilometers away, because he feared for his own legal culpability more than for the grave risk placed on his patient's life. Kasia was delivered to the hospital too late to be helped. She died there. Her family was only informed of her death when they arrived at the hospital."

There have been many complaints from women about the obstacles they meet trying to get a legal abortion. Any of the three points of the law is difficult to prove. A woman's health is rarely seen as poor enough to justify abortion, but there are cases when woman became nearly blind or had a brain tumor and died soon after delivery but still: abortion were refused to them and prenatal examinations were hard to get. Prosecutors often delay

their action beyond the 12th week of pregnancy before they state that pregnancy was a result of a criminal act. There are lawsuits already filed by women who could not get a legal abortion and gave birth to children.

Still another obstacle is the "conscience clause". In theory, when medical personnel claim this clause, they are obliged to inform the women about another place where abortion will be available, but it is done extremely rarely, even though in 2003 the Minister of Health appealed to local authorities to remind them that they are obliged to help women who want to use their right to legal abortion (see also: Women's Hell, contemporary stories 2001).

Those few legal abortions that are performed are done mostly surgically. It is one of the worst methods, which often results in complications. Some safer methods, like the "vacuum method" are not common and the abortion pill RU 486 is not registered in Poland.

Poland is a country rather free of sexually transmitted diseases (STDs), but it is not because of the efficiency of health system, but rather because of condom use and low promiscuity of the population. A network of free health centers dealing with STDs exists, but the centers are mostly located in big cities. Because some men are ashamed to seek help from women, and many family doctors or doctors in public health centers are women, men choose rather not to seek help. Microbiological tests are expensive and insurance does not cover their costs. As a result some dangerous diseases, like HIV, develop undetected for years.

A Book About Women's Life in Contemporary Poland

American women wrote their book from their perspective including social and economic context in the US and the human rights situation there. In the Polish version we refer to our Polish reality. Hence, the Polish "Our Bodies, Ourselves" is more than a medical manual for women. This book is capable of being a true support for all women in the tough times that they have in Poland. It can inspire changes in some particular cases, but hopefully it can also initiate a broader movement for improvement of health care for women.

Many Polish women live some sort of "double lives". They do not express disapproval against moral and legal bans and they learn to live omitting them. This enforced moral hiatus is the result of fear. Women are afraid to be publicly condemned. "Our Bodies, Ourselves" suggests an alternative to this attitude through discussing women's issues openly and in a way which is socially involved. This book pertains not just to women's

bodies. It is a book about women's life in contemporary Poland. Women's situation in Poland is gradually changing, due to many factors like Polish accession to the European Union or development of a civil society. And also thanks to publications like "Our Bodies, Ourselves". The objectives that stood behind its Polish edition like

> "raising awareness within society about health, sexuality and reproductive rights, distribution of practical and usable knowledge, (…) and making recommendations for change"

have been implemented. The popularity of the book proves that it has been useful and also that the goals of the Polish editorial team promotion of choice and empowerment of women have been supported immensely.

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Notes

1   The edition has the title: Nasze ciała, nasze życie (see bibliography).

2   From the website of the Network of East-West Women, http://www.neww.org.pl.he concept of this paragraph has been taken from the introduction to the US edition of „Our Bodies, Ourselves", 1998.

3   This chapter is based on the Beijing+10 Polish Alternative Report edited by eFKa and NEWW. The chapter on Health in the B+10-Report was written by Bozena Jawien.

**Facts and Figures on
Gender and Health in the New Europe**

Gender in the Field of Public Health – Implications for Policy
Peggy Maguiré

Introduction

To achieve the highest standards of health for all, health policies and health care have to recognise that women and men, due to their biological differences and their gender roles, have different needs and are faced with different obstacles and opportunities. Equity in health depends on the recognition by the health sector that men and women differ in terms of their sex and gender. Sex refers to biology whereas gender refers to the social and economic roles and responsibilities that society and family assign to them. Accumulated evidence suggests that both sex and gender influence health risks, health-seeking behaviour, health outcomes, for women and men, their access to health-care systems and the response of those systems.

Reducing inequalities in health is important, not only to increase the number of years lived in good health for the most vulnerable but also because policies aiming at decreasing the gaps increases the health status for the population as a whole. A number of countries monitor different health indicators linked to socio-economic position, but the evidence gained does not always influence health policy development. The interaction between socio-economic position and health is seldom considered in policy. There is a gap between information and policy and a corresponding need to raise the questions posed by such monitoring into each countries parliamentary discussions and to annually look into the effects and consequences of Government policies by tracking changes in different health indicators for vulnerable groups.

Demographic and Socio-Economic Trends

Generally populations in the older EU countries are rising, albeit very slowly. Populations however, in most accession countries are falling, owing to a combination of emigration and deaths exceeding births. This has particularly affected countries such as Bulgaria and Estonia.

We know that almost fifty-five percent of the total world population consists of women (United Nations 2000) and that this percentage is likely to steadily increase over the first quarter of the 21st century. In Europe, women as a percentage of the total population varies, but ranges from

50.3% of the population in Ireland to 53.9% of the population in Latvia. There is no country where women constitute less than 50% of the total population. Europe also has the highest proportion of older women in the world. There are now approximately three women for every two men between the ages of 65 and 79, with over twice as many women over the age of 80.

Life Expectancy

Life expectancy for men and women is increasing in all countries across the EU. Life expectancy at birth is the number of years a new-born infant would live if prevailing patterns of mortality at the time of its birth were to stay the same throughout its life. In 2003 the average life expectancy at birth was 81.1 years for women and 74.8 years for men in Europe (Genderstats 2004). In all countries life expectancy for women is greater than that for men. Generally, life expectancy stagnated for many years in EU-10 before rising in the late 1990s; however, in the older age groups life expectancy is below EU-15 levels. Only Slovenia and the Czech Republic are approaching the life expectancies of the older EU countries (WHO Regional Office for Europe and European Commission 2002).

On 1st May 2004, the European Union (EU) enlarged from 15 countries to 25 member states.

It is a fact that women live longer, but it is also true that they suffer from worse health conditions than men do. The reasons are partly biological, but social influences also play a major role.

Deteriorating health is a frequent, though not inevitable, part of the ageing process for both sexes. Moreover the ageing process itself is highly gendered and old women are biologically more susceptible than men to certain disabling diseases including rheumatoid arthritis, osteoporosis and Alzheimer disease. Because of inequalities in income and wealth in earlier life, older women are also likely to have fewer resources at their disposal and are less likely than men to receive assistance from relatives and friends. Due to women's lower participation in the labour market, they receive fewer pension benefits and their economic situation if they retire or become widowed is more precarious than for men.

Figure 1: Life Expectancy at Birth 2003
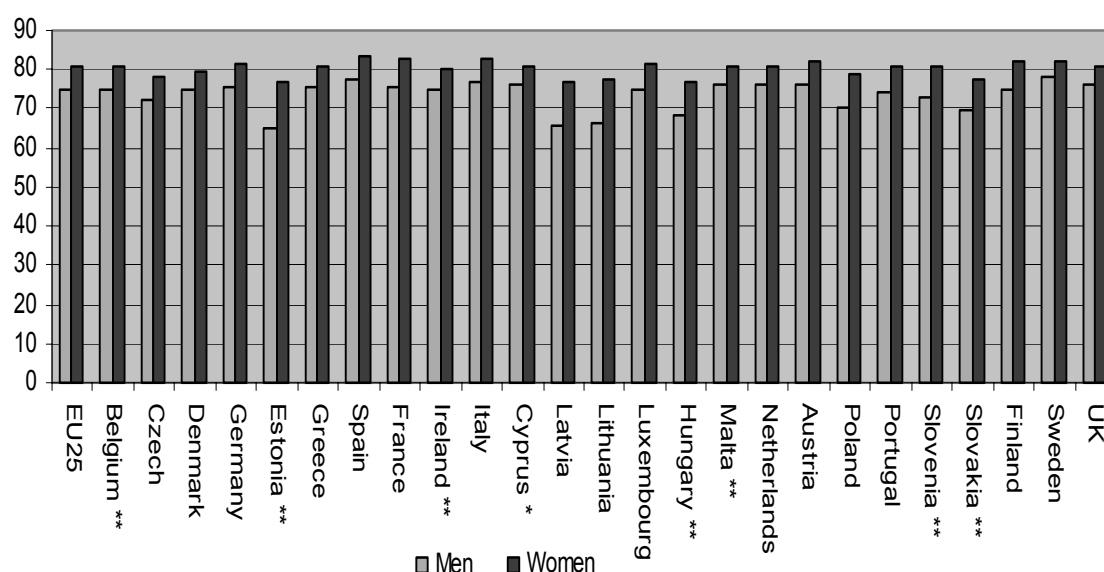
Notes: * data for 2001, ** data for 2002
Source: European Commission 2004: 9

In Europe, the female advantage in longevity started to emerge at the end of the last century and continuously increased since then. In Europe this gap grew as economic development and social change removed some of the major risks to women's health (death in childbirth). In this situation a variety of social and cultural factors have combined to allow women's inherent biological advantage to emerge. The risks of infectious diseases and child-bearing have been reduced while certain risks associated with masculinity have increased, giving women longer lives. Many men feel compelled to engage in risky behaviour in order to 'prove' their masculinity. This means that they are more likely than women to be murdered, to die in a car accident or in dangerous sporting activities. In most societies they are also more likely than women to drink to excess and to smoke, which in turn increases their biological predisposition to early heart disease and other health problems. They also seem to be more likely than women to desire unsafe sex (European Communities 2004). In some of the countries of the European Union the gap between male and female is extremely wide. However, this gap may be narrowing on account of changes in life style among women. In particular smoking has been identified as one of the major factors reducing the life expectancy of women.

Death Rates

There are large differences between the death rates of men and women in the EU. According to the Eurostat Yearbook (European Communities 2004: 69) the death rate from cancer for men (1999: 216 per 100,000 persons) was higher than the rate for women (118). In 1999 the death rate from ischaemic heart diseases was twice as high for men (127) as for women (62); whilst death rates from suicide and traffic accidents was more than three times higher for women (13.6 for men and 4.3 for women and 14.4 for men and 4.4 for women respectively).

Cancer

Cancer kills approximately 1 in 4 people in Europe, affecting one in two men and one in three women at some stage in their lives (EIWH/ EMHF 2004). The figure below compares deaths from cancer for men and women per 100,000 population in Europe.

Cancer, particularly breast and cervical cancer, is the main cause of death for women aged 35 to 64 years. Furthermore, the incidence of lung cancer amongst women is increasing rapidly and is now also one of the most common cancers. Among women the rate of colon-rectal cancer is also high in all European regions. As the incidence of cancer increases steeply with age, and because life expectancy is improving everywhere, the number of cancer cases will continue to increase. At the same time about one-third of new cancer cases are related either to more exposure to risk factors or to the fact that more cancers are being found by more intensive screening methods.

Figure 2: Deaths from cancer per 100,000 persons, 1999
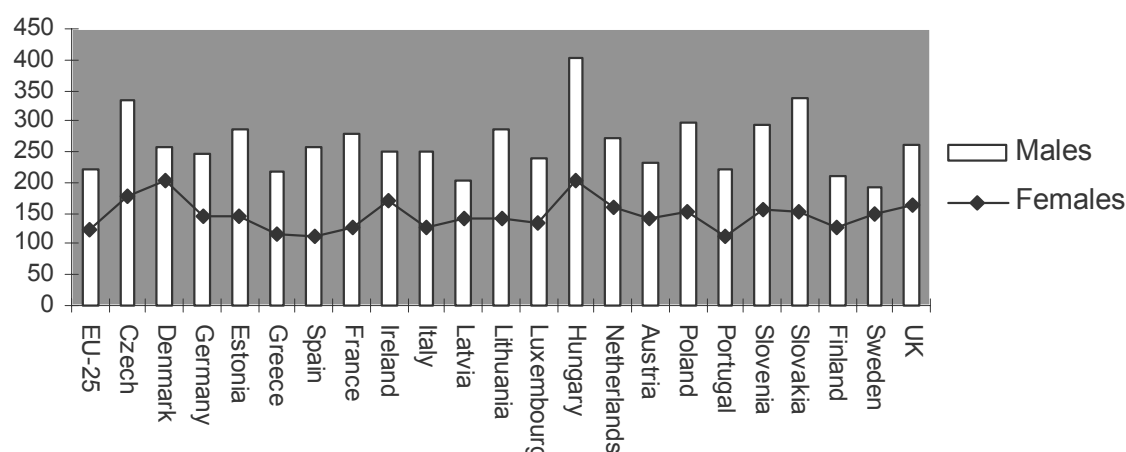
Source: European Communities 2004: 69

Cardiovascular disease (CDV) is the number one cause of death in Europe and most other industrialised countries. It causes 1.9 million deaths a year in the 25 countries of the EU (European Heart Network 2004). The most common cardiovascular diseases are hypertension, ischaemic heart disease and cerebrovascular disease. Cardiovascular disease is an important cause of premature mortality in the accession countries and rates are higher than the EU average. In particular, cerebrovascular mortality is disproportionately higher than levels in the EU, with even the best countries having rates higher than any other EU-15 country except Greece (WHO Regional Office for Europe and European Commission 2002).

Gender and Public Health

Public health policy is strongly influenced by the population indicators used to evaluate the health of a nation. Mortality rates have traditionally been considered to be the main reference point for public health policy and to this end the major targets have been those diseases which are life-threatening, notably cancer and cardiovascular disease.

As an increasing proportion of the population reach old age there has been an increased interest in morbidity, notably chronic illness and pain, and public health researchers have pointed to the need in recent years to focus on the reduction of health related disability. The essential dilemma for policy makers has been that while medical technology has greatly increased survival, it has simultaneously extended the proportion of life spent in states of disability, pain and mental suffering. While survival rates have usually been the gold standard for monitoring the health status of the European states, new synthetic indicators are now appearing such as DALYs (disability-adjusted life years) and QALYs (quality adjusted life years) which examine the state of health of survivors, measuring healthy life expectancy and not just life expectancy. This change in focus has revealed more complex relations between gender and health. For example, we now know that, while women have higher life expectancy, they also spend greater proportions of their life in states of chronic illness and disability at all ages. Unless tackled early rises in incidence rates for diseases such as osteoporosis could, expected increases in male life expectancy, lead to levels of disability in men comparable to that of women. Measuring the impact of public health policy in terms of morbidity as well as mortality will help address gender imbalances. It will also broaden health targets for diseases with high mortality such as cancer and heart disease, so as to include diseases with high morbidity such as arthritis and osteoporosis (EIWH/ EMHF 2004).

Health Issues more Prevalent Among Women

Some diseases are more prevalent among women than men, though both sexes can be affected.

Breast cancer

Although men can get breast cancer too, this condition is typically associated with women. It is estimated that 1 in every 12 women will develop breast cancer at some point in their lifetime. Risk factors for breast cancer can include genetic predisposition, hormonal effects and age.

Age is in fact the most significant risk factor in breast cancer, as the incidence of breast cancer increases with age, doubling about every 10 years until menopause, when the rate of increase slows dramatically. Every year in Europe over 200,000 women will be confronted with a diagnosis of breast cancer. The incidence of breast cancer is still rising in most of the Member States, but it is also acknowledged that this may not constitute a real increase, but be more related to the increased level of early detection through screening programmes. So far, very little research has been done on the possible causes and risks factors for breast cancer. Existing research tells us that the major risk factors are age (the risk increases with age) and having a mother or sister with breast cancer, but many women develop breast cancer without any of these factors present. Because of this lack of knowledge about additional factors contributing to the development of breast cancer, it is necessary to promote more research on the subject. Secondary prevention through early detection by self-examination, clinical examination and mammography become also very important.

Eating disorders

Eating disorders, anorexia and bulimia nervosa, directly linked to the rate of morbidity and mortality are examples of areas where more gender specific research is needed. There are no national statistics on the incidences of these illnesses in any Member State of the European Union. All existing data is based on partial national surveys, but the data presented varies considerably and it presents parameters impossible to be compared at European level.

Despite all the mass media attention given to the issue, there is not national public health policy on eating disorders anywhere in the EU. This lack of national public health policies is important since the treatment of these illnesses require, in most incidences a multi-disciplinary approach using a range of nutritional counselling, psychotherapy, family therapy and

medical supervision. These treatments become impossible if the clinics do not have special units for addressing eating disorders.

Osteoporosis

Osteoporosis is a major public health problem through its association with fracture. Across Europe some 19 million people are considered to suffer from osteoporosis. One in three women and one in eight men over the age of 50 are affected by an enhanced bone fragility and an increased fracture risk (International Osteoporosis Foundation 2004).

Eighteen European centres are participating in a European Prospective Osteoporosis Study (EPOS) which is examining women over 50 years of age with back pain and disability associated with vertebral fractures (O'Neill, Cockerill, Matthis et al. 2004). Another EPOS study is examining the incidence of limb fracture by site and gender in different regions of Europe with men and women aged 50-79 recruited from population registers in 31 European centres (Genderstats 2004). For women they have found that the incidence of hip, humerus and distal forearm fracture increases with age; there was evidence of significant variation of these fractures across Europe with incidence rates higher in Scandinavia than in other European regions, though for distal forearm fracture the incidence in east Europe was similar to that observed in Scandinavia.

Linked to osteoporosis is the issue of limb fracture. One study found that across Europe there are substantial differences in the descriptive epidemiology of limb fracture by region and gender and that amongst women the incidence of hip, humerus and distal forearm fracture increases with age, with incidence rates higher in Scandinavia than in other European regions (Ismail, Pye, Cockerill et al. 2002).

Mental Health Disorders

Statistics on mental health disorders often conceal the considerable differences that exist between men and women in the prevalence of specific types of mental disorders and at different stages of the life-cycle. Worldwide, and in general terms, the mental disorders of childhood are more prevalent in boys, but in later life women are more likely than men to suffer from poor mental health. Depression and depression-related problems are today amongst the most pressing public health concerns. The European Commission claim that depression and depression-related problems account for more than 7% of all estimated ill-health and premature mortality in Europe. The burden of depression, beyond that caused to healthcare systems, include the loss of quality of life for those affected and their families,

a loss of productivity for firms and an increased risk of unemployment for individuals.

Table 1: Prevalence of depression in European epidemiological studies

Country	Age Range	Gender prevalence (%)	
		Male	Female
Greece	All ages	4.3	10.2
Netherlands	18-64	1.9	3.4
Spain	> 17	4.3	5.5
UK	16-54	1.7	2.7
	54-64	2	1.1

Source: Ayuso-Mateos, Vázquez-Barquero, Dowrick, Lehtinen, Dalgard, Casey, Wilkinson, Lasa, Page, Dunn & Wilkinson 2001: 308-316.

One important consequence in relation to mental disorders is suicide and attempted suicides. Risk factors for suicide and parasuicide (attempted suicide with higher rate among women) include alcoholism, depression, and socio-economic problems. Women with eating disorders, such as anorexia and bulimia, are also at higher risk of committing suicide and parasuicide. Statistics also show that women who have attempted suicide are much more likely to try again. Women are twice as likely to be diagnosed as depressed, yet doctors often do not take women with depression seriously. Elderly women have the added disadvantage to suffer the stereotype that depression is a normal part of ageing. But depression can often be treated or at least managed. Specialists point out that women have different symptoms when they suffer depression. On many occasions, physical consequences of depression are classified as something other than depression. Therefore doctors must learn to recognise symptoms of depression among women if they want to provide adequate treatment.

Violence against Women

Gender violence is a greater cause of death and disability among women aged 15 to 44 than cancer, malaria, traffic accidents or war. The World Health Organisation believes that at least one in five women in the world has been physically or sexually abused at some time in her life (World Health Organisation 1997). The consequences of violence against women for their health also constitute an example of the negative effects on women's health produced by gender inequalities.

Health Issues Specific to Women

Reproductive Health

It is important to analyse the development and variations of fertility rates in the European Union before going more deeply into the subject matter. Women's fertility rate in Europe has declined by 45% between 1960 and 1995. The Scandinavian countries had for a time the lowest total fertility rates, but now have one of the highest. At the same time, these countries have now the highest percentages of female participation in the labour market. High fertility rates used to be associated with low labour market participation. This common assumption has been turned upside down in the Nordic countries.

Obviously women are more likely than men to suffer health problems connected with their reproductive systems. For example only women need screening for cancer of the cervix and breast cancer. Their capacity to conceive and bear children brings women into the arena of the health care system more often than men. They may be perfectly healthy but they are either seeking access to fertility control or support during a normal pregnancy, because childbearing and pregnancy still constitute health risks.

Cervical cancer

Cancer of the cervix is the second most common of the female cancers in the European Union. It is a type of cancer that develops very slowly and can be successfully treated if detected early. High rates of cervical cancer can be observed in Eastern Europe, particularly in Lithuania and Hungary. As the burden of cancer grows across Europe, such that cancer is now the second major cause of death, every country in the EU needs to examine its own cancer data and determine its priorities for cancer prevention and care.

Health Issues Affecting Women Differently

The natural development of a disease may be different in women and men. Women and men also respond differently to treatment, have different access to health care and are treated differently by health care providers.

Cardiovascular disease

Cardiovascular disease (CDV) is the number one cause of death in Europe and most other industrialised countries. It causes 1.9 million deaths a year in the 25 countries of the EU (European Heart Network 2004). The most common cardiovascular diseases are hypertension, ischaemic heart disease and cerebrovascular disease. Cardiovascular disease is an important cause

of premature mortality in the accession countries and rates are higher than the EU average. In particular, cerebrovascular mortality is disproportionately higher than levels in the EU, with even the best countries having rates higher than any other EU-15 country except Greece. Much of the research on cardiovascular disease has been based on long-term studies of men, so the findings are not always applicable to women. Yet, cardiovascular disease remains a lead killer of women in most developed countries. Factors that have been identified as contributors to cardio-vascular disease for women include cholesterol, smoking, high blood pressure, obesity, physical inactivity, hormonal changes and diabetes mellitus. The natural development of a disease may be different in women and men. Women and men also respond differently to treatment, have different access to health care and are treated differently by health care providers.

HIV/AIDS

An important increase in the number of HIV positive women reflects their greater biological vulnerability to this illness. It is also a consequence of profound inequalities between men and women that continue to characterise heterosexual relationships.

Biologically, the risk of HIV infection during unprotected vaginal intercourse is 2-4 times higher for women than men. Women are also more likely to have other STD's (sexually transmitted diseases), that can increase the risk of HIV infection by 3-4 times. This is because women are biologically more vulnerable, and because 50-80% of STD's in women have no symptoms or symptoms that cannot easily be recognised. Even if women feel symptoms, they may prefer to suffer the pain because they are ashamed to go to the doctor.

If a woman becomes infected with HIV, she may suffer inequalities during the treatment. In the United States, for example, where there are a lot of resources destined to fight this illness, there appears to be a gender bias in the allocation of resources. Moreover women have been excluded from clinical trials and women are frequently diagnosed at a later stage.

Occupational Health

In the last years, there have been major changes in the working life of women that have had a direct and indirect effect on their health. Musculoskeletal disorders comprising neck and shoulder pain, low back pain and osteoarthritis, are one of the most common diagnoses behind sickness absence and disability pension. A study in Sweden has found the highest incidence and duration of sickness absence for women in male-dominated oc-

cupations. For both genders the lowest cumulative incidence and duration occurred in gender-integrated occupations (Leijon, Hensing and Alexanderson, 2004). These disorders are increasingly common with advancing age, but generally receive little attention, despite enormous costs for society. These diseases affect an increasing proportion of the population, with various degrees of impact on disability and quality of life resulting in a significant number of physician visits, work absence and medication use.

Gender and Research

In relation to research and policy, full attention to the female gender has only been given in the area of reproduction and even there, many gaps still exist between women's health needs and health care provisions. Ignorance to women's health needs or one-sided attention to the health needs of men are not only discriminatory, but may indeed contribute to generating life threatening conditions for women.

Coronary Heart Disease (CDH), for example, continues to be seen as a male disease. Most research studies are carried out only on males because it is understood that more men die from CDH than women do. It is generally ignored, however, that this illness is also the single most important cause of death for post-menopausal women (see report of the European Heart Network -EHN- on heart disease).

Yet another example is the lack of information on the different effects that medicines may have on women and men, and the dosages that may be best for one or the other sex. It is a fact that women consume more medicines than men, but most pharmaceutical research is still carried out on men, even when it is known that the disease in question is more frequent in women than in men. We know today that women react differently to medicines than men because of the different way in which the female body absorbs the medication among other things. This is especially clear in the following cases:

- Anti-depressive pharmaceutics: women need lower doses of anti-depressive
- medicines to get the same results.
- Hypertension: women have yet to be included in research on hypertension.

The exclusion of women from medical research has been justified on the grounds that their cyclical hormonal changes make the results difficult to be analysed. A further argument for the exclusion of women in clinical trials is the fact that they may become or be pregnant during the trial putting

the foetus at risk. Although these reasons may be important, they do not by themselves justify the exclusion of women from medical research and testing. The results obtained from research based on the male body are even nowadays applied to women without taking into account even the known biological differences between women and men. As a result, women are treated as patients with drugs never tested on the female body and without the knowledge of the precise symptoms in a female.

Gender Specific Education

Since education and training plays a central role in providing good health care for all, it is argued here that a gender perspective must be mainstreamed into all institutions that provide education and training on health care. It is of utmost importance that the health professions develop a gender sensitive approach and that the relevant teaching institutions begin to integrate a gender perspective into their curricula. The different health needs of men and women need to be met in an equitable manner in prevention, treatment and care services. Medical care and services often do not respond adequately to the specific needs and concerns of women and men. Health services for women tend to focus on their reproductive functions, neglecting other needs including those before or beyond reproductive age. Conversely, men's reproductive health needs are often inadequately met by health-care policies and services.

The means to help public health professionals to consider gender issues in their work are limited. Specific tools, guidelines, and training are needed to enable them to understand and incorporate gender considerations in their own work. In order to demonstrate that a gender perspective does improve the health of women and men, information about good practices needs to be widely available to public health staff.

Access to Health Care

There is now considerable evidence of differences in access to health care. To begin with, women use medical services more often than men do. Certain type of diseases pose a special risk for women: Obesity is associated with numerous health complications, including osteoarthritis, coronary heart disease and type-2 diabetes.

In the case of diabetes, women over 40 years old are at special risk, maybe because there are higher rates of obesity after menopause. But only 21,6% of women reported diabetes test in 1995. The same with osteoporosis and only 17% of women over the age of 50 have had a test for osteoporosis in 1995.

The reduction of incidence and mortality of cervical cancer through mass screening programmes is sufficiently proven. But in the European Union, it is organised by each Member States, as a result only 40% of all women aged 15 and over report having had a cervical smear in the previous year (Moschner, 1996).

Difference in Quality of Care

Mapping the differences in the quality of care for women and men is a difficult enterprise, largely because of the lack of studies in this area. It is also difficult to ascertain whether the differences in care are related to gender or other factors such as race and class. What emerges, however, is that care provisions are inferior for women who belong to another under-privileged group, such as black, migrant and ethnic minority women. However there are consistent indications that gender divisions can be a causal factor limiting the quality of care women receive.

This is especially evident in reproductive health services where providers are often too concerned with controlling women's fertility especially when it concerns marginalised groups of women such as disabled, poor and/or black and migrant women. They often suffer the adverse effects stemming from lack of information, cultural insensitivity and degrading treatment. Different treatment for women than men is the norm rather than the exception especially when it comes to treatment of heart disease.

Differences in Measuring Health

Measuring the state of health of one population group or another is important in ascertaining differences and adopting medical intervention to the needs of the group in question. It stands to reason that the collation and analysis of statistics on risk factors is an important tool in this context. It is therefore surprising that alcohol consumption among the female population in the EU is not measured.

Excessive consumption of alcohol is related to different types of cancer, mental health, cardiovascular diseases and reproductive health illnesses. Even worse, recent studies have suggested that health risks associated with alcohol abuse may be greater for women than for men.

Despite all these reasons, there is not gender-specific data on alcohol consumption at the European Union level. There are several studies carried out at Member State level, but global, i.e. comparable data is not available.

Similar picture emerges with obesity/diet and weight. These two factors have been linked to the development of a number of cardiovascular dis-

eases and cancer. There is data on overweight in the population in the EU, which shows that more women (20% of EU population) than men (15%) are overweight.

But there is a lack of specific data on diet habits. What is known is that there are only different dietary habits between the North and South of Europe, but data on differences in gender does not exist.

The same holds true for exercise. Although regular exercise is acknowledged to reduce heart disease, stress and other illnesses, and especially important to prevent osteoporosis in women, there is no gender specific data on physical exercise at EU level.

Conclusions

Scientific data that reflects the state of health of different population groups and divided along gender lines is an essential tool for improving the state of health of the population in Europe. Despite considerable progress in recent years at both national and international levels, gender inequalities in health remain in many areas across Europe. Strategies for promoting health at the community level have not yet been introduced in any systematic way to the enlarged European Union. Neither has a systematic analysis been undertaken of how the healthcare sector could or should respond with greater sensitivity to the varying healthcare needs of women across EU-25. There is a growing understanding of gender as a key determinant of health, and an appreciation that gender is equally as important as the social, economic or ethnic background of any individual. Crucially, we all seem to have moved on from the idea that women's health is considerably more than just reproductive health. There are still a number of conceptual barriers to overcome to get across this message, particularly in the new member states, but our experiences to date should facilitate us in making progress. All healthcare services in every country of EU-25 need to be sensitive to women's health needs, and to ensure gender mainstreaming in health it is necessary to make explicit how women's physical, psychological and social health should be addressed. The *Strategic Action Plan for the Health of Women in Europe* (World Health Organisation 2001: 8) seeks to:

- address the links between gender inequity and health
- ensure that women's health needs at every stage of their lives are fully considered
- facilitate the implementation of gender mainstreaming in health

Determinants of women's health stem from both sex differences and gender differences and interdisciplinary research into both these aspects is nec-

essary as well as tackling ways of reducing the magnitude of some of these differences. At its most simplistic level this requires the disaggregation of all health and healthcare statistics by sex to provide a more complete picture of women's health. Interdisciplinary collaborations to analyse existing data sources are also necessary: research on women's health generates a wide variety of data, ranging from essentially qualitative assessments, through to epidemiological and clinical trials. There is a need for research methods that can integrate data from diverse measures, which draw on many dimensions of individuals' or groups' social, cultural and biological backgrounds.

Determining the prevalence of certain diseases and conditions is difficult. Studies on prevalence often have to rely on either self-reports of a diagnosis or on extracting data from general practitioners or hospital records. Both these methods are limited because they omit cases of undiagnosed conditions and the criteria used by healthcare professionals in making diagnoses can vary. There were a number of issues pertaining to women's health for which there are no comprehensive statistics, and these ought to become research priorities in conjunction with the initiatives mentioned above. For example, there are no EU-wide studies on migraine and its effects on women. Health surveys are limited on Musculoskeletal diseases but would be a valuable source of information. Reporting on HIV infections is also incomplete although considerable progress is being made. Some of the countries with the largest HIV/AIDS epidemics, such as Italy and Spain, do not yet have national reporting systems; and this problem is common across a range of conditions and for both older and newer member states. One problem with 'official' reporting systems, such as those for drug or alcohol use, is that not all cases are diagnosed and reported, thereby leading to a misrepresentation of the situation. Tackling cases of under-reporting and improving the collection and collation of data across national and community systems ought to become a research priority.

We know that research priorities are shaped by the prevailing social climate, as much as the availability of resources. Different influences also guide the evolution of 'men's health' and 'women's health' as political issues. Good health is an integral part of life and an important resource for the quality of life of citizens across the European Union, the success of the economy and social cohesion. We all however, have a role to play in terms of advancing the cause of gender and health across the enlarged European Union, both in terms of providing encouragement for change and lobbying those with the power and influence to effect real and long-lasting change.

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Women's Health in Hungary

Csilla T. Csoboth

The concept of women's health in Hungary has only emerged in the past decade, even though women's physical and mental health in developed countries emerged as an important and separate entity of health research in the later half of the 20th Century. Women's health has not yet been addressed sufficiently as a separate health issue in Hungary, because the morbidity and mortality statistics of the whole population causes such concern that there are not enough resources left to deal with gender specific issues separately. Important women's health issues that need to be addressed are the high incidence of cardiovascular disease, lung and breast cancer, alcoholism, suicide, induced abortion, and violence against women.

While life-expectancy rates are increasing in North America and Western Europe, the health conditions of the Hungarian population are deteriorating, even though the political and economic system has improved through the past decade. The life expectancy of Hungarian women and men is the lowest, and the morbidity and mortality rates of certain chronic diseases are the highest among the European countries. Hungarian women live longer than Hungarian men, but their longevity is shorter, and their health and quality of life are lower than those of women living in other developed countries.

Health care financing has a tremendous impact on the health of women. In the past decades, health care expenditures have increased in many Western countries, but unfortunately they remain low in Hungary. The Hungarian health care system is a social health care system with free health care for all of the country's citizens. The total health expenditure of Hungary as a percentage of the GDP was 6.8% in 2001 (WHO, 2001). Comparatively the average percentage of health care expenditures of the GDP in the European Union was 8.6% in 1998.

Life expectancy at birth for women is 76.6 years and 68.3 years for men (Central Statistics Agency, 2004). This gender gap in mortality is especially important in Hungary, mainly because the gender difference in mortality rates is much narrower compared to other Western European countries. The gender difference in life expectancy (8.3 years) is much greater in Hungary (Central Statistics Agency, 2002) than for example in Sweden, where the difference is 5.2 years, in Austria, where it is 6.5 years (Euro-

pean Commission, 1997). Therefore even though Hungarian women live longer than their male counterparts, their health and illness state is much worse than in other countries.

Physical Health

Subjective health, the way a person perceives her own health, is a good indicator of objective health. The percentage of women in the European Union reported as in very good health varies from 45.9% in Ireland to 6.9% in Portugal (European Commission, 1997). Only 6% of Hungarian adult women rated their health excellent in 2002, compared to 8.9% of men (Csoboth, 2005). Of the surveyed adult women 5.3% rated their health very bad. In another survey, 34% of women older than 56 years rated their health worse when comparing themselves to their own age-group (Central Statistical Agency, 2004).

Preventable chronic diseases are mostly responsible for premature death among women in Hungary. Compared to men (37.1%), a higher percentage of women (59.6%) take medication regularly. In a community survey 19.6% of women were found to be chronically ill patients and 25.3% of women reported to have three or more physical complaints regularly (Central Statistical Agency, 2004). There are certain physical illnesses that have a higher prevalence among women, for example more women than men suffer from hypertension, ischemic heart disease, malignant tumors, osteoporosis, asthma, and diabetes (Central Statistics Agency, 2004). Compared to Western European countries, the occurrence of risk factors for cardiovascular disease varies. Results of the MONICA study (MONItoring trends and determinants in CArdiovascular disease, WHO) show that obesity among Hungarian women, specifically the waist-hip ratio, does not differ significantly compared to Western European women (Bobak, 2002), but nevertheless a large number of the female population are overweight. Sedentary life-style is frequent, especially among older women. Only 39.8% of adult women reported doing regular and intensive physical activity (Central Statistics Agency, 2004).

Mortality rates have increased among Hungarian women significantly since 1960 (9.6/1000 inhabitants). After a peak rate in 1990 (12.8/1000 inhabitants) there was a decline to 12.0/1000 inhabitants in 2002, but this rate is still higher than rates up to 1975 (11.6/1000; Central Statistics Agency, 2002). The leading causes of death among Hungarian women are ischemic heart disease, cerebro-vascular disease, acute myocardial infarction, malignant neoplasm of the lung, and neoplasm of the breast, the first two resulting in higher number of deaths among women, than men. The cause spe-

cific mortality rate for women (1994, latest available data, World Health Statistics Annual 1961-1994) shows a drastic increase with age, namely, while the mortality rate of cardiovascular disease was 12.6 (relative to 100,000 inhabitants of the same age group) in the 25-34 age group, it increased to 472.5 in the 55-64 age group (in comparison to France, where the cause specific mortality rate was 4.2 for 25-34 age group and 94.3 for the 55-64 age group in 1991).

The most frequent malignant diseases among Hungarian women is pulmonary, mammary, colon and rectal, cervical, and gastric cancer. The mortality rate of malignant tumors was 16.1 for the 25-34 age group, which increased to 425.0 in the 55-64 age group. The above mentioned mortality rates in the 25-34 age group have decreased since 1960, but have increased considerably in the elder age groups. Despite these tragic figures in Hungary, women's health to this day has not been addressed sufficiently as a separate health issue.

Reproductive Health

The population of Hungary is 10.1 million, but has been decreasing since 1981 (Central Statistical Agency, 2004). The female population is decreasing at a rate of –0.3. Of the 5.35 million women 93 thousand belong to the Roma minority group, the biggest minority group in the country. The crude rate of live births decreased from 13.9 in 1980 to 9.5 per 1000 inhabitants (Central Statistical Agency, 2004), which means a number of 38.3 live births per 1000 15-49 year old women. The fertility rate of Hungarian women is 1.31 per woman. Fertility rates have declined since 1960 when it was 2.02. The fertility rate is lower in the capital city (1.1) and higher in small rural towns (1.48). The average age of giving birth (first child) increased from 24.8 years in 1998 to 26.8 years in 2002. In the age group of 15-49 year old women, 38.8% were childless in 2003.

Family planning, maternal care, prevention and treatment of STD's are well organized in Hungary. All possibilities of contraception are available and most even affordable. Methods of contraception varies, of women between the ages of 19-41 years 37.7% reported using oral contraceptives, 17% intra-uterine device, and 8% condom (Social and Family Ministry, 2000). Abortion is permitted in Hungary, under certain criteria and conditions. There is a general time limit of the first trimester, has financial consequences, but is still cheaper than use of contraceptives (one induced abortion costs around 100 Euros for contraceptives? what quantity?), and the woman is required to attend pre-abortion counseling. Nevertheless, abortion is still quite high despite family planning services, but probably due to

the lack of information given to women. There are circa 60 thousand abortions per year in Hungary, meaning 58 abortions per 100 live births. 18% of these abortions are among women under the age of 18 years (Due, 2005). The number of abortions has substantially declined in the past two decades; it was 21.0 per 1000 women between the ages of 15-49 years in 2003 (Central Statistical Agency, 2004). This rate is still higher than the rates of countries in the European Union with the highest number of abortions, like Sweden (18.3 abortions per 1000 women) and France 13 per 1000 women; European Commission, 1997). The highest number of abortions was among women in the 25-29 year age group and among women with high school education. The frequency of abortions was the highest among single and married women, mainly among those who had three children or more (mhdsz, 2005).

Health Damaging Behaviour

The use of nicotine and alcohol is a major public health concern in Hungary. Although the frequency of smoking decreased from 47% to 40.7% in the general population between 1984 to 2000, it increased from 20.7% to 26,3% among women. This rate is somewhat higher than the average percentage of smokers in the European Member States (25%; European Commission, 1997). Excessive alcohol consumption in Hungary has resulted in a significant increase in mortality rates from liver cirrhosis, which is currently the highest among countries that report statistical data to the World Health Organization. Available evidence suggests that alcohol consumption is rising among women in Finland, Sweden, Denmark, the UK, the Netherlands (European Commission, 1997), and in Hungary also. There are very few gender-specific data on alcohol consumption at European Community level and this area or research needs to be emphasized in the future.

Smoking: Cigarette smoking is widespread among Hungarian women, which accounts for the high mortality rate from lung cancer. The percentage of deaths due to smoking related diseases in Hungary is steadily increasing among women and unfortunately smoking has increased among young women in Hungary in the past years, in fact it has surpassed smoking among young men. The average age of smoking initiation was found to shift to a younger age, in 1994 it was 18.1 years of age (Józan, 1999). In the HUNGAROSTUDY 2002[1] 22.8% of the adult female population smoked, which shows a decrease from 28.1% in 1995 (Csoboth et al., 2002). 12.3% smoked in the past but have already quit, and 64.9% of the sample never smoked. Women smoked an average of 13.5 cigarettes per day. The average age of starting to smoke for adult women was 20.13

years. Another study found that 24.7% of women smoke daily and 3.3% rarely (Central Statistical Agency, 2004). In the Better Health for Women Health Survey[2] (Csoboth, 2003), conducted among 15-24 year old young Hungarian women in 1998, smoking was present in 31.9%. Young women smoked an average of 10.7 cigarettes per day. The average age of smoking initiation was 15.88 years.

Excessive alcohol consumption: In Hungary the estimated number of female alcoholics is a quarter million in the country (Central Statistical Agency, 2002), which is very high compared to Western countries. The officially registered and treated alcohol dependent women comprise less than two percent of the estimated number. Cirrhosis mortality is high in Hungary and 77 % is due to alcoholic cirrhosis in women (Central Statistical Agency, 1997). Statistics show that the mortality rate from alcohol induced cirrhosis and hepatic disease in women was 22.5/100,000 inhabitants in 2002 (compared to 3.8/100,000 in the Netherlands) (See Figure 1). According to recent studies approximately 2.9% of women can be regarded as heavy drinkers (Józan, 1999). Of the 15-64 years old female population, 2.9% reported drinking everyday and that about 2% of the female population over 20 years of age can be regarded as alcohol dependent (Józan, 1999). Studies among Hungarian high-school students show that almost 45% of female students have been drunk at least once in their life-time and more than 16% had been drunk in the past month (Elekes, 1999).

Figure 1. Standardized death rates per 100,000 for chronic liver disease and cirrhosis
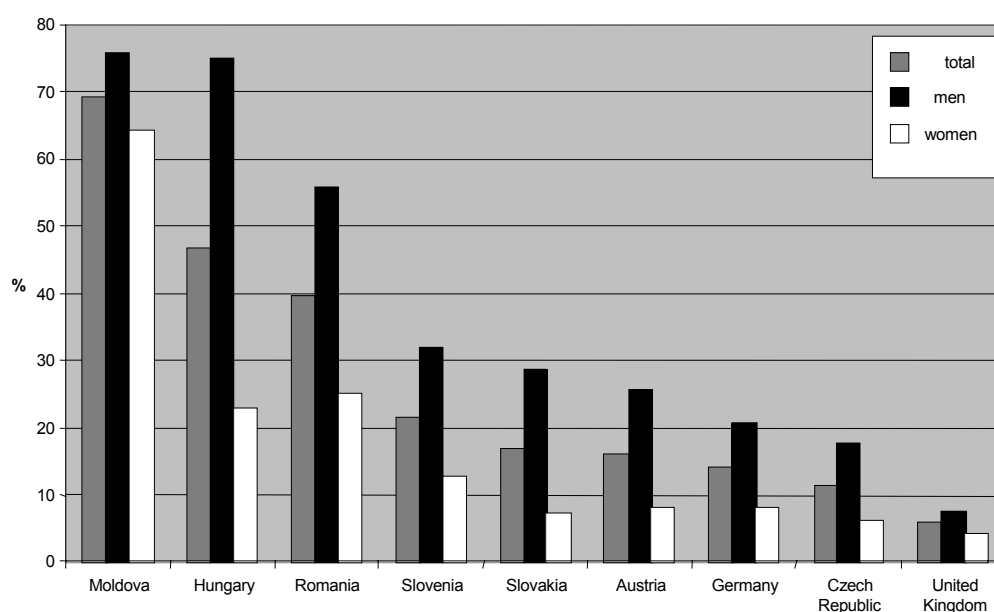
Source: Global Status Report, 1999

In the Better Health for Women survey, alcohol consumption was present in more than two-thirds of the studied young women (Csoboth, 2005). 18.0% of women never drank alcoholic beverages, 65.2% drank infrequently and small amounts, 3.2% reported drinking regularly and small amounts, 13.3% infrequently and large amounts, and 0.3% drank alcoholic beverages regularly and large amounts. Drinking in different situations was also analyzed. Drinking alone was present in 5.2% of the sample. 82.5% drank with others, 12.0% during weekdays, 46.2% on weekends, and 14.6% if they had problems. 39.5% of the sample had been drunk once or twice and 8.4% many times. In the HUNGAROSTUDY 2002, alcohol consumption was present in less than half of the adult women. 55.6% of women never drank alcoholic beverages, 30.8% drank monthly or even less frequently, 9.1% reported drinking two-three times monthly, 3.2% drank two-three times a week, and 1.3% drank alcoholic beverages four or more times a week.

Illicit drug use: Drug abuse is becoming increasingly widespread in Hungary, but its magnitude is not really known because of underreporting. Certain estimations predict that 1.5% of the adult population has used drugs at some point of their lives (Paksi, 1998). Most epidemiological studies report a male dominance in illicit drug use, but some have already found a female predominance among youth (Lajtai, 2004). A nationally representative study found a 5.5% prevalence of drug use in the Hungarian adult population, but this figure increased to 10% when studying young adults under 24 years of age (Csoboth, 1997). Women were more liable to use sedatives and other prescription drugs as a means of drug use and are less likely to use illicit drugs (Lajtai, 2004). In a national representative survey conducted in 2002, drug use was reported by 1.5% of the sample, 0.3% reported regular use and 1.2% reported occasional use. Marihuana use was the most commonly reported, 1.1% of the sample have used this drug. Illicit drug use was found to be as high as 11.4% among high school women and legal drugs were used by 12.1% (Elekes, 1999). In 1998, drug use was reported by 9.1% of the sample. Marihuana use was the most commonly reported, 7.5% of the sample tried it and 5.5% have used this drug many times (Csoboth, 2003).

Although illicit drug use seems to be lower among women in Hungary than in Western European countries, the rising frequency of drug use among young women especially warrants caution. Multiple substance use increases the risk to women's health even further. Many young women have tried "gateway" drugs, meaning cigarettes, alcohol, and marijuana,

and are predisposed to the use of hard drugs (illicit, other than marijuana; Kandel, 2003). This poses immediate danger for the increase in the prevalence of hard drug use because Cannabis (marijuana) use has been steadily increasing in the developed countries. Therefore preventive measures must take the "gateway effect" and multiple use into consideration in order to prevent early damage to women's health.

Mental Health Problems

Another major issue concerning women's health in Hungary is the high prevalence of mental health problems, mainly depression and anxiety disorders. In one survey conducted in Hungary, almost 60% of Hungarian women reported being frequently tired and depressed (Elekes, 1999). In a nationally representative study conducted in 1995, Kopp et al. found depressive symptoms in 33% of Hungarian adult women, which showed an increase from 1988 (29%), and also significant regional differences in the prevalence of depressive symptoms. In a community survey, 9.5% of women living in the capital of Hungary reported depressive symptoms (Zonda, Bartos & Nagy, 2000). A one-year figure of 9% has been found for clinical depression (according to DSM-III-R) among Hungarian women, with the prevalence in the 45-54 age-group (14.3%) (Szádóczky, 2000). In 2002, depressive sympomatology was present in 30.7% of a nationally representative sample. The frequency of depressive symptoms increased with age and was especially high among women over the age of 66 years (Kovács, Kopp, Rózsa, 2003).

Results of the HUNGAROSTUDY 2002 showed, that the occurrence of all categories of *depressive symptoms* increased with age (Figure 2) the difference in frequency of severe depressive symptomatology being especially significant (Csoboth, 2005). While only 2.1% of the youngest age group (18-25 years) reported severe depressive symptoms, 19.0% of the oldest age group (>65 years) reported severe depressive symptomatology.

Suicide rates in Hungary, especially of men, have been high for many decades. A slow decrease in suicide mortality can be seen in the past few years. Suicide rates of women are not as high as of men, but the suicide rate among women in 1994 was 16.8 per 100,000 inhabitants, again among the highest of the western countries. Comparatively, in the European Union the average mortality rate from suicide has decreased to 6.24 deaths per 100,000 among women (European Commission, 1997). In Hungary, the highest frequency of suicide is among women over the age of 60 years (Figure 3.), but this also has shown a slight decrease in frequency since the year 2000. The rate of suicide is much higher among women living in the

capital of Hungary (31.4% of all suicides in Budapest) and is significantly lower in small rural towns (18.9%) (Central Statistical Agency, 2004).

Figure 2. Prevalence of depressive categories according to age-groups
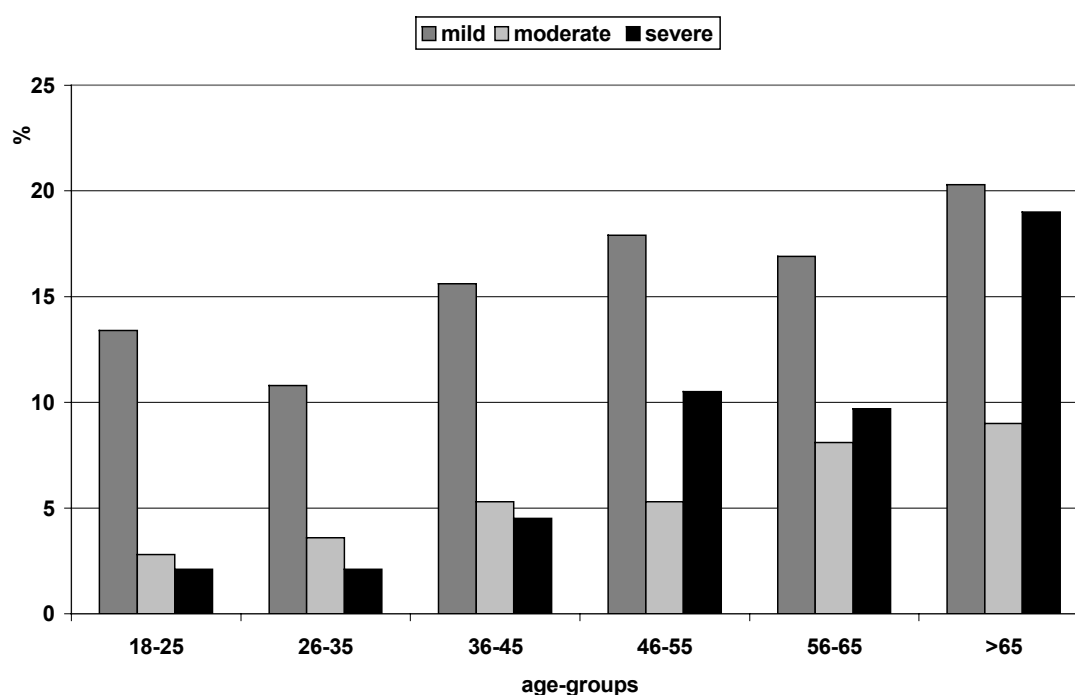
Source: HUNGAROSTUDY 2002

Occasionally women suffer from depression during pregnancy or after delivery. The direct effect of depression during pregnancy is unknown, but indirectly it has negative impact on the development of the fetus through health damaging practices of the mother. A community survey in Hungary found a 5.5% – 13.6% rate of severe or moderate depression in women during pregnancy (Szádóczky, 2002).

Anxiety disorders were reported to start in the early 20s, with a lifetime prevalence of 33.1% and a one-year prevalence of 23.5% (Szádóczky, 2000). Anxiety symptoms are significantly more frequent among those with or less than 8 elementary (35.5%) than among those who completed high school (23.2%) or college/university (20.5%) (Csoboth, 2005). The occurrence of anxiety also increased with age. While 26.0% of the youngest age group (18-25 years) reported anxiety symptoms, 32.6% of the middle-aged group (46-55 years) reported frequent anxiety symptoms and a slight decrease could be seen in the oldest age-group (28%; p<0.001).

Figure 3. Changes in suicide rates among Hungarian women according to age-groups
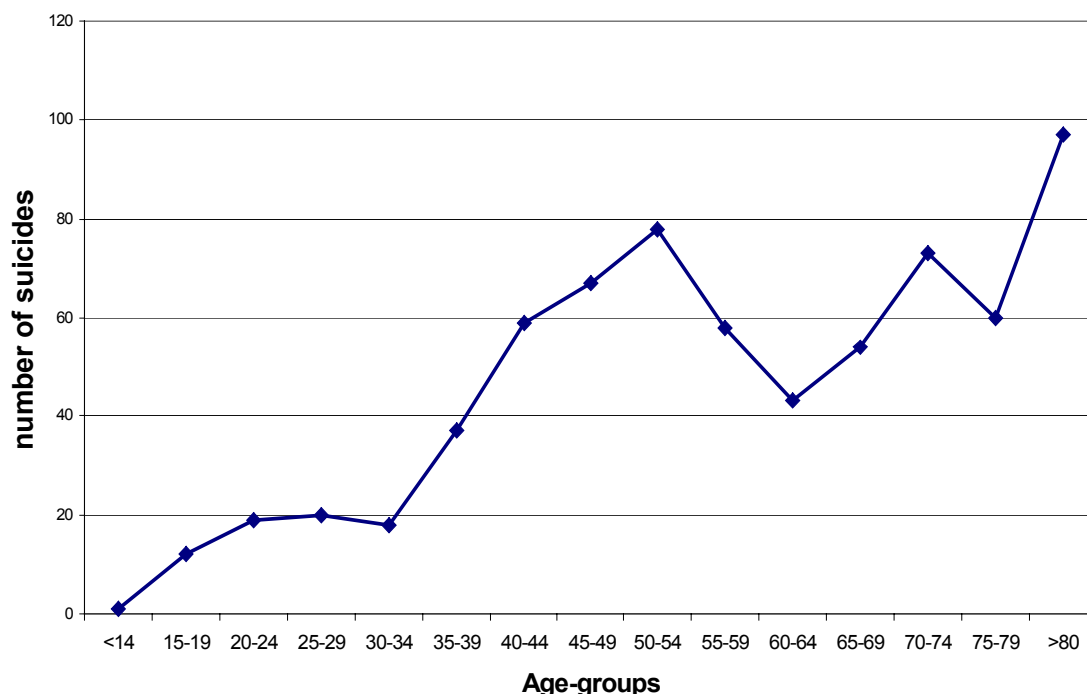
Source: WHO, 2001

Physical and Sexual Abuse

To this day, only a few surveys in Hungary or in the European Union are concerned with the frequency of physical and sexual abuse among women. Tóth's survey (1999) among Hungarian women older than 18 years, 2.2% of women reported rape, 7.6% reported being raped by husband, and 8.1% reported being molested as a child. Father abusing mother was present in 19.6% of the sample. Being beaten by parent was present in 12.6% of the sample and 4.9% reported being beaten regularly. Domestic violence by husband was reported by 13.4% of wives, but 18.1% were afraid of being beaten. Morvai (1998) reported that in Hungary every week one woman dies from injuries acquired from violence in the home.

The Better Health Women (Csoboth, 2003) nationally representative Hungarian survey of young women, found that 31.7% (N=1141) of young women between the ages of 15-24 years reported having experienced some type of abuse. Physical abuse by important person was reported by 22.9% and 7.4% of women reported abuse by partner sometime in their life. Physical abuse in the past year was reported by 12.7% of the sample. Forced sexual intercourse was reported by 2% of respondents. Regional differences were not found in the instances of abuse.

A survey of the adult female population (HUNGAROSTUDY 2002) found that the frequency of life-time physical abuse by partner was 8.3% (N=583) and life-time physical abuse by another important person was 9.7% (N=679). Physical abuse in the past year was reported by 2.1% (N=149) and fear from someone because of abuse was reported by 2.1% (N=199) of women. Middle- aged women had the highest frequency of reporting abuse (21.4%), but 19% of the youngest also reported abuse. Abuse was lowest in the oldest age group (12.7%).

These figures are especially important now, when there is intense debate concerning the legislation of domestic violence in Hungary (Juhász, 2004). Due to the differences in cultural norms, acceptance of domestic violence as a norm, referring to domestic violence as a private family issue, labeling it as a feminist, or chauvinist issue (Dénes), all complicate the possibilities for regulation in the society. Many criticize the Bill on the grounds that it does not regulate domestic violence as a separate criminal act and does not restrain the perpetrator from violence. Instead it forces abused women and children to leave their home and become homeless (Habeas Corpus & NANE, 2004). Access of shelters and care for women experiencing domestic violence is very limited. A few shelter houses have been developed, mainly in the capital. There are also two hot-lines women can turn to when experiencing violence or are in need of gender specific information.

The Relationship Between Health and Socio-economic Background

In the past decades research has shown that socioeconomic status (SES) significantly influences physical and mental health (MacIntyre, 1986). Social inequality, reflected by socioeconomic status and level of education are associated with differences in physical and psychosocial health (Blaxter, 1987). The changes in the social system (such as higher number of women not employed, limited opportunities in the job market for women with young children, lower salaries of employed females, etc) of Hungary have diminished the social conditions of women. In the past years, the number of working women has decreased, but still almost fifty percent (47.3%) of women are currently working and are assuming partial responsibility for the financial situation of the family. Maternity leave, which was very suitable for families in the previous decades, was substantially decreased (EU discussion about balancing work and family), and many believe that the birth rates have also fallen in the past decade due to this. The opportunity of a paid maternity leave of three years seems like a very unwise social policy, considering the nation's economy, but families can rarely afford to live

on one payroll and therefore women are usually unable to stay at home to take care of their children for a longer time and so have to work.

Educational qualifications have been reported to be a good indicator of socioeconomic status and also good predictors of women's self-assessed health (Arber, 1997). Large health inequalities due to educational differences have been found among women between 25-69 years (Cavelaars, 1998) across Europe. Regarding the educational level of Hungarian women, only 4.4% of the female population had less than 8 elementary, 35.4% had finished 8 elementary, 47.8% finished high school, and 12.4% had a college or university degree (Central Statistical Agency, 2004).

Low education has been found to be associated with worse physical and psychological health. Lower social standing not only increases the likelihood of negative outcomes, but also decreases the chance for positive well-being (Ryff, 1998). Low educational level may lead to inadequate personal resources to cope with everyday stressors, to master, reduce or minimize person-environment transactions occurring in everyday life (Folkman, Lazarus, Dunkel-Schetter, Delongis & Gruen, 1986). In the HUNGAROS-TUDY 2002 a strong socioeconomic gradient was also seen in relation to subjective health, 16.4% of women with less than 8 elementary compared to 0.8% of women with college or university degrees rated their health very bad. The frequency of women who rated their health excellent was higher among women with an educational level of high school or higher (68.1%), than among those who had skilled worker training or less

Studies have shown that depression and anxiety symptoms are common especially among those with low socioeconomic status (Kessler, 1994). A vicious circle might be hypothesized between a socially deprived situation and depressive symptomatology, which might play a significant role in higher morbidity and mortality rates in connection with lower socioeconomic status. This interrelationship was found to be more significant among men, than among women (Kopp & Skrabski et al., 1995; Kopp & Szedmák et al., 1998; Kopp & Falger et al., 1998, Kopp & Skrabski et al., 2000), postulating that women are less susceptible to the effects of relative income inequality and GDP (Gross Domestic Product) deprivation than men (Kopp, Skrabski, & Székely, 2002). Low education has been found to be associated strongly with worse psychological health (Rahkonen, Lahelma, & Huuhka, 1997). A gender difference can be found, and educational attainment in particular has been found to be more closely connected to depression in women than in men (Réthelyi, Purebl, & Kopp, 2002). In the HUNGAROSTUDY 2002 survey, women with low educational level were more than four times more likely to have moderate/ severe depressive

symptoms (95%CI: 3.276 - 5.010) than those with higher educational level. In fact high educational level proved to be a protective factor against depressive symptoms (Csoboth, 2005). Research in Hungary (Csoboth, 2005) shows that women with low education are at an increased risk for depression and anxiety compared to women with college degrees. Health damaging behavior is less frequent among those with very low educational level. This supports the theory that alcohol consumption is more widely accepted in higher socioeconomic status, and that abstinence is found at a higher rate among women with lower status.

Occupational class and employment status are also important structural factors associated with limiting long-standing illness among women (Arber, 1997). Employment status preoccupied by women in the Western labor force have steadily changed over the last half-century. In Hungary employment rate shows a decline in ten years, which was 45.6% in 2001 compared to 51% in 1992 (Central Statistical Agency, 2002), and this decline was in majority among women with low education (Frey, 1999). Women with higher education are more likely to be working, women in managerial positions constituted 34% of the managers in 1999 (Nagy, 2001). In 2001 the unemployment rate for all women was 5% (KSH, 2002). Being economically inactive (unemployed or on disability) increases the risk for depressive, anxiety symptoms and health damaging behavior, but retirement serves as a protective factor against health damaging behavior. Other studies suggest that unemployment affects women less than men (Theodossiou, 1998), but nevertheless a rise in depression and anxiety and a decline of over all psychological well-being among unemployed women was found in Hungary. This supports the fact that paid work, that even though there is an increased exposure to stress and conflict, is found to be beneficial to women's physical and emotional health (Arber, 1997; Waldron, Weiss, & Hughes, 1998).

The increase of divorce rates, single-parent households represents an existing and continuing demographic trend (KSH, 2002). Of Hungarian women over the age of 15 years, 50.5% were married, 21.2% single, 18.2% widowed, and 10.1% divorced (Social and Family Ministry, 2000). Marital status has been shown to be in association with overall mortality among women, finding worse mortality rates among younger widowed women (Hajdu, McKee, & Bojan, 1995). The multiplication of single-parent households is one of the major causes of the increasing level of poverty in many developed countries (Najman, 1993) resulting in an increase of physical and mental health problems in this sub-population. There are a growing number of single-parent households in Hungary, in 1994 the number of divorces was approximately 23,500.

Conclusion

In conclusion the health status of Hungarian women is better than of their male counterparts, but unfortunately worse than women in Western countries. Many reasons for this disadvantage can be hypothesized, such as socioeconomic hardships, underdeveloped health care, etc., but neither explains this phenomenon exclusively. The gaps in health care affecting women in Hungary are different than the ones in Romania and other Eastern-European countries, with facilities and the health care system on the whole resembling Western Europe, but still, the health of Hungarian women is worse compared to certain Eastern European countries, such as the Czech Republic or Slovenia. The organization of the state health care system is such that it is accessible for the majority of the population, but unfortunately prevention is not accounted as one of the major issues of the system.

Hungarian studies conducted in the past decades have called attention to the alarming state of physical and mental health of the population. Women are affected by different psychosocial factors than men, such as multiple roles that cause chronic stress, domestic violence, etc., which lead to health problems. Possibly these psychosocial factors are present to a greater magnitude in Hungarian society than in Western European countries, which results in the differences in health state. Depressive symptoms and anxiety have been shown to be in close connection with ill health and the increased stress present in today's Hungarian society probably contributes to the frightening epidemiological numbers. The political, socioeconomic, and social transitions of the past decade and a half presumably transformed the situation of women in this new modern society, therefore one might hypothesize that the physical and mental health state of Hungarian women has also changed. The relationship between physical illness, health behavior, and mental health problems seem to be the most important issue to be addressed in the Hungarian female population in order to decrease high rates of morbidity and mortality.

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Notes

1   This cross-sectional national representative self-report questionnaire study of
Hungarian adults was conducted in 2002 (Rózsa, Réthelyi, Stauder et al., 2003). The
sample consisted of 12,634 individuals ages 18 years or over, of which 6987 were
women. A clustered sampling method was used by combining stratified and multi-step
sampling procedures and was representative according to age, region, and settlement
size. The refusal rate was 17.7%. The questionnaire design was a home-based interview
with questions asking about social state, and physical and mental health.
2   This cross-sectional national representative study of young Hungarian women was
conducted in 1998. The sample consisted of 3615 women, ages 15-24, of which 2016
were students and 1599 were not students. A multi-stage stratified sampling method was
applied and the sample was representative of young Hungarian women according to
age, school type or employment status, and settlement size (Csoboth, Birkás, Purebl,
2003). The refusal rate was 6%.

Cultural Determinants of Social Position and Health Status of Older Women in Poland

Beata Tobiasz-Adamczyk

The position of elderly women in Poland has been largely shaped by the transition of the Polish economy into a market economy that has brought about various social consequences such as changes in the distribution of incomes, growth of poverty in some groups of people, unemployment and homelessness.

Political and economic changes since 1989 have been accompanied by the changes in the system of values, standards and behaviours. These processes have reduced in many elderly people feeling of social security, causing problems with self-identification, alienation and discrimination (Tobiasz-Adamczyk, 2002).

Demography

At the end of 2004 women constituted 51% of the population, and there were 106 women for every 100 men (110 in the urban areas and 101 in rural). The 0-40 age-group was over-represented by men (feminization ratio 96), in the age-group of 40-year-olds the corresponding feminization ratio was 121, and in the age-group 65 and more, there were on average 167 women for every 100 men.

The expected increase of the population over 70 years of age between 2000 – 2030 means that women will constitute 57.8% in this age category, though the increase of the average life expectancy of men will be a little faster than of women. As estimated, the age group of people, aged 80 and more will be overrepresented by women (67.9%) (Jelonek, 2004). In 2020 the average life span of a woman after 60-years of age will be 27 years and 23 years of a man (Jelonek, 2004).

The tremendous increase of the 80 and older age-group will occur between 2000 – 2020; women will live longer than men, but the feminization ratio will drop from 235 women for every 100 men in 1997 to 187 women for every 100 men in 2020.

The population at the post-productive age will increase from 14.7% (2000) to 24% (2030), and there will be 63 persons at the post-productive age for every 100 persons at the productive age, and 72 in 2030 (Szatur-Jaworska, 2002; Hrynkiewicz, 2003). The tendency observed corresponds

with that noticed in other European countries, but the process of increasing non-working population is slower.

Data for general population show that the level of education of Polish women in comparison to men showed that 10.4% women graduated from university (vs. 9,3% men), postsecondary education had 4.6% women (vs. 1.6% men), 30.4% finished secondary school (vs. 26.0% men), occupational education had 16.9% women (vs. 30,1% men), primary school 31,4% women (vs. 28.0% men), uncompleted primary school 4.3% women and 3.0% men.

Different distribution of educational level presents the population of older people. The analysis of education level in the age-group of 60 and more showed that in 1995, 7.7% of men and 3.0% of women had higher education, 16.7% and 14.5%, respectively secondary education, 14.0% and 5.0%, respectively vocational training, 46.7% and 53.6%, respectively elementary education, and other types of education 14.9% of men and 23% of women.

De facto marital status of women informed that in 2002 23,7% was single, 54,3% married, 15% widowed, 5% divorced or separated. (Statistical Yearbook, 2003). Significant differences have been observed in the marital status of women and men – as shown by figures: 40.7% of women, in the age-group 60 – 74 are widows, and 77.4% in age-group 75 years or more (Central Statistical Office, GUS, 1999). The corresponding figure for men up to 74 years is 9.1% and in 75 years and older age-group 30.4%. The same stable increase has been observed since the 70s. At the same time half as many elderly women as men remain married. The changes taking place in relation to family life and in the attitude towards marriage are gender-related. The marriage rate is higher in men than in women (4951 for men and 2649 for women per one year). Twice as many older men as women make a decision to marry or more commonly re-marry, and often their spouses are younger. The marriage rate of women is declining with the age, being 42.3% in the age–group 60 – 64, and 11.6% in 80 years or older.

The studies conducted by Halik in 1995 showed that 51% of women aged 60 were widows, 41% were married, 3% divorced, and 5% single. The same investigation in men showed that 81% were married, 13% widowers, 3% divorced, and 3% single. Older men's partners in second marriage are usually younger women; they are interested in younger women even in the age of reproductive health; also a physical attractiveness is very important factor in decision making process about the remarriage. Contrary to men – women have no chance to marry a younger partner (it is culturally not accepted), and there is still a negative attitude to remarriage of older

women (grandmothers). Low numbers of elderly women entering into new marriages is mostly due to the fact that elderly women are expected to play a role of grandmother in the family, and also due to the fact that such decisions are not accepted by children.

Independently, in the younger age groups below 20, 9.9% women and 15.7% men remain in the non-marital cohabitating relationship compared with corresponding 1.2% women and 1.4% men in the age-group 50 and more. The attitude towards marriage is shaped by cultural determinants and strongly influenced by Catholic Church.

Historical Background

Traditional roles and behavioural patterns of elderly women in Poland were shaped in the 19th and in the first half of the 20 century and later on strongly influenced by hard reality of the years 1945 – 1989. In the 19th century women lived in patriarchal families; in a better position were those born to the noble class. The myth of the "Polish Mother" created under the pressure of the uneasy history of Poland in the 19th century symbolized her strength, heroism in everyday life, fighting for independence, readiness to cope with all duties, taking care of family and children, running family businesses and teaching children to become good and patriotic. Such were the demands of Polish national tradition and religion. After 1918, women became more active. They were educated, and increasingly went out of their family households. In the period between wars women's participation in the labour market was low, and in 1931 only 6% of married women were employed outside agriculture.

Then the period 1945 – 1989 saw still more intensive activization of women towards searching for paid employment. This transition was dictated by the communist ideology and also by the increasing industrialization, urbanization and mass migration of people from the rural to urban areas (Titkow, 1999).

In communist Poland, came much deeper changes in the status of women. They were granted constitutional rights that were ensured by law, and their participation in labour market changed.

Women's increasing participation in the labour market was done without their initiative but forced by the growing demands of the market, by the demands of the communist system, and purely economic reasons. At that time woman was often photographed in the role of work leader, for example, on a tractor, or in other "unfeminine" jobs.

Many women were forced to work under economic pressure of that time. The salaries were low and their share in the family budgets significantly increased standard of life. From the time perspective the opinions concerning women entering the labour market vary and often their participation in the labour market is perceived as the "enslavement by communism" (Titkow, 1993, 1999).

In the past many women did not care for their career as they saw this as the domain of men. Their attitude towards professional activity is not well established and often treated as another example of the "enslavement by communism". Deep change has been observed in women's attitudes to professional career. Today well-educated women concentrate on personal professional career achievements (job satisfaction is one of the main domain of women's quality of life).

Working Life of Women

In communist Poland uneducated women from the rural areas migrated to towns to find a job. The education was of secondary importance, quite the opposite of the western countries, where education was most important and well-educated women have started their occupational activation labour market.

Currently, work for young women in Poland has autotelic value, and they compete with men for jobs; a professional career starts to be the main value for young well-educated women, who prefer it to marriage, and there are many single women the 30 age group.

Since 1950 women in Poland have made up 45 – 48% of labour force and the 60s saw even higher rates of working women aged 15 and more, reaching 63%; then a decline was observed and the corresponding rate in the mid 80s was 58%. Women's participation in the labour market increased with the growing employment of women with elementary education forced to work by the economic difficulties, but on the other hand work gave them higher social status.

Labour force participation rate in 1994 was 67 for men and 52.2 for women, and correspondingly in 2003, 62.4 for men and 47.9 for women. In 2003, 50.9% men were professionally active, 37.6% professionally inactive, and 11.5% unemployed; correspondingly, there were 38.2% professionally active women, 52.1% professionally inactive, and 9.7% unemployed. These figures reflected lower labour force participation of women than of men – in 2003 there were 603 men professionally inactive for every 1000 men professionally active and 1088 women professionally inactive

for every 1000 professionally active. There was observed feminization in the professionally inactive population. Females, aged 35-44 and those with higher education or secondary education represented the highest rates of labour force participation comparable with those of men. Between 1994 – 1998 female employment rate ranged from 44.0 – 43.7, and declined since 2000, reaching 38,1 in 2003. At the professional level women constitute the majority of office administrative jobs, where 235 women are employed for every 100 men. Data provided by the Central Statistical Office (GUS, 2005) shows that the most feminized public sectors are health protection – 412 women for every 1000 men, education – 337 women for every 100 men, and finance – 243 women for every 100 men. The feminization ratio of the medical profession ranged from 55.2 – 54.9 – 54.1 in the 90s.

Generally, women's salaries are lower than those of men. In 2000 the average man's salary was by 8.8% higher than that of a woman. Additionally, women's salaries were 16.9% lower than the average salary, which means that the average woman's salary was 17.0% lower than the average of men's (Central Statistical Office, GUS, 2005). According to Domański (2002) in the 90s of the 20th century the changes in the mechanisms of the distribution of incomes changed – previously the average women's salaries were as a rule lower than those of men, but since the 90s the discrepancies have slowly been disappearing.

Women increasingly at risk of permanent unemployment reached 57.5% in 2003 compared with 54.2% of men, who remained unemployed for one year. The unemployment rate in 1994 was 12.3% for men and 15.7% for women, and correspondingly in 2003, 18.4% for men and 20.3% for women.

The comparison of working life of women in Poland and in other European Union countries shows that in Poland employment rate of women is much lower compared to Sweden, the Netherlands, the United Kingdom, Finland or Portugal. The unemployment rate is generally lower in the European Union than in Poland, but the corresponding unemployment rate of women in Poland is higher than of men (Central Statistical Office, GUS, 2005).

Non-working Women

The purpose of the proposal by the government to delay retirement age for women till 65 years of age is, according to the official declaration, to grant equal rights for men and women and to raise the retirement pension for women by increasing women's contribution amounts into pension fund.

According to the survey conducted in 1999, the majority of Poles (78%) were of the opinion that women should retire at the age of 55, being a privilege for them, and at the same time they criticized the proposal of the government to lower the retirement age of women and to lower their retirement pension as a sign of discrimination. In the opinion of 85% Poles, women should be entitled to earlier retirement at the age of 55. It is now 60 but earlier retirement at 55 is also possible.

The population at the post-productive age will increase from 14.7% (2000) to 24% (2030). There will be 63 persons at the post-productive age for every 100 persons at the productive age, and 72 in 2030 (Szatur-Jaworska, 2002; Hrynkiewicz, 2003).

The relation between non-working population and working-age population was 70.4 in women in 2002, in males 51. 4. Non-earned resources of maintenance showed that in 2002 retirement pay received 15.9% women and 11.8% men; pension 10.5% women vs. 7.8% men, social assistance 0.7% women and 0.6% men. (Statistical Year book, 2003)

There are serious threats to the financial stability of the social insurance system in Poland caused by the low economic growth and stable high level of unemployment. Thus, the real danger to the insurance system is not increasing numbers of people at the postproductive age but rather high unemployment rates and low employment (Hrynkiewicz, 2003).

Family

According to A. Titkow (1993, 1999) a specific form of matriarchy that emerged in East Europe in the times of communism was characterized by the woman assuming the role of a family life manager irrespective of her own health and successful connecting this role with the occupational activity and taking up duties that could be shared by a few persons. Occupationally active women added one more role to all those played and work for money was less important activity than the usual responsibilities at home.

Functioning of multi-generation family co-habiting together in one household assigned new specific role to the senior women in this family. In Polish tradition a retired woman is entirely devoted to her family, and grandchildren, doing all household duties and bringing up grandchildren. This stereotype assumes also devotion to religious practices, especially in the old age groups. The analysis of family budgets shows that highest expenditures on health-related purposes are borne by the retired people and pensioners.

The involvement of the family members into the care for the elderly people is expressed by the fact that the number of women in age-group 49 – 69 years for every 100 people aged 70 and more was 185 in 1999 and it was higher in the urban than in rural areas (219 vs. 142 women). There was a decline in the corresponding figure to 180 in 2005, and according to the estimates a further lowering tendency to 179 is expected in 2110 and to 159 in 2020 (Szatur; Jaworska, 2002).

Family still plays the most important role in caring for elderly people but structural changes in family life start to create new challenges in the model of elderly care. In 2001 there were 13 450 pensioners in old people's homes. Though the numbers of new places in old people's homes are increasing (by 60% since 1990) still low numbers of old age people can benefit, and in 2001 13,7-thousand were on the waiting lists (Hrynkiewicz, 2003).

In 2002, 35.99% of households contained persons over 60 years; the number of single-person households, aged 60 and more was 23.1%, and systematic increase of single-person households, aged 60 and more is expected (Hrynkiewicz, 2003).

Women's Rights, Women's Discrimination

The Constitution of Poland in 1921 granted women the right to vote and unlimited right to learn at the universities.

Occupational activity of women after 1945 had no effect on the traditional stereotype of their roles in society shaped in the 19th century. From an historical perspective this was a time of wasted opportunities to transform woman's identity based on the deep-rooted traditional model (Titkow, 1999).

Titkow (1993) argues that professional activity of Polish women had no deeply rooted consequences in their awareness of emancipation and did not change the individual attitudes, motivations or self-evaluation. Occupational activity was accepted in the same way as traditional models of sharing family roles.

Even in the times of the democratic movement "Solidarity" in Poland women did not benefit from the political and social changes as they did not openly speak and defend their rights (Warzywoda-Kruszyńska, 2004).

The question of the equal rights of women and men is the question about women's status after the period of political and economic transformations. There are no clear and definite answers to these issues according

to Titkow (1993, 1999). The ideological dispute about the position of women has become sharp and still some conservative right wing political parties tend to limit women's role to "Kirche, Küche, Kinder"; thus it happens that the stereotype of "Polish Mother" is still valued. The ideological discussions concern most frequently such controversial issues as, for example, women's right to legal and safe abortion, and although these problems should not concern women from the old age-groups, strangely enough they speak most loudly about them and they are present in media discussions about protecting the unborn child. Poland reinstituted abortion restrictions in the early 1990s ending decades of the liberal law during the communist era. The restriction of abortion gave rise to discussions about the abortion underground and about migration of women for abortion to the countries with more liberal abortion policies. The size of this phenomenon has not been made known.

In communist Poland women's rights became an important part of the official propaganda but in fact they were very limited.

There is legislation protecting maternity, women's right to paid maternity leave and unpaid childcare leave with the right, in force since 1982, to receive childcare benefits if the family income is low. Many women took advantage of childcare leave, because the availability of pre-school nurseries and day-care centres for children has not been adequate to their needs.

In the 70s, 16% of women with higher education attained management level positions compared with 30.5% of men, and correspondingly in 1990 women held only 12.7% of all these posts. The proportion of professionally active women with high level of education increased but the number of management posts occupied by women did not change.

The Office of Women's Rights Protection and Family established by Polish government in 2001 has started to work.

The actions of the organizations aim at solving the most urgent problems of Polish families including unemployment, poverty, single motherhood, family pathologies or alcoholism.

The National Plan of Action for Women included specific objectives: human rights of women, education, violence against women, women's health, women's participation in public authorities, decision-making, mechanisms of cooperation of the government administration with other organization outside government.

Unfortunately the Office of Women's Rights Protection and Family has been canceled after a new Government elections in autumn 2005.

Women's Organization in Poland

The tradition of the women's organizations in Poland dates back to the second half of the 19th century, where the first Rural Women's Circle was founded in 1877. In the communist times, two powerful women's organizations were active: the Women's League founded in 1945 (since 1983 *The Polish Women's League*) and the formally reactivated in 1957 Rural Women's Circle. Both organizations still exist and attract a number of women. The Women's League was a large organization with educational program that followed the ideological principles of the communist regime and aimed at the collectivization of the activities. From the historical perspective the League was blamed for the failure to cultivate feminist awareness in women (Malinowska, 1999). Both the League and the Rural Women's Circle were blamed for their excessive servility towards the past government authorities. There is also lack of unanimity of organizations in supporting women in coping with the everyday life hardship, their needs as well as family or professional problems. Until the transformation period there were few legal feminist organizations. There was a Klub Kobiet Twórczych – the Club of Creative Women (an élite organization existing since 1979), the catholic organization active outside the government, Polish Feminist Society that came into being in 1981, and still other. In 1987 the first Post-Mastectomy Women's Clubs were founded, the Association for Natural Birth and Breast Feeding, the Association of Women with Oncological Problem, Polish Federation for Women and Family Planning, Pro Femina with its program defending the rights of women to legal and safe abortion, and the Association for Promoting Women' Health. In the Polish government structures there is the Centre for Family Counselling Services, Centre for Counselling and Crisis Intervention at the Collegium Medicum Jagiellonian University in Krakow covering wide range of services, as well as individual and family psychotherapy groups.

The studies on the situation of women have been conducted by the Interdisciplinary Research Group at the Institute of Social Studies of the University of Warsaw and by the Interdisciplinary Group involved with the problems of women at the University of Poznań.

Currently around 70 different feminist organizations exist in Poland. They have different programs and address different populations of women. For example, the organizations based on Christian values are in contrast to those with feminist orientations.

Also among women-physicians there is a clear tendency to organize women's associations focused on specific health problems: Women Cardi-

ologist Association exists, concentrated on specific women health related problems in cardiology.

Women's Health

The overall mortality rate in Poland in 2004 was 9.4 per 1000 population: 8.5 per 1000 in women and 10.4 per 1000 in men. Women's mortality constituted 47% of overall mortality. Between 1990 – 1999 standardized by age death rate from circulatory system diseases declined by 23% in men and by 18% in women; in the same period death rates from traumas and poisoning fell by 16% in men and in women was even lower. In the age-group 35-59 that is most prone to diseases, overall mortality rate lowered in 1999 – 2000 by 20% in men and by 15% in women (Okólski, 2002).

The distribution of deaths by causes shows that circulatory system illnesses were responsible for 41.8% deaths in men and 53.1% in women, malignant cancers for 26.2% deaths in men and 22.3% in women, accidents for 9.9% deaths in men and 3.9% in women. The comparison of data with the respective numbers from 1963 shows increased death rates from circulatory system illnesses that accounted for 45.4% of deaths in 1963 in women, decline in death rates from traumas from 9.9% in 1963, and almost stable rate of deaths from cancer diseases in women (22.1% in 1963). In the same period of time there were more deaths from circulatory system diseases in men (27.8% in 1963) from cancer (14.0% in 1963), and almost stable rate of deaths from accidents (9.3%) (Wojciechowska, 2004).

Overall mortality from suicide and self-inflicted injury constitute 32.5 deaths in men per 100 000 in the age group 60 and more, and 7.3 in women (Central Statistical Office, GUS, 1999).

Registered new cases of the leading cancer sites by frequency in women (2002) – standardized rates – were: breast 42.0%, lung 13.8%, cervix uteri 13.2%, corpus uteri 12.6%, ovary 11.3%, colon 9.4%, rectum 5.8%, thyroid gland 5.6%, stomach 5.2%, and kidney 4.7%.

Mortality standardized rates in women in 2002 were: breast 15.0%, lung 13.6%, colon 7.3%, ovary 6.9%, stomach 5.3%, pancreas 4.9%, cervix uteri 6.2%. In men: lung 68.6%, stomach 15.3%, prostate 13.5%, colon 11.9%, bladder 8.3% and pancreas 7.9%.

In 2002, the number of disabled women over 60 years of age was 52.3% in the urban areas, and 56.3% in the rural areas, and disabled women constituted 28.85% of the general women's population in urban areas compared with 31.2% in the rural areas. It is believed that there are prospects

for strengthening the supporting role of family in Poland, mostly owing to its traditionally highly valued role in our society.

In the studies conducted in Poland, the investigators paid much attention to the higher mortality of middle-aged men, higher rates of the average life expectancy in women, and high figures of deaths from circulatory system diseases, cancer, accidents and traumas. Epidemiologic studies were mostly oriented at the analysis of the population of men, and if conducted on the level of general population, gender was always one of the analyzed variables.

Also, most of the studies in the populations of the elderly people concentrated on the selected aspects of the quality of life, paying little attention to women's health. The only exceptions were investigations conducted in Kraków in a cohort of women, aged 65 (Tobiasz-Adamczyk, 2004).

In the performed study gender-related differences have been observed in non-medical predictors of mortality in the senior old age groups of the resident of Kraków (Tobiasz-Adamczyk, 2002).

Mental disorders are very often deeply rooted in earlier and current life experiences, particularly in the personal life and at work. Prevalence of mental disorders in age group 60-74 was 26.4%, similar to data observed in age group 45-59, where it was 28.0%, but higher in comparison to the younger age group 30-44 (20.0%), and in age group 15-29 (5.7%). In the elderly people, aged 75 and more the incidence of mental disorders was 16.5% (Wróblewska, 2002).

The studies of Czapiński on the non-clinical determinants of mental health of people in Poland (2000), confirmed that women had more depression symptoms than men, and self-assessed their health and satisfaction of marriage less. They reported more frequently deterioration of the family financial situation. However, women were more satisfied with their relationship with other family members, they were more under pressure of their parental responsibilities, but for men their own health status was more stressful. The studies demonstrated different gender-related stress-coping strategies. Women more frequently than men asked others for advice, prayed to God for help or used sedatives. They received higher social support than men, however after 65 years of age more frequently experienced loneliness.

The aging process dramatically increased symptoms of depression connected with health more frequently in women than in men. Also, elderly women tend to abandon the strategy of seeking advice when in difficulties and they are less active in counteracting their problems. A syndrome of res-

ignation was more typical for women in the urban areas. Also, praying to God was age-related (70% of women in the oldest age –groups vs. 30% in the younger groups) and similar strategy was employed correspondingly by 38% of the oldest men vs. 12% youngest. Generally, women in age-group 45-49 years more frequently used the advice of a psychologist/psychiatrist than men, used these advice at younger age (Czapiński, 2000).

Disability

The disability rates in the age groups in Poland are high and reach in the age group 20 – 29, 3.2% for men and 2.3% for women; age group 30 – 39. 6.3% for men and 5.6% for women; age group 40 – 49, 16.2% for men and 15.9% for women; age group 50 – 59, 38.0% for men and 32.2% for women; age-group 60 – 69, 41.9% for men and 36.4% for women; age group 70 – 79, 39.9% for men and 41.0% for women; and age group over 80, 48.5% for men and 45.6% for women. With regard to functional disability and problems with walking demonstrate 35% men and 46% of women, aged 65 years; 73% of men and only 59% of elderly women can use public transport without help (Halik, 2002).

In 1995 in population of 65 years and over 53.6% men and 63.5% women suffered from disability (Central Statistical Office, GUS, 1999).

In 2002, the number of disabled women over 60 years of age was 52.3% in the urban areas, and 56.3% in the rural areas, and disabled women constituted 28.85% of the general women's population in urban areas compared with 31.2% in the rural areas.

The number of functional limitations in the older age groups (all) of Polish women is higher than in men (Miller, 1998). The studies conducted in 1995 showed that 46% of women reported being limited in walking outside home compared to 35% of men; 41% were not able to use public transport vs. 27% of men, 57% could run errands unassisted vs. 74% of men, 64% could do the household chores vs. 75% of men, 63% could do shopping vs. 78% of men (Halik, 2002).

In spite of the observed aging of the population in Poland, the number of geriatricians and geriatric wards at the hospitals is completely insufficient. There are 214 homes for the elderly people 227 for those with somatic diseases in all age groups, 167 for intellectually disabled, and 14 for functionally disabled.

Health-related Behaviours

The rate of the elderly men-smokers is thee-times as high (40.8%) as that of women (18.33%). Almost twice as many elderly women never smoked (66.7% vs. 34.5% men). The rate of elderly women drinking alcohol was much lower than that of men and lower than that of younger women (Central Statistical Office, GUS, 1999).

Health Self-assessment

The results of Polish studies on health-assessment (group 65 yrs and over) show that elderly women assessed their health status poorer than men, only 5% of women and 8% of men as very good, 34% and 42%, respectively as rather good, 36% and 27%, respectively as rather bad, and 22% and 19% as very bad (Halik, 2002).

Availability of Medical Assistance in Poland

The assessment of the availability of medical service or meeting family doctor upon arrival in the outpatients' clinic varied, as 51% of women and 47% of men assessed it as easy, 36% and 38%, respectively, as rather easy, 8% and 11% , respectively, as rather difficult , and 3% of women and men as definitely difficult (Halik, 2002).

Women's Health Strategy

The National Plan of Action for Women has strategies and policies regarding important issues of women's access to public health care including pre-adolescents, in the reproductive years, and menopausal with special attention paid to cancer and infectious diseases including sexually transmitted diseases, reproductive health, all range of menopausal problems, addiction and mental health disorders. The most important task is the improvement of prophylaxis and diagnostics by increasing the availability of screening programs against cancer, genetic diseases, and care for mother and child.

One of the tasks is undertaking efforts to create medical care system taking care of the elderly women that would include diagnostics, treatment, and rehabilitation related to all sorts of age-related psycho-physical disabilities.

According to the Report, the Ministry has already started elaborating standards with the aim to improve geriatric management by launching a new model of management of the elderly people, defining the tasks and duties of physician, nurses, psychologists, therapeutic group leaders, rehabili-

tation teams, social workers and volunteers. There is also an outline for a program, which has so far not been launched, focusing on the topics related to women's health and issues important for shaping national health policy by including women's health and reproductory health to the acts, documents, strategies and government programs.

The Office points to the necessity of continuing screening programs for the early detection of breast cancer, of cervical cancer, care for the families at high risk of genetic cancer diseases launched in 2004.

Actions should be taken towards introducing the issues related to the health of elderly women into the curriculum of medical staff training in the selected specializations and into the postgraduate training. Also, patient's rights should be addressed as well as possible mechanisms that would allow them to be pursued.

The strategic aim of the government policy with regard to reproductory health is introducing the standards of modern medical knowledge and international legal acts (also introducing modern contraceptives to the list of refunded drugs from the national budget – a decision to ban refunding contraceptives was made by the Polish Parliament on the 27th August 2004.

Conclusions

In the last few decades the political and economic transformations caused by the collapse of the communist system in Poland have resulted in deep changes in the mentality of the younger women. They have become more practical and career oriented. Today women in Poland are generally better educated, and their roles in the family have changed. All these provide hope, that in future status of elderly women will be much better and their social and economic stability safer.

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Current Perspectives in Women's Reproductive Health Care in Slovenia

Irena Kirar Fazarinc & Dunja Obersnel Kveder

Background

In Slovenia the development of reproductive health care is based on a long tradition of mother and child health care. After 1920 the innovative concept of women's health care (WHC) began to be developed and it was characterised by comprehensive dealing with women's health problems on an outpatient basis (outside hospital) that were organised at special units called "dispensaries for women" (Andolšek 2003). In the last 50 years the greatest developments of Slovene WHC have been achieved, characterised by the prompt introduction of modern improvements of medical science and new technologies and their immediate implementation into the national health care system. Therefore, in Slovenia, we adopted sooner than elsewhere in western and central Europe the modern concept of family planning, enabling the modern contraceptives and safe methods of pregnancy termination to be fully implemented. Moreover, other preventive reproductive health programmes were introduced, especially programmes in antenatal and perinatal health care.

At the same time there was strategic investment in reproductive health care services, developing a dense network of organisational units at the primary level and providing competent professionals i.e. gynaecologists who were able to comprehensively deal with reproductive health problems. These activities were supported by appropriate legislation, starting with the constitutional enactment of the right to decide freely on the number and spacing of children and the law on the development of comprehensive reproductive health care services taking into account broader approach to health (involvement of different professionals, whole-day access to service, etc.) (Obersnel 1998).

Consequently, we have achieved very good accessibility to reproductive health services on primary and secondary levels and high standard of the implementation of reproductive rights of women.

It is very important to stress that the approach in Slovenian reproductive health care substantially differs from that which other European countries have developed in this time period. While most of western European countries integrated reproductive health issues within family practice and east-

ern European countries established specialist oriented primary health care systems, in Slovenia women's reproductive health care has been managed by gynaecologists working in dispensaries (public or private) at primary health level. This means that every woman has the opportunity and right to choose her own personal gynaecologist and family practitioner.

Good accessibility and quality of reproductive health services is one the most important aspects used in public health methodology to assess the improvement of reproductive health of population. For this purpose, indicators such as availability (geographical, affordable access), acceptability and quality of health care are used. Moreover, other indicators are needed to assess the improvement of population's reproductive health, among them the most important being premature mortality (including maternal mortality) and morbidity rates, hospitalisation rates (degree, reasons), the referral rates to secondary level, abortion rates, the prevalence of contraceptive users, incidence rates for cervical and breast cancer, incidence of sexually transmitted diseases, hysterectomy rates, premature deliveries, etc. Some of these indicators are connected mostly to the quality and accessibility of the reproductive health care at primary level; the others are achieved through reconciliated activities and interactions between primary and secondary levels of reproductive health services and society as well (Fazarinc 2004).

In the last ten years, the level of the reproductive health in the Slovene population and the effectiveness of reproductive health services have been affected by the social changes of transition, the health system reform, the lack of public health principles implementation, methodology and women's health needs assessment in reproductive health. While some EU countries have already integrated a gender mainstreaming approach into the health care sector, unfortunately we still have to argue the traditional aspects of women's reproductive health. Therefore, in spite of high standards developed in the past, the impairment of some reproductive health indicators is observed nowadays, and especially alarming are high maternal mortality rates and incidence of cervical cancer (Fazarinc 2003).

Ultimately, improving reproductive health requires very important prerequisites in terms of supportive environment and the active involvement of national government and national public health institutions for appropriate coordination to be established.

Current Health Status in Slovenia

The fertility of the Slovenian population is low. The crude birth rate has been decreasing continually since 1880. At that time crude birth rate was

about 35 per 1000, while nowadays is less than 10 per 1000. In other words women born around 1885 had an average of 5 deliveries, their daughters 3, granddaughters 2 and great grand daughters only 1,5. The generation born in the 1960 began to postpone childbirth. Total fertility rate began to decline after 1980 (2,1). The rapid decline was due the postponement of childbirth as well as to lower fertility because of economic recession.

In 1970 only 10% of the children were born out of wedlock. Recently the number of children born out of wedlock have increased and reached almost 40% in the last few years. The population is getting older and ageing of the population causes the series of negative consequences with lower share of active population.

In 1991 almost 47% of the entire female population were economically active and 90% of them between 25 and 44 years of age. We would like to stress that economically active women have different reproductive needs, especially on the field of family planning and pregnancy.

According to the health indicators Slovenia's health status is quite close and comparable to many western European countries. Mortality has been decreasing since the second half of the nineteenth century. The difference between the life expectancy for men and women is increasing, primarily due to the premature death of men from malignant disease, disease of circulatory system, injuries (including suicide) and disease of digestive system (mainly liver cirrhosis). The highest years of potential lost is due to deaths from injuries: almost four times more men than women die in traffic accidents and suicides and twice as many men died due to other accidents. The most common causes of death in women 20 to 64 years are breast cancer and cardiovascular diseases; the leading causes of death in women over 65 are cardiovascular diseases in the first place, followed by malignant diseases. The difference in mortality rates between men and women in this age group is much smaller. Less educated people are more exposed to premature mortality from circulatory, digestive diseases and accidents. For a long time of the period before 1988 the number of accidents was underestimated. The suicide rate is one of the highest in Europe (but men have four times higher risk) and the estimates are even higher than official statistics (10 times higher). The data on mental status are scarce as well as the data on violence. Many women do not report the acts of violence. There are some shelters for women who wish to escape violence but the legislative procedure for protection of the victims is rather complicated. The incidence of HIV positive and AIDS cases is rather low compared to the rest of the EU, but the risk is greater for men than for women. The data on drug use are rather scarce. The studies show that the drug use is much higher in

some places than 10 years ago. The drug use and the consumption of the pharmaceutical psychotropic substances is gender differentiated. The consumption rate among is more than twice that among men.

Current Status on Legislation and Health Reform in Slovenia

The Slovenian Constitution from 1991 guarantees the freedom of individuals to decide freely the number, spacing and timing of their children. Due to this fact the Law on freedom of choice in childbearing, enacted in 1977, remain unchanged. According to this law, induced abortions are performed until the 10th week of pregnancy on demand of pregnant women and the choice for sterilisation for both sexes after 35 years of age is offered. The promotion of women's health is supported by legislation from social and labour sectors: the Law on Labour Relations, The Law on Marriage and Family relations, Law of Employment. Moreover the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), adopted in 1979 by the UN General Assembly, has been ratified. According to new health laws and national health insurance scheme introduced in 1992 each woman can select her own personal gynaecologist without referral. Compulsory national health insurance cover for all women free health services related to family planning, contraception, pregnancy and delivery, organized cervical screening programme, passive breast cancer screening and prescription and care for women with hormone replacement therapy during perimenoupose and menopouse. For other services concerning women's reproductive health 85 – 50% of expenses are covered by compulsory insurance. For the differences in fees women could be insured, the price of this insurance represents € 17 per month, but implementation might be a problem.

Reproductive preventive programmes for women on the national level were introduced in 60s.

National Guidelines for preventive programmes for protection of women's reproductive health, which assures to all women access to reproductive preventive programmes in health care system, have been renovated in 2002. In the programme 5 preventive programmes for women's reproductive health were newly defined covering family planning, organized cervical cancer screening, perinatal care, opportunistic breast cancer screening and preventive programme for perimenopausal and menopausal women.

Two years ago substantial efforts for health care sector reform started and many reproductive rights are under debate, since gender differences in

health are not integrated into documents. It is known that increasing out of pocket payments and privatisation measures might cause several inequities, particularly in the access to the health services and in health seeking behaviour that have affected women more than men. If there is a lack of proper statistics and the use of biased methodology based on selected health indicators which do not support the diversity in gender health needs this might lead to underestimation of the incidence of ill health among women. The studies showed that health sector reform may differentially affect women and men due to the position they occupy in society, the different role they play and different social and cultural expectations made of them. It is more likely that women are also under-represented among policy makers, so special attention must be made to ensure that the gender differentiated needs of men and women are adequately represented.

Reproductive Rights Agenda and Current Reproductive Health Status

In the last few years in Slovenia reproductive health and rights advocates have placed contraceptive coverage at the forefront of their proactive agenda. Abortion is an issue for which it is expected that the restrictive legislation indicated by a more conservative policy will be a contentious issue. So far there is no problem with obstetric and gynaecology residency programs provide abortion training, but some of them may opt for religious solutions.

Current reproductive health status is influenced by the large proportion of women older than 15 years of age that represents almost half of our population and by the age at first birth that has steadily been increasing: in 2001, on average, those giving birth for the first time were 26 years old. Diseases due to either the reproductive role or to insufficient reproductive health care provision contribute substantially to reducing the differences in life expectancy between males and females, as life expectancy of women at birth is 7 and half years longer than that of men. At the age of 65 the difference is reduced to three years. Women are particularly at risk because of their reproductive function and diseases, which are specific for them (breast cancer, cervical cancer, pelvic infections, complications due to pregnancy and abortion, etc.).

Morbidity and mortality due to sexually transmitted diseases and the consequent pelvic infection, which, uncontrolled, may cause a high degree of infertility, disability, and mortality, were reduced to fewer than 5%; this classifies Slovenia among the countries with the lowest risk. The average number of cases of serious pelvic infections, which require hospital treatment is 2 per 1000 hospital treatments; ectopic pregnancy rate which act as

indirect marker for untreated sexual transmitted diseases and pelvic infections among female population has remained stable in the last ten years. This success was achieved through easy access to women's reproductive health services, introduction of modern concepts of treatment and easy access to treatment in the early stages of diseases.

Cervical cancer incidence started to grow in the beginning of 90s. The organized screening programme was started in 2003 and is supposed to include as many women as possible. The current results are quite impressive – almost 70% of women in target group (20 do 64 years) have been screened in last three years. Breast cancer incidence is not so high compared to western countries but the incidence of this disease in higher each year. The share of the woman over 50 years include in passive screening programme is to small. An organized programme would certainly give better results.

Since women bear the burden of gestation and their lives and health are more at stake in pregnancy and childbirth than those of men, women are more centrally concerned than men in the legal protection, promotion of reproductive health and followed in different reproductive health indicators. Among them maternal mortality is the most important one. It is a good comprehensive indicator which shows how society as a holistic body protects women's reproductive health not just from the perspective of health sector but also from the labour, social, economic perspectives as well. Maternal mortality is often only the end point of a series of injustices that women face. In the first half of 90's maternal mortality in Slovenia reached the European average level, but after that maternal mortality began to increase. The last national report of maternal deaths for period 1995-99 showed that the share of indirect causes has been growing, while the number of easy preventable causes such as abortion, ectopic pregnancy and postpartum complications has diminished. The indirect maternal causes took the leading position and the women who had no access to the reproductive health care are at greater risk. While we are still waiting for the national report for the period 2000-2003 it is already clear that the high maternal mortality needs to be looked from broader perspective. In contrast to maternal mortality there are some other indicators showing the brighter side of reproductive health status like perinatal mortality, stillborn infants, etc. which have been diminished.

While the legal abortion rate has declined to 15 per 1000 women of reproductive age and the use of reliable contraceptive methods has improved in the last ten years, further improvement should be made more widely available and the choice of the methods and the access to the different reli-

able methods should be altered for better. But the lack of population research and the shortage of the assessment of women's needs and perspectives together with the absence of the strategy for reproductive health promotion block further development and improvement in the area of reproductive choices, which in the course of reform might bring further deterioration of reproductive health indicators.

Conclusion

Advances in the further recognition, promotion and protection of reproductive health must be accelerated. It is necessary to re-assess and reform the policies, laws and practices in the light of this mission. The strategy on reproductive and sexual health should be made in near future in order to ensure gender mainstreaming and better chances for keeping the level of the sexual and reproductive health of our population as high as possible. For that reason reproductive health should be put higher among the priorities of society, especially in health and social sector.

In order to maintain the level of reproductive health already achieved in Slovenia and to ensure further development of reproductive health services several steps are needed. Firstly, a strategy on reproductive health should be created and accepted by health politicians, tackling comprehensively reproductive health issues in a gender specific and sensitive manner and taking into account the reproductive health needs of women and men, respectively. The non-governmental organisations dealing with women's and reproductive health problems should be in an active partner-ship position. Secondly, a plan of action should clearly define the steps in the implementation process, the partners involved and especially the development of reproductive health indicators in relation to the reproductive choice in terms of reproductive rights and contraceptive options, to safe motherhood, to mental health, to cervical and breast cancer and adolescents' sexual and reproductive health. It is important to build up the research capacity, which would serve gender-oriented research and use the gender approach methodologies in order to select the proper priorities. Thirdly, it is essential to further develop and strengthen reproductive health programmes and to monitor and evaluate, on a regular basis, the progress, quality and effectiveness of these programmes. In the fourth place, further strengthening of reproductive health services for both gender is needed taking into account the national approaches that were proven to be effective, based on capacity building of health providers and on partnerships' building within the health sector and among other sectors.

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The Glasgow Women's Health Policy – A Model for Local Strategies

Monika Scheffler

Introduction

The Glasgow Women's Health Policy was first launched in 1992. It combines the ideas of the Women's Health Movement with the 'Health for All' principles of the New Public Health Movement, as they were particularly defined by the Ottawa Charta of the WHO. It contains a coherent concept of an interdisciplinary, multi-organizational women's health policy. This approach has had a number of successes in Glasgow in recent years and is regarded in Great Britain as being the furthest developed approach to women's health:

> "This initiative is based on a social model of health. It is multi-sectoral in its approach and represents the most advanced strategy for women's health in the UK".

Unfortunately it still receives only little publicity in the rest of the Europe despite the appointment as the WHO-Collaboration Centre for Women's Health in 1997 and being a very practical model, it was given the Commonwealth Award for Excellence.

This article will give a short idea of the theoretical background by relating the objectives and principles of the Women's Health Movement to those of the New Public Health Movement. Then the Glasgow Women's Health Policy, its different levels, foci and agents will be portrayed, because intensive networking is a substantial key to success. Furthermore the article will highlight the work that has been carried out to implement the Policy, to consider progress but also the barriers to further progress. It identifies the need for a strategic approach within the Health System to addressing the health consequences of social inequalities. Finally the chances of the approach for the development of a European Women's Health Strategy will be underlined.

Women's Health and New Public Health

It has been the merit of the Glasgow approach to combine the principles of the Women's Health Movement with those of the New Public Health Movement. Although both movements started nearly at the same time and,

although very similar in their critique of the medical model, both movements are based on different analyses.

The Women's Health Movement took as a starting point an analysis which revealed male dominated practices and institutions within a health care system which control and incapacitate women. A masculine, mechanistic and individualistic understanding of modern medicine determines the approach to health and thus disguises societal origins of illness which are rooted in power imbalances between the sexes. Initial counter strategies for women then consisted in regaining knowledge and control of their bodies, knowing that the body plays a central role for the self-confidence of women. Accordingly discussions emerged around topics such as the pattern of "medicalisation" of societal problems (depressions) or even the female body itself (menopause). A free female body, free in the sense of not being at someone's mercy on the gynaecologist's chair, became the vision.

With the fragmentation of the Women's Movement throughout the 1980s only few feminist support groups survived. Now there are more professional women's health activists who seek to re-establish a health care system which recognises gender differences and includes preventive care in order to be able to respond to objective living conditions and to recognise women's rights more adequately. Within women's health research specifically, many authors argue for a promotion of women's health through social changes.

In spite of a complex and differential development of the women's health movement many common aims can be identified. Following demands were always given priority:

1. the right of reproductive self-determination
2. affordable, adequate and humane medical care
3. satisfaction of basic needs
4. safe working conditions and
5. physical health and security

In most cases the women's health movement did not go beyond the limits of the health care system. Instead of criticising the system itself, they kept on criticising its gender specific character and male dominance.

In contrast the New Public Health Movement fundamentally criticised the medical system as a starting point. They focussed on the evidence, that the health status of the population is not as much related to a progress of medicine but more to a higher standard of living. Furthermore they highlighted the fact that many curative measures are not only ineffective but injurious. Damage, according to radical critics, is not only caused by nega-

tive side effects of medical treatments. Health damages are rooted in a medical system which undermines people's autonomy and people's abilities to organize their own lives and to respond to societal realities.

This radical critique was endorsed by few yet it still led to the theoretical knowledge that a further improvement of people's health status can only be achieved by changes of living conditions, being accompanied by medical science and health care. This change of paradigm is reflected to a substantial degree by the WHO Health for All by the Year 2000 strategy. Six basic directions can be filtered out from those 32 directives which were identified by the WHO regional office in 1985:

- struggle against inequality within the health care status
- promotion of health instead of treatment
- participation and empowerment instead of incapacitation
- multi-sectoral co-operation
- focus on basic health care
- re-enforcement of international co-operation.

Based on those directives the WHO Ottawa Charta redefined the objectives of health care in 1986 as follows:

- establishment of a health promoting structure in all policy fields,
- creation of a healthy environment,
- support of grassroots activities through social networks,
- development of personal abilities to control one's own health,
- re-orientation within health care services from curative to preventive models.

The combination of the theoretical basis of the Women's Health Movement with the 'Health for All' principles of the New Public Health Movement opens new horizons for the Women's Health Movement. The analysis done by the latter, which reveals the damaging character of gender hierarchies and resulting social conditions, and which stresses the demand for a preventive approach which keeps those conditions in mind could easily be integrated into the former.

Accordingly the feminist version of the Ottawa Charta should imply the following:

- the attainment of gender equality in all social spheres
- the creation of a healthy, women-friendly environment
- the strengthening of grassroots activities such as local women initiatives and support groups,
- the development of personal abilities, to give control back to women etc.

The Health for All principles, which are generally accepted by now, make it possible to attack gendered power imbalances in all social spheres which constitute a hindrance to the promotion of women's health. A health care system which considers gender differences however is only one of the aims of this encompassing concept.

Characteristics and Development of the Glasgow Women's Health Policy

The first Glasgow Women's Health Policy was launched in 1992 under the auspices of the Glasgow Healthy City Partnership. This was the first example of public involvement in the development of local health policy following research and discussions with women and women's groups. This work made it clear that women considered that the determinants of their poor health were not being addressed and health and social services were not meeting their needs. The policy has been modified over succeeding years to reflect new developments in Glasgow. But it always had some coherent characteristics which relate to the Health for All principles:

- It tries to connect women's health to the social, hierarchically marked role of women,
- it has an explicitly strategic perspective, i.e. changes within institutions and its policies,
- it tries to integrate all legal and voluntary organizations, not only health services,
- it has got a strong community perspective,
- internal organizational efforts and external pressure were combined in order to push changes,
- it has sought connection with activities of the women's movement.

The latest version was re-launched in January 2002. The aims of the policy are:

- To increase awareness and understanding of the factors which affect the health and wellbeing of all women in Glasgow
- To shape general policy development, planning and service delivery to improve the health and wellbeing of women
- To ensure that there are structures within organisations which take account of the factors affecting the health and wellbeing of all women
- To ensure that the key issues identified by women – emotional and mental health; health affects of poverty; safety in the home, community and workplace; sex differences in the presentation of various diseases,

    reproductive health and support for women as carers – are addressed as
    priorities

The Women's Health Policy for Glasgow is based on evidence that there is a correlation between gender inequality and poor health in women, that there are sex differences in the aetiology and presentation of disease which are not sufficiently understood and that women have a more complex reproductive system than men.

The Policy recognises the importance of gender as a fundamental determinant of health. Gender has been defined as the socially constructed and culturally determined characteristics associated with women and men and the value that they are accorded by society. Internationally, there has been a recognition that a focus on gender and health is the best way forward to address the health needs of women and men and that a population approach which is gender blind does both sexes a disservice.

Historical Development of the Glasgow Approach

The following summary will emphasize the potential for change and actions which enabled success. The idea was born during the Women's Health Fair in Glasgow in 1983, which was organised by women from different organizations. The resulting demands were included in a campaign, which was founded in 1984 and which became a central place for hundreds of women from various fields. A Women's Health Charter contained many demands, amongst others the demand for a publicly financed Centre for Women's Health. The campaign substantially contributed to a women's health profile within key organizations. It was always an objective to make as many women and men participate in a democratic way, which enabled a net of ideas and informal relations between women and organizations, which even got strengthened further through common actions.

After Glasgow had been admitted into the WHO Healthy City Project 1988 the issue of women's health moved into the core of municipal institutions. Because the women's health activity then already contained the Health for All principles, they became one of the foci within the Healthy City Project in 1990. The already existing Women's Action Group got transformed into the Women's Health Working Group. This Group now offers a forum for representatives from partner organizations of the Healthy City Project and some other organizations, projects and initiatives which are interested. It is their task to promote discussion on women's health and to find practicable ways to implement new strategies. The Women's Health Working Group is represented on the executive board of the Healthy City

Partnership, through which they can get hold of some limited resources for their own work.

After its establishment the Women's Health Working Group faced a lot of tasks and expectations. One big difficulty was the fact that on the one hand representatives of different organizations were willing to question the practices of their organization, but that on the other hand the same people were captured by exactly those structures which they questioned. Additionally it was difficult for some of the members to convince their organizations to collaborate in that group. Thus the challenge for the Women's Health Group was enormous. It was essential to secure an effective structure, which was able to sustain the engagement of its members and to support them in their own work. Besides it was necessary to promote women's health questions in a way which allowed a visible influence.

The creation of the Women's Health Policy as a lever for change was a strategic means. It was published as a consultation paper in 1991, which was an important step. The responses proved the interest which was stirred through previous activities. The Women's Health Policy was formally accepted by partner organizations and one women's conference. It became a general objective to improve women's and girls' health in Glasgow. Recommendations are mainly directed towards structural changes. They contain the creation of gender sensitivity within existing services as well as the development of special organizations for women. Five priorities were named within politics: Mental health, poverty, reproductive health, declining of illness incidences, health and security at home and in the work place.

A co-ordinator for women's health was employed by the public health department of the Health Board in 1993 with the task to co-ordinate the implementation of the Women's Health Policy.

The success of the first years work done in Glasgow is explained by the co-ordinator of the Women's Health Policy as follows:

> "In no little measure this progress can be attributed to persistence, a willingness to work across boundaries and grasp opportunities as they occurred, combined with the support of some key politicians and officers in the organizations concerned. A strategic perspective together with some fine examples of good practice by women's projects have been also vital." (Sue Laughlin)

Links to the World Health Organisation

The World Health Organisation (WHO) in Europe has identified the work on women's health in Glasgow as an example of good practice. Glasgow was first designated as a WHO Collaborating Centre for Women's Health

in 1997 and it has been re-designated in 2003 as a Collaborating Centre for Policy and Practice Development in Women's Health and Gender Mainstreaming. Coordinated by the Greater Glasgow National Health Service Board (GGNHSB) Women's Health Coordinator, the following organisations are represented within the Collaborating Centre: GGNHSB Public Health and Health Promotion Directorates, Greater Glasgow Primary Care Trust through the Sandyford Initiative, North Glasgow National Health Service Trust through the Women's Reproductive Health Service, University of Glasgow Department of Public Health and Glasgow Healthy City Partnership.

The Collaborating Centre has contributed to the development of the WHO Strategic Action Plan for Women's Health in Europe and to the production of information for other European countries on the nature of the work in Glasgow. It has provided training for personnel from countries within Eastern Europe and has supported programmes of work in addressing gender based violence. Currently, it is working with WHO in the development of gender and health indicators.

The Implementation of the Glasgow Women's Health Policy

Greater Glasgow Health Board first adopted the policy at the time of its initial launch and appointed a Women's Health Coordinator. The other partners of the Healthy City Partnership similarly adopted the Policy. Currently, implementation within National Health Service of Greater Glasgow takes place in two main ways. Firstly, there are programmes of activity on women's health and gender-based violence (aimed at addressing the health consequences of domestic abuse, rape and sexual assault and child sexual abuse) led from within the Public Health and Health Promotion Directorates. The main focus of this work is to inform the National Health Service planning process, to develop models of good practice, to ensure that women are involved within the work on patient and public involvement and to develop programmes of patient education. Monitoring of the Cervical and Breast Screening programmes is also carried out within the context of this work.

Secondly, there is a Women's Health Policy Planning Group. The Group comprises representatives of the Trusts and of the Glasgow Health Service Board Directorates. Its role is to coordinate activity on women's health to ensure a standardised response, to agree programmes of work which ensure that women's health needs are taken into account in the delivery of services and to identify resources.

For years now the Glasgow Women's Health Policy has been trying to achieve changes through looking for adequate switches for the respective levels. In other words: on the upper levels one tries to influence politics, on community levels one tries to build up pressure from below.

Influencing Politics in the City of Glasgow

To lobby for the improvement of general politics became more and more important as a defined working area for the Glasgow Women's Health Policy. While in 1991 the consultation paper only generally demanded equality in all living spheres, the first policy document of 1992 asked to include general knowledge about women's needs and about women's health perspectives into the policies and planning process of statutory and other institutions. With ten sub headings the following recommendations were listed: to consider women's issues in all strategy papers of the city council, to create a paper for the psychological health of women, to create alternative patterns of nursing, to keep questions of security and access in mind while planning new buildings and to introduce flexible opening hours of all service providers. In the policy document of 1996 the objectives are stated as follows: „To improve the health and well-being of women through changes within general politics, planning and providing of services." Only six sub-categories are formulated which no longer define concrete tasks but are more comprehensive. Moreover the means are better defined in order to reach the aims. For example there is an explicit demand to use the available data concerning women's health and well-being within policy development, or that all services have to undergo a quality assessment in order to make sure that they meet women's needs. As the city of Glasgow and the other partner organizations of the Healthy City project accepted the Women's Health Policy, it is also their responsibility to implement it.

Implementation and Participation on a Community Level

Participation and consultation on a community level is a very important principle of the Women's Health Policy. The way in which those concerned see their health and its influencing factors shall be relevant for the development of policies. As women's access to the decision-making level in local authorities is limited, it is necessary to integrate them through formalised processes. The Women's Health Working group is trying to establish a flow of information between decision-making and grassroots levels in different areas, and they are trying to sustain this flow of information by organising regular network meetings. Health projects, civil servants, women's groups and also individuals are being integrated in order to firstly

determine foci of politics in a bottom to top approach and secondly to em-
body and broaden politics on a local level.

Apart from those network meetings a series of initiatives was developed
for the promotion of participation on a community level. Seminars were
organised. There were events with black women, women of ethnic minori-
ties, disabled women or young women which were supposed to secure the
consideration of specific health needs.

At the end of 1997 an initiative started in order to implement the
Women's Health Policy in different communities. Women were identified
as key persons, focus groups defined the factors which influence their
health status (such as double and triple loads, missing child care institu-
tions, responsibility for care, isolation and stress), independent activities
were developed (such as public surveys amongst women concerning child
care and its effects for women's participatory opportunities in the commu-
nity.) More recently, work has been carried out with a women's mental
health network and with community health projects.

The Influencing of Health Care

There have been a variety of efforts and approaches which are able to re-
shape health services in a way that they can meet women's needs. Above
all the establishment of a Centre for Women's Health has to be mentioned,
whose task amongst others is to identify women's needs which are not met
and to find adequate practical ways which close the gaps through special
services or within the regular system. There is to mention the transforma-
tion process of the 22 family planning clinics in Glasgow at the end of the
1990. Furthermore two new institutions were installed with the aim to fur-
ther lobby within the health care system: one official working group estab-
lished in 1992 and one coordinator for women's health in 1993, who was
placed under the director of Public Health's, is also very important. It com-
bines clinical with counselling services which transcend the narrow idea of
health and which include support and health promoting, offered in a
women-friendly atmosphere. Moreover a strategy was developed for the
improvement of psychological health and for a improved response to
women who had experienced violence. Gender sensitive practices of diag-
nosis and referrals, treatment, rehabilitation and successful cures of heart
diseases were scrutinised. Guidelines to influence the process of instruction
and planning were developed. Women-sensitive services were demanded
and their implementation watched within quality agreements. The next step
was to introduce data collecting systems for domestic violence within
emergency services and dental clinics and to institute guidelines for the bet-

terment of psychological health of women in psychiatric and communal services. Beyond that gender-specific guidelines for the examination of successful cures are being elaborated and its resulting recommendations shall be considered while planning further strategies. This programme shall be accompanied by well-aimed awareness-raising including seminars for women managers and practitioners. There have been manifold achievements including the promotion of women-sensitive and specific services. Furthermore two more institutions were installed with the aim to further lobby within the health care system: one official working group established in 1992 and one coordinator for women's health in 1993, who was placed under the director of Public Health.

Main Areas of Work

In the past main areas of work emerged and changed. Thus the following issues will not show a comprehensive list but they will present the most important areas of work. Additionally attention has been given to topics such as nursing women, reproductive health, health in the work place, women and heart diseases, incontinence etc.

Women's Poverty

A gender-specific data analysis of the last years revealed that 45% of all women under 50 are living in the poorest areas of Glasgow. This is not surprising if one looks at women's income and at the same time keeps in mind that a third of all households are single-headed (90% by women). This data also show that the chance of dying before the age of 65 is twice as high for women in the poorest suburbs as it is for women living in wealthier areas. The likelihood to die of lung cancer or heart disease is even 3.5 times higher.

These facts led to the understanding of poverty being the most impeding factor for people's health and to the necessity of making this issue a subject of discussion and a working area of its own. One group is trying to improve poor women's inclusion in decision making about social and economic regeneration. It is looking at local policy-making under the point of view of the coincidence of women's poverty and poor women's health.

Psychological Well-being and Health

In all examinations first priority was assigned to psychological health by the women in Glasgow themselves. In spite of the fact that women's psychological health cannot be achieved through health services only and that

substantial societal changes are also necessary, health services still play an important role. One working group, consisting of representatives of the respective health authorities, the communities and psychiatric services examined the activities of practitioners in the communities and looked at the role of counselling in the area of psychological problems. It was the group's task to advise and accompany the planning and contractual process of health services within the field of psychological care. One result of their work is the systematic screening of postnatal depression.

Domestic Violence

Domestic violence has a profound effect on the health of women and has major implications for health care. Accordingly the health authorities in Glasgow co-financed a big publicity campaign against domestic violence, which was called the Zero Tolerance Campaign. It proved to be very successful with regards to publicity but at the same time it revealed a lack of support institutions for women with experiences of violence. In addition an examination was initiated which looked at how doctors and services in different settings react to women with experiences of violence and how they can improve their handling through the introduction of training programmes and guidelines. Former studies unveiled, that on the one hand practitioners improved their knowledge and changed their attitudes, but that on the other hand their approaches didn't really change. At the moment other modes of transformation are being researched. GGNHSB now has a well-funded programme aimed at addressing the health consequences of all forms of gender based violence

Recognising the Needs of Different Groups of Women

Although there are many factors influencing all women's health, there are still groups of women who are, out of different reasons, more or differently affected than the majority of women because they suffer from additional discriminations, e.g. ethnic minorities, disabled women and lesbian women. Therefore it is one main focus of the Glasgow Women's Health Policy to intervene on behalf of those women and to respond to their special health needs.

As several smaller studies revealed, women of ethnic minorities and black women suffer to a strikingly higher extent than other women from psychosomatic symptoms, from heart diseases and strokes. Culturally caused barriers often limit the access to health services. A sub-group of the Women's Health Working Group therefore is exclusively operating with the aim of detecting special health needs of women of ethnic minorities.

There were some studies done on Chinese and Pakistani women's health needs and the results were translated into several languages.

Disabled women also suffer in many ways from double discrimination. Societal reactions to disability often lead to unavoidable restrictions. Limited access to health services unfortunately is part of disabled women's every day reality. It is not only inaccessible buildings, but also practitioners' attitudes, for example towards reproductive health of disabled women, which make lives difficult for women.

Lesbian women feel particularly discriminated against by gynaecological treatment. Therefore consulting hours especially for lesbian women were established in the Centre for Women's Health.

Main Agents

There are hundreds of women in the communities, administrations, welfare work, initiatives, women's groups etc. who develop and carry out the Glasgow Women's Health Policy. Such a wide approach of women's health needs to be supported by a well-functioning co-operation between women of different areas. The Women's Health Working Group, the Centre for Women's Health and the Women's Health Team of the Health Board however have a special strategic significance and will therefore be briefly outlined in the following.

The Women's Health Working Group

The Women's Health Group was established in 1990 under the roof of the Glasgow Healthy City Project. It is the central coordinating group for the development and implementation of women's health policies in Glasgow. The Women's Health Group is represented within the executive board of the Healthy City Project. Members of the group are representatives of different departments of partner organizations of the Healthy City Project, i.e. the City of Glasgow, Glasgow Health Authorities, universities and other organizations and initiatives.

The task is to discuss women's health issues and to find practicable ways to constitute the advancement of women's health. The group can present many results so far: the development of a Glasgow Women's Health Policy, the Centre for Women's Health, the establishment of sub-groups working on different focal issues and the editing of many publications and work materials.

The Centre for Women's Health

The Centre for Women's Health is the most tangible result of the Women's Health Policy. It was inaugurated in 1995 after ten years of hard struggle and it became relatively well equipped. The idea of the centre is to give space for informational services, counselling, support groups and childcare as well as to identify unmet health needs of women, to find adequate answers, to anchor good practices within general health services and to educate co-workers in the health care system and women's groups.

Being different from other Women's Health Centres in the rest of Europe the Centre for Women's Health in Glasgow does not only aim at supplying women with special services which are not necessarily covered by a general health care system. Moreover it plays a very strategic role in transferring its experiences into the general health care system and into city policies. To this end one development agent, one educational consultant and two field workers were employed whose task it is to keep the contact to other organizations and suburbs. The Centre recently mostly focused on providing a women's counselling service because of demand.

The Women's Health Section of the Glasgow Health

The Women's Health Team is a multi-disciplinary team of eight women who are specialists in the areas of health care, social sciences, epidemiology and demand analysis within the department of public health. The team is headed by the Women's Health Coordinator. It is obliged to the Health for All principles, especially to the view point that health is related to gender hierarchy within society. It is a principal aim of the Women's Health Section to reach best effects for the health of women within the areas of health supervision, health protection and health planning. Main activities of the team are describing pathological patterns, their origins and necessary care for women as well as looking at ethnic and social origins. Planning and implementation of innovative projects and the advisory activities are based onto that work. The teams operations however are not limited to the area of health care. They are also supporting women's health activities of other groups. The Women's Health Section works on issues such as psychological health, domestic violence, incontinence, reproductive health and cancer. Black and ethnic minority women and poor women are special target groups. Beyond that the Women's Health Section is coordinating the co-operation with the WHO.

Progress to Date

Successful implementation of the Women's Health Policy or indeed any such policy which seeks to address the health consequences of social inequalities presents a number of challenges and difficulties to the health service. Firstly, considerable responsibility has been placed on the National Health Service by national health policy to address causal factors over which it has little control. Secondly, there has been little application of a social model of health to improving the quality of practice and delivery of health care.

Within this context, progress on implementing the Glasgow Women's Health Policy can only be regarded as partial. Both women's health and the issue of gender based violence have been identified within the Local Health Plan and resources allocated to programmes of work. Some hospitals and primary care services have responded by ensuring that work on addressing women's health needs are included in their implementation plans whilst others have been less proactive in incorporating this work into their change planning in a coherent, consistent and corporate way. The Glasgow Primary Care Trust has been particularly innovative in this regard. In general however, it seems that change of this sort does not attract the level of priority and corporate ownership accorded to other more traditional Health Service change programmes. Considerable attempts have been made to integrate an understanding of the effects of abuse into planning for mental health and into the delivery of services for homelessness people.

There have also been some notable service achievements particularly in relation to the development of the Centre for Women's Health and latterly, the establishment of the Sandyford Initiative an integrated sexual, reproductive and mental health service. These services strive to ensure that the social determinants of health are taken into account in the assessment and management of sexual health, reproductive health and mental health problems and to ensure that an understanding of gender issues is integral to planning and practice. As such, the Sandyford Initiative serves as a model for other health services and settings.

The development of the user involvement network for maternity services (MATNET) can also be viewed as a major success and the model used is also one which would be replicable for other services and areas of health.

A shift in approach towards gender and health has ensured there is now thinking emerging within health authorities as to the implications of gender for women and men. Both the women's health team and a men's health of-

ficer within the Health Board have been collaborating with addictions services to identify how an understanding of gender is integrated into the practice of Community Addiction Teams. The expectation is that this will contribute to addressing the current excess of abuse problems amongst men but should also ensure that the reasons for female drug use will be better understood and taken into account in redesign of services.

There is other progress in other areas but so far it has been very diverse and complex. To describe it comprehensively would go far beyond the limits of this paper.

The Importance of the Glasgow Approach for Women's Health in Europe

The Glasgow approach can be very significant for the development of a European Women's Health strategy. It presents an adequate, theoretically based and practical response to the analysis of the women's health movement. By attacking a gendered power imbalance it reveals that societal conditions induced by gendered hierarchies get women down. In that sense the Glasgow approach is advanced in comparison to other European versions of strategies for women's health, which concentrate on health services.

Longstanding practices in Glasgow prove that an approach inherent in the Health for All principles is not only practicable but that it can be successful. Efforts in other European cities which aim at practising a similar local approach can refer to that model of effective practice which is accepted by the WHO. Moreover the wealth of experiences, which has been collected and published in many areas, presents an incomparable store of knowledge for political women's health activities.

One big but not insurmountable hindrance consists of the provocation to define women's health on the background of gender inequality. So the growing chorus of voices demanding more resources for men's health need to be constantly responded because it endangers the limited resources for women's health.

As the Glasgow approach runs counter to other societal developments in many respects, it needs to swim constantly against the current main stream. But its approach can be successful even in times which are not that promising. The agents of the Glasgow Women's Health policy encourage others to go on trying as the coordinator of Women's health in Glasgow states: „Opportunities obviously vary from city to city and area to area but themes and the direction of the work could be transferred to any area."

Summary

The Glasgow Women's Health Policy contains a coherent concept of a communal, interdisciplinary and multi-organizational approach to women's health in accordance with the Health for All Principles of the New Public Health Movement as they were described in the Ottawa Charta. It connects women's health with the social gender-hierarchical role of women and its radius of action is not only within health care but has got a strong communal perspective. Its chances improved with the entry of the city of Glasgow into the WHO Healthy City Project in 1988. Since then its influence on the policy-making of Glasgow authorities and the structures of health care has risen and at the same time the efforts for participation on a community level got stronger. There are a lot of working foci which concentrate however on priorities defined by women themselves, such as psychological health or domestic violence or particularly disadvantaged target groups, for instance poor women or ethnic minorities. The Glasgow Women's Health Group is the central policy-determining body, furthermore the Centre for Women's Health and the Women's Health Section within Glasgow Health Authorities. In spite of its complexity there are a lot of concrete achievements. Therefore Glasgow can be used as a valuable practicable model project for other communal women's health policies.

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