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DISCRIMINATION AGAINST WOMEN AND YOUNG GIRLS IN THE HEALTH SECTOR

WOMEN RIGHTS AND GENDER EQUALITY

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Authors: **European Institute of Women's Health, Dublin**

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Copies can be obtained through: Tel: 32628
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DISCRIMINATION
AGAINST WOMEN AND YOUNG GIRLS
IN THE HEALTH SECTOR

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Compiled by Rachel Iredale and Amanda Reid
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French translation Nadine Mezard

EXECUTIVE SUMMARY

The European Union (EU) is undergoing significant demographic, social and economic changes. The impact of these changes on society at large, and for women and young girls in particular, has not yet been fully explored. Despite considerable progress in recent years at both national and international levels, gender inequalities remain in many areas across Europe. This report examines data from 8 EU Member States to explore the issue of gender discrimination in the health sector.

The aim of gender equity in health is for men and women to be treated equally where they have common needs, while at the same time addressing their differences in an equitable manner. Yet there is currently a lack of sex-disaggregated information available and this report explores some of the problems for data collection and analysis, including dated practices, anomalies in approaches to data gathering and a plethora of indictors for measuring health. Although calls for sex-disaggregated data have been made for decades, it is necessary for this to become embedded in all EU policies, using for example, Gender Impact Assessment tools to facilitate this process.

Gender mainstreaming has been advocated as a major strategy for achieving gender equality for many years, but its implementation has been uneven and often ineffective, due partly to insufficient resources and partly to the absence of sufficient political will at the highest levels within the EU. Our primary objective must be to design and implement policies, programmes, and practices that do not reinforce existing gender inequalities and that attempt to redress existing gender imbalances.

There are significant differences in the way men and women are diagnosed and treated within the various health care systems in Europe. Part of this stems from the fact that men and women have different biology and that certain diseases are more prevalent in women than in men. But beyond these ‘natural’ differences there is also an increasing body of evidence to suggest that women do not receive as effective treatment or health information as men and that women respond differently to treatment. Most research and clinical trials are done on men and extrapolated to women and research on the kinds of treatment that are best for women remains limited. Furthermore, women and young girls are disproportionately represented among the most vulnerable population groups and it is becoming clear that the health sector might be increasing rather than reducing gender inequality.

Specific health issues for women, and in particular, the situation for young girls, are discussed in this report, for example, in relation to cancer, heart disease and lifestyle choices. The report concludes with some examples of good practice in the 8 countries studied which could lead to an improvement in gender-aware data collection and offers some recommendations.

SOME HIGHLIGHTS FROM THIS REPORT INCLUDE:

Women Society and Health

- Social issues such as education, employment and family life have significant consequences for health.

- Women are generally living longer, are better educated, having fewer children at later ages and increasingly participating in the labour force, though working part-time is more widespread than in men.

- Women experience fewer economic opportunities, less empowerment, and unfulfilled educational attainment than men. These factors can exacerbate inequalities in health and can leave women vulnerable in the way they access and receive health services.

- Socio-economic differences between men and women can impact on patterns of behaviour and access to resources. Therefore, many of the biological advantages women experience can be cancelled out by social disadvantage.

Gender and Health

- Mainstreaming gender is both a technical and a political process. It requires a shift in organisational culture and ways of thinking, as well as a change in the goals, structures and resource allocations of our societies.

- Rapidly rising health expenditures related to declining working-age populations and increasing numbers of elderly have put healthcare even in wealthy countries under pressure, necessitating healthcare reform.

- Healthcare reforms discriminate to varying degrees against the underprivileged and marginalised, and women are proportionately over-represented in both these groups.

- Healthcare revenue collected from general taxation or social health insurance is associated in theory with improved equity and better cost control. A move toward privatisation of services would have a significant impact on gender equity in health care access.

- As women predominate in part-time, flexible and short-term employment, their contribution to health insurance can be limited and they may have fewer financial resources for out-of- pocket spending on health care.

- Comparisons of health expenditure data are complicated by a paucity of reliable national data, wide variations across countries, and multiple data sources.

- The tools are lacking which can demonstrate clearly and unequivocally how funding is spent in Member States to address gender-specific and gender-influenced health conditions.

- Attempts to introduce qualitative research on social models of gender are often seen as being outside the accepted paradigm, and even as being non-scientific.

- Data collected from research with unequal genders has little statistical power to prove clinical benefits for women and will fail to determine whether a treatment is cost-effective. This can have serious implications for healthcare planning, and resource allocation.

- Findings from clinical and epidemiological studies show that women's experience of disease can be at variance with men's experiences. Cardiovascular disease is a good example.

- There has been limited consensus on the design of indicators for health research and the poor comparability of data continues to affect the application of results to future health policies.

- Basic principles of epidemiology have proven useful for measuring the status of health within populations, but fail to provide clear information on the influence over the years of wider health determinants and inequalities in health.

- Data collected using self-reported health status can complement more objective indicators and introduces the patient perspective into health monitoring.

- It is important to collect data in a format that can easily be processed and interchanged between local, national and international levels. Good primary data is essential, and all EU Member States should be encouraged to work to standard templates for data collection.

- It is difficult for an aggregate EU measurement of health status to escape national and sub-national particularities.

Health issues for women and young girls

- The diversity of women's – and particularly young girls' – health-influencing experience and behaviour needs to be reflected in data.

- Special attention should be given to vulnerable and marginalised groups of women to ensure that discrimination is recorded, and measures taken to counter the effects of inequity.

- The life quality of carers, lone parents, migrants, refugees, and those who are coping with chronic disease or long term disabilities are all subjects for further research.

- Caution must be exercised when using lifestyle choices as health determinants as these may result in interpretations which blame the victim, or in policies that focus only on behavioural change at the individual level and which ignore policies at population and structural levels, such as those relating to the environment or employment.

- Socio-economic factors have a significant influence on the health of children. Children and adolescents from families of low socio-economic position have more health problems than those in high socio-economic position, e.g. in mortality, injury, self-rated health and subjective health complaints, and risk behaviour.

- Gender differences emerge in adolescence. For example, girls are more likely than boys to take up smoking as a means of weight control, and to continue smoking, rather than risk putting on weight. Yet, among 13 year olds, obesity is higher in girls than boys. Evidence suggests that being overweight during adolescence compromises long-term health, as it is associated with increased mortality.

- Young women who are prepared to make healthy lifestyle choices related to nutrition, exercise, tobacco, alcohol and drug use, and sexual health will have enhanced physical and mental health, and may avoid major diseases later in life.

- Gender determines the power and control men and women have over their lives. It affects their social position, status and treatment in society, and consequently, their susceptibility and exposure to health risks.

- Our primary objective must be to design and implement policies, programmes, and practices that do not reinforce gender inequalities and attempt to redress existing gender imbalances.

CONTENTS

Chapter 1 : WOMEN, SOCIETY AND HEALTH

1.1. Background: The aim of this report is to explore the issue of discrimination against women and young girls in the health sector in 8 EU Member States.

1.2 The Countries: The EU countries studied in this report are , Belgium, Bulgaria, Germany, Greece, Poland, Portugal, Sweden and the United Kingdom (UK). The population of women in each these eight countries exceeds 50%; Portugal has highest percentage of women (51.9%) in the total population, and Sweden the lowest (50.5%). In Europe, there has been a steady increase in the number of people living to more than 65 years of age. Europe has the highest proportion of older women in the world and more women than men live to 85 years of age. The difference in life expectancy between men and women in some countries is striking, as are the differences between women in different countries. Of the countries studied, Sweden has the highest life expectancy for women at 82.7 years and Bulgaria the lowest at 76 years (Table 1).

Table 1. Life expectancy at birth (2004) ([1])

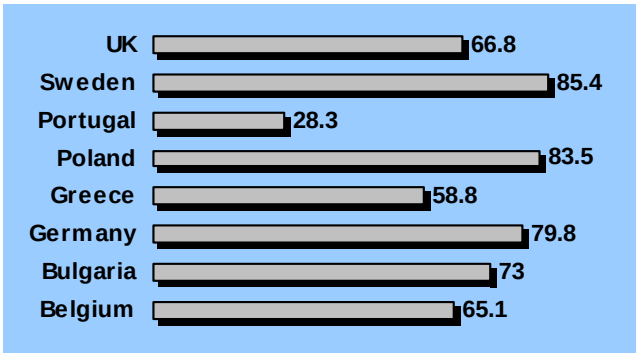
Country	Men	Women
Belgium	76.5	82.4
Bulgaria	68.9	76.0
Germany	75.7	81.4
Greece	76.6	81.4
Poland	70.0	79.2
Portugal*	74.2	80.5
Sweden	78.4	82.7
UK*	76.2	80.7

* 2003

1.3. Women in Society: Some of the social issues most relevant to women, with significant consequences for their health, are education, employment and family life. Across the EU women are increasingly engaging in education. Education is an important determinant of health behaviour and generally, the prevalence of ill-health increases steadily with decreasing educational level. Table 2 illustrates the percentage of women aged 25-64 who have at least upper secondary level education. Portugal is an exception.

[1]Eurostat: Key figures on Europe - Statistical pocketbook 2006 edition. Data 1995 -2005. http://www.eds-destatis.de/downloads/publ/en1_key_figures_on_europe_pb.pdf

Table 2. % of 25-64 year old women with upper secondary education, 2005 ([2])



In 2004 the percentage of the labour force that were female ranged from 41% in Greece to 47% in Sweden ([3]). Although working part-time is more widespread amongst women than men, the nature of female labour generally can affect women's health. Whilst paid employment provides income, structure and meaning to personal existence, sometimes the costs of work-related illnesses can be high. Similarly, household work can be exhausting and debilitating especially if done with inadequate resources or combined with pregnancy.

The average age of first marriage for women across Europe is rising, as is the mean age of mothers at (any) birth, with an increasing proportion of multiple births ([4]). However, there has also been a marked increase in the number of teenage pregnancies in recent years (Table 3) with the highest rates in Bulgaria and the lowest in Sweden.

Table 3. Live births by mother's age last birthday - % of total ([5])

	< 15	15 –19	20-24	25-29	30-34	35-39	40-44	45-49	50 +
Belgium*	---	---	---	---	---	---	---	---	---
Bulgaria	1.56	13.62	29.02	32.18	18.45	5.34	0.77	0.03	0.00
Germany	0.02	3.61	16.56	28.84	30.19	17.49	3.13	0.11	0.00
Greece	0.06	2.82	13.92	31.18	33.37	15.75	2.63	0.24	0.03
Poland	0.01	5.28	26.22	37.68	21.72	7.31	1.68	0.09	0.00
Portugal	0.07	4.98	15.32	31.19	32.12	13.48	2.69	0.14	0.01
Sweden	0.00	1.66	11.82	28.97	37.01	17.16	3.23	0.14	0.00
UK	0.03	6.94	18.81	25.40	29.21	16.18	3.25	0.15	0.01

*Data not available for Belgium

Women in the EU are generally living longer, are better educated, working more, and having fewer children at later ages. Yet women disproportionately experience fewer economic opportunities, less empowerment, and unfulfilled educational attainment when compared to men. These factors can exacerbate inequalities in health and wellbeing can leave women particularly vulnerable in the way they access and receive health services. Equitable social, educational or employment policies are therefore necessary to reduce gender differences concerning health and illness ([6]).

[2]Eurostat. op. cit.
[3]World Bank Group: Genderstats http://www.genderstats.worldbank.org.home.asp
[4]European Commission: *The Health Status of the European Union*. Luxembourg, 2003. p 16
[5]European Commission: Health & Consumer Protection Directorate-General http://ec.europa.eu/health/ph_information/dissemination/echi/echi_03_en.pdf. (From New Cronos Database). 2005
[6]Klinge, I., & Bosch, M.: *State of the Art – Transforming Research Methodologies in EU Life Sciences and Biomedicine: Gender Sensitive Ways of Doing Research*. European Journal of Women's Studies, Vol 12(3): 377-395; SAGE Publications; 2005

Chapter 2: GENDER AND HEALTH

2.1. Sex and Gender: The concept of gender has been used in the social sciences since the 1960s to describe socially determined norms and roles for each sex. 'Sex' is a biologically determined concept, whereas 'gender' is socially constructed, and contains a multitude of influencing connotations. Gender is a key determinant of health and is vital to understanding how women and men experience and respond to health care services, interventions and their outcomes ([7]).

Women and men differ in their vulnerability to specific illnesses through both genetic causes and environmental exposures, as well as through the interaction between the two. Sex-related biological differences can affect susceptibility and immunity for example. This in turn can influence the means or degree of exposure to infection, and the effect of a condition on an individual's quality of life. We know from the previous chapter that socio-economic differences between men and women can alter patterns of behaviour and access to resources, and many of the biological advantages women experience can be cancelled out by social disadvantage. Furthermore, some contemporary health issues (e.g. fast food, pollution, bullying) continue to ignore gender completely ([8]). Yet acknowledging the interaction between sex and gender opens up possibilities for improved health care ([9]). The ultimate aim of gender equity in health is for men and women to be treated equally where they have common needs, while at the same time addressing their differences in an equitable manner ([10]).

2.2. Mainstreaming Gender: There is considerable emphasis in the EU and some Member States towards imbedding gender equity into policy and planning. The mainstreaming of gender into policy is about finding ways to move from the theoretical/academic debate about women and men, femininity and masculinity, in order to measure the concrete effects of gender on women and men's development. Inequities and inequalities arise as a result of unequal gender roles and relations. These must be planned for, and addressed in a viable form. The primary objective is to design and implement policies, programmes, and practices that do not reinforce existing gender inequalities and attempt to redress existing gender imbalances. If gender-sensitive research and policies are to be achieved, monitoring and evaluation for gender awareness needs to be built explicitly into programme objectives. Analysis of the context in which a policy will be operating will facilitate a clearer understanding of the gender issues involved. Similarly, building a mapping process and action plan into the implementation of new policies will ensure they are sensitive to women and men in their approach and equitable in their effects ([11])

Mainstreaming gender is both a technical and a political process. It requires a shift in organisational culture and ways of thinking, as well as a change in the goals, structures and resource allocations of our society. These changes need to occur at several levels: in agenda setting, policymaking, planning, implementation and evaluation. For example, new policy procedures and guidelines on staffing and budgeting practices are

[7] Keleher H. (2004) *Why build a health promotion evidence base about gender*? (Editorial) Health Promotion International, Vol.19, No.3, pp 277-279.
[8] Green, L. *An unhealthy neglect? Examining the relationship between child health and gender in research and policy*. Critical Social Policy 2006, 26(2): 450-466.
[9] Klinge, I., & Bosch, M., op. cit.
[10] Östlin/WHO Regional Office for Europe's Health Evidence Network (HEN); *What evidence is there about the effects of health care reforms on gender equity, particularly in health?* WHO/HEN, 2005
[11] Doyal, L., *A Draft Framework for Designing National Health Policies with an Integrated Gender Perspective*, 1998.

required. Training programmes too, are needed for planners, staff, and service users in order to build capacity for operating gender-sensitive services. This is especially important in the health care sector, where the focus needs to be on the wider aspects of gender, and how this affects access to health care.

Gender Equality Impact Assessment

In 2001, a series of Gender Equality Impact Assessment (GIA) studies were commissioned by the European Commission as part of the Research Framework Programme (FP5) Gender Watch System, to examine earlier Programmes for gender awareness. On their release in 2002, the new FP6 framework texts reflected many of the recommendations made by the GIA studies, and consequently gender mainstreaming became a prime focus in policy development across the EU. In 2007 the principles of GIA should continue to be rigorously applied to all current and future policy and research documents.

Recent EU policy documents recognise that access to, and utilisation of, health services are heavily influenced by socio-economic and cultural factors. For example, amendments have been recommended to the *Community Programme for Employment and Social Solidarity* (2005) that propose reform in several areas which impact on gender in the hope of combating discrimination based on sex, and to ensure improved long-term care and support for vulnerable groups. They also consider more effective ways in which reforms could be implemented, requiring further analysis to be conducted on social exclusion, poverty, and poor working conditions. In addition, they promote the use of quantitative *and* qualitative indicators, broken down by gender and age group, in the hope that assessments of the impact and effectiveness of legislation, policies and practices will be clarified.

2.3 Gender and Health Sector Reform: Most countries are experiencing an epidemiological transition in the major causes of morbidity and mortality, e.g. populations alter, new infectious diseases materialise, disease burdens shift, and economic or even civil unrest can alter health policy. Rapidly rising health expenditures related to declining working-age populations and increasing numbers of elderly have put health care in even in wealthy countries under pressure, necessitating healthcare reform. Reforms discriminate to varying degrees against the underprivileged and marginalised, and women are proportionately over-represented in both these groups.

WHO defines health sector reform as involving a significant, purposive effort to improve the performance of the health-care systems. Key elements are fiscal reform, the introduction of market mechanisms and decentralisation. These naturally raise contentious issues across the sector. Many publications have reviewed the topic, but few of these have focussed on the impact of reform on gender equity in Europe ([12]).

Östlin (2005) argues the consequences of health sector reform can have a negative effect on women, due to their over-representation among patients and carers ([13]). Furthermore, while the health care industry is itself a source of jobs and income, health reforms have brought changes in the numbers the industry is able to support. In some countries patient/staff ratios have increased, personnel have been shifted, duties have

[12]Doyal, L., op. cit.
[13]Östlin/WHO Regional Office for Europe's Health Evidence Network (HEN), op. cit.

been reassigned to less skilled workers, and the use of casual workers has risen. As women are over-represented not only among patients, but also amongst health care personnel, the negative consequences of these policies affect them more than men ([14]).

2.4 Health Financing: Most health care systems in Europe are funded from a mixture of sources. These include taxation, social health insurance, private health insurance and out-of-pocket payments. Taxation and social health insurance dominate as the primary method of funding, with private health insurance playing a minor role. Health care revenue collected from general taxation or social health insurance is associated in theory with improved equity and better cost control. As women predominate in part-time, flexible and short-term employment, their contribution to social health insurance can be limited. In an equal-access type system this is of low importance, but systems dependent on out-of-pocket top-ups can be discriminating. As no clear causal relation has been demonstrated between the source of funds and improvements in allocations or technical efficiency, it is not yet clear whether women's access to health care would be improved by restructuring employment bands or levels of contribution ([15]).

Some EU countries source additional revenue through private health insurance and out-of-pocket payments; for example, in the period 1999-2001 out-of-pocket payments ranged widely: 41.4% in Greece, 19% in Belgium, and 16% in Sweden. In contrast, in the Netherlands the payments stood at 6.3% and in Ireland 9.1%. These payments are defined as any direct outlay, including gratuities or in-kind contributions, that households make for services and goods from health practitioners, pharmacists, medical supply vendors, or others. They can affect access to care and health-seeking behaviour. In high-income countries, out-of-pocket spending accounts for less than twenty percent of total health spending but it continues to account for the bulk of total health spending at the lower end of the income spectrum ([16]). These are perceived to be less equitable than taxation and social health insurance. As disadvantaged people have a limited ability to pay the costs, out-of-pocket spending acts as a key measure of inequities in health financing. Women in general have fewer financial resources, and they are likely to suffer the effects of these inequities ([17]). A move toward privatisation of services, with its emphasis on reducing costs and maximising efficiency, would have an important impact on gender equity in health care access. For example, given their lower financial status, women could find themselves without access to vital but expensive services, such as cervical cancer screening and mammograms.

Comparisons of health expenditure data are complicated by a paucity of reliable national data, wide variations across countries, and multiple data sources. Health expenditure on individuals can vary considerably depending on personal characteristics such as age, sex, and morbidity. Some EU Member States, such as England and Italy, are turning their attention to risk adjustment as a method for gaining an unbiased estimate of the expected expenditure. In this system, each individual is measured by their personal characteristics. The capitations set can vary widely and range from less sophisticated schemes to the very complex, but highly predictive, capitations seen in Denmark. Sweden, for instance, applies an advanced matrix

[14]Ibid
[15]Gottret, P., Schieber, G.; *Health Financing Revisited - A Practitioner's Guide*. World Bank, 2006
[16]Ibid: see chart pg 303
[17]Ibid

approach, using age, sex, marital status, employment status, occupation, and housing tenure, as well as previous high utilisation as risk adjusters on an individual level ([18]).

Table 4. Risk adjusters in capitation formulas for resource allocation in countries with tax-financed systems[19]

Country	Risk adjuster
Australia	Age, sex, ethnic group, homelessness, mortality, education level, Rurality
Canada	Age, sex, socio-economic group, ethnicity, remoteness
Denmark	Age, number of children in single-parent families, number of rented flats, unemployment, education, immigrants, social status, single elderly people
England	Age, mortality, morbidity, unemployment, elderly people living alone, ethnic origin, socio-economic status
Finland	Age, disability, morbidity, archipelago, remoteness
Italy	Age, sex, mortality, morbidity, utilisation
New Zealand	Age, sex, welfare status, ethnicity, Rurality
Norway	Age, sex, mortality, elderly living alone, marital status
Portugal	Based mainly on historical precedent; age, relative burden of illness (diabetes, hypertension, tuberculosis, AIDS)
Spain	Percent of population older than 65, 'insularity' (region/islands)
Sweden	Age, sex, marital status, employment status, occupation, housing tenure, high utliser

Risk adjustment may provide some insight into the weightings that are given when allocating funds, and could act as a source of data for comparative measurement of funding allocation according to gender. However, our attempts to analyse gender-specific economic and human resource allocations in European funding streams serves to highlight the lack of easily accessible, comparable, material. Health funding and competition frequently drive the funding agenda, not gender or equity. The tools are lacking which could demonstrate clearly and unequivocally how funding is spent in Member States to address gender-specific and gender-influenced health conditions.

2.5 **Gender and Research*:*** *Under the 6th Framework Programme (FP6) for Research (2002-2006), attention to gender-specific research outcomes was included as a quality criterion for EU research. This encouraged researchers to establish gender differences in morbidity and mortality, and to examine issues such as the differential effects on women and men of dosages of medicines and other treatments. For example, formerly, the exclusion of women from medical research was sometimes justified on the grounds that their cyclical hormone changes made results difficult to analyse, and that a pregnancy occurring during the trial period might put the foetus at*

[18]Gottret, P., Schieber, G., op. cit.
[19]Ibid

risk. As a result, women have often been treated with drugs that have never been tested on females, and without any precise knowledge of their affect on the female body ([20]). It has been argued that:

> '*A gender perspective in medicine implies that living conditions, positions in society and societal expectations about 'femininity' and 'masculinity' should be considered along with biology on professional relationships, as well as when theorising about women and men. Unawareness of gender aspects among health-care professionals and medical researchers can lead to gender bias*' ([21]).

It has been argued that medical science has been slow to respond to evidence of gender difference and negative attitudes to gender issues have been reported, as has resistance to the introduction of gender aware practice: '*Entrenched biomedical paradigms and* [non-compatible] *interdisciplinary terminology*', and '*a high degree of theoretical abstraction*' are cited as reasons for this intransigence ([22]). Attempts to introduce qualitative research on social models of gender are often seen as being outside the accepted paradigm, and even as being non-scientific. Data collected from research with an unequal gender balance has little statistical power to prove clinical benefits for women with any certainty and will fail to determine whether a treatment is cost-effective – or indeed effective at all - in women. This can have serious implications in economic analysis for health care planning, and will influence decisions on resource allocation ([23]).

Although men and women's physiology, disease processes, clinical presentation and outcomes differ, it is still common practice to extrapolate research results from male patients to reflect women's conditions. Findings from clinical and epidemiological studies show that women's experiences of conditions can be at variance with men's experiences ([24]). Cardiovascular disease is a good example of a condition where sex-disaggregated data is vital:

Adapting Standards in Cardiovascular Disease

CVD is the leading cause of death in Europe accounting for 1.9 million deaths a year across the EU. The most common cardiovascular diseases are coronary heart disease, hypertension, and cerebrovascular disease. Recent statistics reveal that CVD accounts for 46% of all deaths in women, compared to 39% of all deaths in men in the EU, and that stroke kills more women than men, even though more men have strokes ([25]).

Of women who survive a first heart attack:

- 42% die within a year following a heart attack, compared to 24% of men
- 46% will be disabled by heart failure within 6 years: two times the rate in men
- More will have a second heart attack/stroke compared to male survivors ([26]).

[20] Klinge, I., & Maguire, P.; *The Policy Implications of Gender Mainstreaming for Healthcare Research in the EU*. Pharmaeconomics 22 Suppl. 2: Adis Data Information BV, 2004

[21] Risberg, G., Hamber, K., Johansson, E.; *Gender perspective in medicine: a vital part of scientific rationality. A useful model for comprehending structures and hierarchies within medical science*. Umeå University, Sweden, 2006

[22] ibid

[23] European Heart Network/European Health Management Association/Bristol-Myers Squibb; *A healthy heart for European women*. 2005. http//www.ehnheart.org

[24] European Commission: *The Health Status of the European Union*. op.cit.

[25] European Foundation for the Improvement of Living and Working Conditions: *Illness, disability and social inclusion*, 2003

[26] European Heart Network/European Health Management Association/Bristol-Myers Squibb. Op.cit.

It is clear from these figures that women treated with ‘male-based’ treatment regimes may not respond in the expected manner. Standards adapted to better serve women’s needs have led to the creation of smaller stents and catheters for women, and this has made a significant difference to women’s access to key procedures such as angiography, angioplasty and coronary bypass surgery.

Chapter 3: GENDER AND DATA COLLECTION

3.1. Outdated Policy and Practice: The use of existing data presents several challenges when examining gender issues. For the most part, data is categorised on the basis of such indicators as age, condition or sex. Sources of data vary, and have many inadequacies. A tendency to focus solely on biological differences, and a failure to consider differential social characteristics, is limiting. Historically, data was collected according to rigid bio-medical and economic approaches that are now deemed to be outdated. For example, morbidity and mortality statistics continue to be framed within standard biomedical categories and the findings generated by these statistics are frequently inadequate for the implementation of gender sensitive policies. Statisticians have commented that these classical approaches, though effective for measuring common infectious diseases with known aetiologies, barely acknowledge psychological, social issues, or mental illness, let alone measure them for gender difference ([27]). In addition, baseline data supplied by EU Member States is processed according to a multitude of diverse frameworks that do not always produce material suitable for comparative analysis.

Health care reform seeks to improve efficiency, equity and effectiveness in health care services. Health care research therefore, has tended to produce data that promote improved health care management systems, priority setting, and broader financial options ([28]). This trend reflects traditional data collection methods within the EU since the 1970s whereby data was based on demographic, economic, and social statistics. These were insufficient to show that disease, disability, quality of life and (ultimately) death are the result of the interaction of human biology, lifestyle, social and environmental factors, and modified by health care interventions ([29]). Since then there has been limited consensus on the design of indicators for health research and the poor comparability of data continues to affect the application of the results to future health policies.

3.2. Merging Health and Socio-economic Issues: The growing awareness of the influence of socio-economic factors on health has allowed the development of a defined set of concepts, classifications, frameworks, and methodologies for measuring health status. Organisations such as Eurostat and WHO have been working supra-nationally to bring together common frameworks, and are developing commonly agreed and tested indicators which produce comparable data ([30]). In 2006 an EU report on gender equity asked that special attention be paid to statistical methodology and classifications. It called for policy monitoring to be supported by the collection, compilation and dissemination of timely, reliable and comparable data disaggregated by sex ([31]). The recent provenance of this report has not allowed sufficient time to pass to judge its success.

The collection of evidence which records the development of health over time and the effect it can have on an individual's personal experience is important in the planning of health care services. Basic principles of epidemiology have proven useful for

[27]Robine, J-M., Jagger, C, Van Oyen, H.; *The Euro-REVES Approach: A Vision For Europe*. UNECE/WHO, 2004
[28]Östlin/WHO Regional Office for Europe's Health Evidence Network (HEN), op. cit.
[29]Moliner, A. M.; *What Should Be Measured In Relation To Health Status: The EU Aggregate Experience*, European Commission, 2004
[30]De Smedt, M.; *Towards A Common Framework To Measure Health Status*. Eurostat/European Commission, 2004
[31]European Commission: *Report from the Commission to the Council, The European Parliament, the European Economic and Social Committee and the Committee of the Regions on Equality between Women and Men*, 2006

measuring the status of health within populations, but fail to provide clear information on the influence over the years of the wider health determinants and inequalities in health ([32]). Wider health determinants include demography, geography, socio-economic, personal and biological factors. They also encompass health behaviours such as substance abuse, nutrition, physical activity, sexual behaviour, and living, working and environmental conditions. They demonstrate that experience of health can vary widely according to an individual's gender and environment.

The range of indicators needed to reflect these aspects will be unavoidably wide if data is to demonstrate gender difference in all these areas. Since behavioural patterns can vary according to gender and circumstance, transparent data must reflect the needs of all groups and reflect the individual – and perhaps differing - effect of medical conditions on women and men in any potentially marginalised situations ([33]).

European Community Public Health Indicators

The ECHI build on the work and activities of previous programmes from the public health framework (Cancer, HIV/AIDS, Drugs, Health Promotion, Health Monitoring, Pollution related Prevention Programme, Rare Diseases and Injuries and Accidents) which include indicators on:

- Increasing life expectancy without disability or sickness
- Dealing with health threats, e.g. communicable diseases and bio-terrorism
- Reducing differences in health status and health outcomes
- Attention to major burdens of disease
- Addressing health determinants through promotion and prevention – e.g. tobacco, nutrition and alcohol in all EU policies and activities
- The citizens' dimension and equal access to information
- Needs of the new EU Member States

There is a need for evidence that the process of collecting comprehensive, comparable and compatible age and gender-specific data has begun to happen in the European context. Policy documents in current use need therefore to be reviewed and amended to ensure that they include directives for the provision of gender proofed methodology and classifications.

3.3. Approaches to Data Collection: Given the number of agencies involved in collating and interpreting data and the range of indicators used to gather information, it is no surprise that discrepancies have been observed in data collection systems. For example, the use of different sources to record an event can result in different outcomes. Anomalies of this type have been observed, for example, in statistics on deaths from road traffic accidents where numbers have been taken both from the Causes of Death (COD) data and from differing figures in police reports ([34]).

Similarly, as the indicators required for monitoring the progress of programmes have often been user-driven and target oriented, the resulting compilations can be lengthy. It is difficult for an aggregate EU measurement of health status to escape national and

[32]Bonté, J.; *Health Indicators and Eurostat*, UNECE/WHO, 2004
[33]Klinge, I., & Maguire, P., op. cit.
[34]Bonté, J., op. cit.

sub-national particularities ([35]). It has proven immensely complicated to reach a consensus on common instruments for measuring health status in different languages and in different cultural settings, in order to produce results that can be compared within, and across, countries of the EU ([36]). Cultural and language differences - even within Member States - can lead to differing interpretations when questions are set. The composition of data templates therefore requires not only cultural sensitivity, but excellent linguistic and translation skills ([37]). Success in this area will allow researchers to follow developments over time, and to formulate explanations for health differences between regions and countries. It is a challenge to create a simple but comprehensive base template, which can produce information that is easily comparable with information from other Member States ([38]).

Member States will need to consider modifying their national data collection practices in the interests of sharing information, future planning, and learning from other Member States. Although most European countries run regular health interview surveys to monitor population health some, such as the UK's General Household Survey, were set up before the recent trend to harmonise information collection within the EU, and are at variance with the standard. Some Member States have been resistant to change when proposed new systems infringe on long-standing practice ([39]).

3.4. **Frameworks for Measuring Health*:*** *Data for European health statistics are derived from a wide variety of sources. DG SANCO (the Directorate General for Health and Consumer Affairs) has been endeavouring to bring these together by developing a European Union System of Information on Health and Knowledge (EUIHK). Data sources for EUIHK are based on figures from the Health Monitoring Programme (HMP), on the Injury Prevention and Rare Diseases Projects, on current work in DG SANCO, Eurostat, DG RTD, and on data from other contributing EU and international bodies.*

Base data are drawn from core modules of data on health, which are required from all Member States at regular intervals. *Health* and *Disability Interview Surveys* (HIS/DIS) complement the *Health Examination Surveys* (HES), which in turn provide data on identifiable and measurable physical and mental characteristics and which can be linked to demographic and socio-economic characteristics ([40]). These data are then fed into the *European Core Health Interview Survey* (ECHIS). Other subject matter for HIS statistics are collected in special surveys, called *European Special Health Interview Surveys* (ESHIS). The *Health Monitoring Programme* (HMP) database provides specific information on particular topics like self-reported health, lifestyles, or use of services. Unfortunately, it has become unwieldy, covering at total of more than 5000 *Health Interview Survey* (HIS) questions, both in the original language and in English.

An exemplar of data collection is the Euro-REVES (*International Network on Health Expectancy and the Disability Process*) project which was set up to provide comparable health indicators that would address inequalities in the health of European

[35]Klinge, I., & Bosch, M., op. cit.
[36]De Smedt, M., op. cit.
[37]Bonté, J. op. cit.
[38]Robine, J-M., Jagger, C, Van Oyen, H., op. cit.
[39]Ibid
[40]De Smedt, M., op. cit.

populations. Euro-REVES promotes the use of health expectancy as a population health indicator. Health expectancies extend the concept of life expectancy to morbidity and disability. Being independent of the size and age structure of populations, they allow - in theory - direct comparison of the different groups that make up populations (e.g. sexes, socio-professional categories, regions or countries), as well as estimating changes over time. These indicators can simultaneously assess the evolution of mortality, morbidity and disability and thus determine the likelihood of questions such as whether we are exchanging longer life for poorer health ([41]).

Disability Adjusted Life Years (DALY)

DALYs are a method used to measure the burden of disease ([42]). Used in conjunction with Quality Adjusted Life Years (QALYs) which measure healthy years lived, DALYs combine information about morbidity and mortality in numbers of healthy years lost. DALYs measure the time lived with a disability in a manner that can be meaningfully compared with the time lost due to premature mortality. The use of methodologies such as DALYs, although inclusive of sex-disaggregated data, have revealed disease gender biases which have lead to the underestimation of women's burden of disease ([43]).

Data collection that makes use of self-reported health status can complement more objective indicators and introduces the patient perspective into health monitoring. Although they contain certain disadvantages, they reveal dimensions of health that may not be accessible to more traditional measuring methods. Unfortunately, the subjective nature of self-reporting may not always correctly identify a condition. For example, a person might have a disease but be unaware of it, or they may have incorrectly diagnosed a condition themselves. Individuals may use different references or *comparators* to report their functioning. For example, they may report their mobility to be as good as (or worse, or better than) that of their peers, dependent upon their idea of youth and ability, or their own expectations. Furthermore, there is considerable diversity in the concepts and definitions that are adopted in different countries when surveying chronic conditions ([44]). Implausible results have been noted which may indicate systematic biases between men and women, rich and poor, or in educational, ethnic or geographical groups ([45]).

3.5 Gender Analysis Tools: In recent years a variety of tools have been developed which employ both socio-economic perspectives and methods for gender-proofing research. These tools can offer a means of identifying major biases and can point the way to preventive or counterbalancing solutions ([46]). Using tools of this type, all regional, national, and European level policy documents could be subjected to gender proofing and Gender Equality Impact Assessment before they are issued, thereby facilitating the provision of disaggregated data.

[41]Robine, J-M., Jagger, C, Van Oyen, H., op. cit.
[42]Homedes, N.; *The Disability-Adjusted Life Year (DALY) Definition, Measurement And Potential Use*. HCO Working Papers. Undated
[43] Östlin/WHO/HEN, op.cit.
[44]Klinge, I., & Maguire, P., op. cit.
[45]Üstün, T.B.; *Measuring Health: An International Perspective*. WHO, 2004
[46]Eichler, M., Burke, M. A.; *The BIAS FREE Framework: A New Analytical Tool for Global Health Research*. Canadian Journal of Public Health 2006; 97 (1): 63-68

Examples of Gender Analysis Tools ([47])
Global Forum for Health Research (2002) *Sex, Gender and the 10/90 Gap in Health Research: A Briefing Document and Resource Guide*. A guide for researchers trying to incorporate a gender perspective into their work. It begins by setting out the main arguments in favour of gender-sensitive health research, and continues with an exploration of the implications of these arguments for the research process itself. The second part is a review of available resources on integrating gender in health research, including articles, books, tools, and websites. http://www.globalforumhealth.org/FilesUpld/47.pdf Health Canada (2003) *Exploring Concepts of Gender and Health.* A capacity-building tool for researchers, policy analysts, programme managers and decision makers, intended to help them integrate gender-based analysis (GBA) into their policy and programme work. http://www.hc-sc.gc.ca/english/women/exploringconcepts.htm Liverpool School of Tropical Medicine (1998) *Guidelines for the Analysis of Gender and Health*. Enhancing the ability of those involved in the planning, implementation, and evaluation of health care provision and health research to understand, respond to, and integrate gender issues. The guidelines cover gender and health; gender analysis; gender-sensitive planning; strategies to address gender inequalities in health; and case studies. http://www.liv.ac.uk/lstm/GG-1.html

To date, much of the work on disaggregating data by sex has occurred in relation to developing nations. The UNDP has developed a number of gender-related indicators that assess the levels of gender equality in society. These indicators are based on a socio-economic model and domains include *longevity, knowledge, a decent standard of living, economic participation and decision-making, political participation and decision-making, power over economic resources, and inequalities in achievement*. Table 5 shows the UNDP's Gender Development Indicator (GDI) scale. On this scale, adjustments for inequalities in achievement in human development (HDI) are compared with the Gender Empowerment Rank (GEM). The GEM is a composite index measuring gender inequality in three basic dimensions of empowerment (economic participation and decision-making, political participation and decision-making and power over economic resources). Discrepancies in these figures indicate that while legislation may be in favour of the empowerment of women (GEM), the opportunities for this are often not being realised (GDI).

Table 5. Gender empowerment ranking

Gender Empowerment Rank (GEM)	Country	GDP per capita rank 2003	Human Development Indicator (HDI) Rank 2003	GDI*2003: GDP per capita rank minus HDI rank (higher means better on HDI)
3	**Sweden**	20	6	14
6	**Belgium**	12	9	3
9	**Germany**	14	20	-6
18	**UK**	18	15	3
21	**Portugal**	32	27	5
27	**Poland**	48	36	12
29	**Bulgaria**	65	55	10
36	**Greece**	26	24	2

Source: UNDP 2005 ([48])

[47]WHO/Pan-American Health Organization: *Annotated Bibliography on Gender Mainstreaming and Analysis Resources for Health Programmers*. Pan-American Health Organization Gender and Health Unit, 2003
[48]UNDP 2005: http://hdr.undp.org/statistics/data/countries.cfm

*The GDI adjusts the HDI for inequalities in the achievement of men and women. Comparing a country's ranking on the HDI and the GDI can indicate the existence of gender discrepancy.

3.6 Upgrading quality in data collection and analysis: It is important to collect data in a format that can easily be processed and interchanged between local, national and international levels. Good primary data is essential, and EU Member States should be encouraged to work to standard templates for all data collection. Templates with common indicators, which capture patterns of behaviour and access to resources ([49]), and which can be conveniently used by grass-root health care delivery agents, can then be channelled through regional and national statistics to the European level. We have seen that the systems of data collection that have developed over the years have grown unwieldy. Capturing information at source in a simple, usable form, and feeding it to higher levels in a common format may counter professional, economic, and national bias and produce a useful source of primary data.

For decades there has been an awareness of the need for greater representation of women's issues in the data used for planning and policy design. The EP's *Programme for Community Action in the Field of Public Health (2003-2008)* ([50]), *Equality Between Women and Men* (2006) ([51]), and the amendments for the *Community Programmes for Employment and Social Solidarity*, seek to streamline the involvement of Member States in the collection, processing, and analysis of compatible and comparable data. However, stating that data *should* be disaggregated by sex could leave the collection of disaggregated data open to choice. Sex disaggregated data *must* become a requirement for all future research.

Of particular importance for this report is that the diversity of women's, and young girls', health-influencing experiences and behaviour need to be reflected in data. Special attention should be given to vulnerable and marginalised groups of women to ensure that discrimination is recorded, and measures taken to counter the effects of inequity. The life quality of carers, lone parents, migrants, refugees, and those who are coping with chronic disease or long term disabilities are all subjects for further research. The identification and measurement of health-damaging cultural attitudes and practices such as domestic violence have not yet been adequately documented ([52]). Abusive behaviours such as sexual violence, rape and female genital mutilation have a dramatic influence on physical and psychological health and need to be placed on the political agenda ([53]). Much of this information is available at present at local and regional levels. Methods must be found which collate this information for use in planning and policy development at EU level.

Some suggestions are offered to improve quality in data collection and analysis:

- Develop appropriate conceptual frameworks for data collection
- Expand and standardise existing indicators for health
- Recognise the importance of the social construction in gender indicators
- Seek simple yet comprehensive methods of collection that provide information which is comparable between Member States, which follow developments over

[49]Doyal, L., op. cit.
[50]European Parliament: *Report on Programme for Community Action in the Field of Public Health (2003-2008).* Brussels, 2005
[51]European Commission: Report on *Equality between Women and Men*, op. cit.
[52] Doyal, L., op. cit.
[53] Klinge, I., & Bosch, M., op. cit.

time, and which offer explanations for existing differences

- Ensure these methods are ethically and culturally appropriate for the collection of data from women in their own environments
- Promote effective monitoring and planning through the use of analytical tools that examine documents for gender balance.
- Pre-2006 policy documents should be reviewed and amended to include gender proofing methodology and classifications.
- Member States must consider modifying their national data collection practices in the interests of sharing information, future planning, and learning from others
- Member States must sign up to standardised systems of data collection.

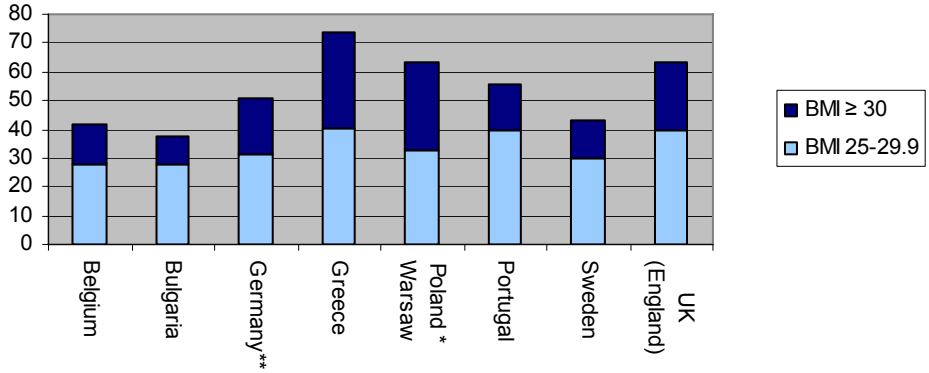
Chapter 4: HEALTH ISSUES FOR WOMEN AND YOUNG GIRLS

4.1 **Lifestyle and consequences for health*:*** *Lifestyle has a considerable impact on health and disease and on life expectancy. However, caution must be exercised when using lifestyle choices as health determinants. These may result in interpretations which blame the victim, or in policies that only focus on behavioural change at the individual level and which ignore policies at population and structural levels, such as those relating to the environment or employment.*

Many health problems are thought to begin *in utero*, influenced by the health and behaviour of the mother. For example, children born weighing under 1500g are more likely to have visited a GP, physiotherapist, speech therapist and eye specialist, and to require additional help in school ([54]). Low birth weight is more common in deprived communities, and a correlation has been seen between low birth weight and increased risk of death from coronary artery disease in adults ([55]). Poor nutrition in the mother during pregnancy can also increase the child's vulnerability to several conditions in adulthood, including obesity, diabetes, raised blood pressure, and stroke.

In all Member States the least educated consume fresh vegetables less frequently, and are on average shorter and more obese than the most educated, though the dimension of these differences can vary between men and women and in accordance with the drinking and diet culture ([56]). Obesity, reduced physical activity and poor nutrition are increasing in young people from all social groups. Whatever their background, overweight children are likely to become overweight adults. There are concerns in the EU that the number of overweight children is rising each year by 400,000. A Eurobarometer survey shows that in 11 out of 15 Member States the weight of citizens has increased, with the most striking increases in Luxembourg (2.7 kg), Denmark (1.7 kg) and Ireland (1.6 kg) ([57]).

Table 6. Estimated prevalence of overweight and obesity in women in % ([58])



Notes: * restricted age groups
** Germany over weight figures derived from WHO MONICA studies

[54]Middle C, Johnson A, Alderdice F, Petty T, Macfarlane A.: *Birthweight and health and development at the age of 7 years*. Child Care, Health & Development 1996; 22(1): 55-71
[55]Matharu, K., Ozanne, S; *The Fetal Origins of Disease and Associations With Low Birthweight*. NeoReviews Vol.5 No.12 2004 e522. American Academy of Pediatrics, 2004
[56]European Commission: *The Health Status of the European Union*. op.cit.
[57]European Commission/Eurobarometer: *Health and Food*, p 13. November, 2006
[58]International Obesity Task Force and European Association for the Study of Obesity: *Obesity in Europe: the case for action*, p 6. London. 2002 See: http://www.iotf.org/media/euobesity.pdf

Other lifestyle choices which impact on the health of women include the consumption of alcohol, smoking, and drug use. We have chosen to address the issue of smoking as many differences between the sexes are evident.

Smoking: A report in 2002 stated that there were slightly higher rates of regular daily smokers in the then ten Accession Countries than EU-15 (32% vs. 29%) with the highest prevalence in Hungary and Poland ([59]). There are some important gender differences in smoking behaviour and several common reasons why women take up smoking. As the majority begin smoking during the teenage years, smoking is often seen as an act of rebellion against social pressures to be feminine, and as a way to gain independence from parents. It can be viewed as a way to make friends and be accepted by peers. Many women smoke in order to relax and relieve stress, or use it as a food substitute in order to stay slim. Women are more likely than men to take up smoking as a means of weight control, and to continue smoking, rather than risk putting on weight.

The issues around the quitting of smoking are complex. Evaluations need to take account of variables such as socio-economic status and educational level as well as gender roles and expectations. Women who continue to smoke, and those who fail at attempts to stop smoking, tend to have lower education and employment levels than women who quit smoking. They smoke a higher number of cigarettes per day and tend, therefore, to be more addicted to cigarettes. They have less social support for stopping smoking, are less confident in resisting temptations to smoke, and are thus are cognitively less ready to stop smoking. There is also evidence to suggest that pharmacologically-based aids to cessation are not equally effective for both sexes ([60]).

Eating disorders: The main types of eating disorders are anorexia nervosa and bulimia. Eating disorders are amongst the most debilitating psychiatric disturbances that affect women and they are most common in cultures focused on weight loss and body image. There are many different theories regarding the causes of eating disorders. It is most likely that they are caused by a combination of psychological, genetic, environmental and social factors. The media can promote unrealistic role models for beauty and weight, which can have a strong influence on an individual with low self-esteem, leading to disordered thinking and behaviours. An individual with a family history of mood disorders such as depression may be especially affected. Eating disorders are often associated with feelings of helplessness, sadness, anxiety, and the need to be perfect. They can cause a person to use dieting or weight loss to provide a sense of control or stability. According to Makino *et al* ([61]) the prevalence rates in western countries for anorexia nervosa in female subjects range from 0.1% to 5.7%, and for bulimia it ranges from 0.3% to 7.3% in women and from 0% to 2.1% in males.

According to our Belgian expert as many as 5 out of 100 women in Belgium have a bulimia problem (See Appendix 2 for expert contributors) and it has been noted that bulimia is 3 to 5 times more apparent in urban areas than in rural areas. However, there is often doubt about the reliability of data on eating disorders, particularly as research

[59]World Health Organisation Regional Office for Europe & European Commission. *Health status overview for countries of central and eastern Europe that are candidates for accession to the European Union*. European Communities & WHO July 2002
[60]National Center for Chronic Disease Prevention and Health Promotion Tobacco Information and Prevention Source: *Women and Smoking – A Report of the Surgeon General, 2001*.
http://www.cdc.gov/tobacco/sgr/sgr_forwomen/sgr_women_chapters.htm
[61]Makino M, Tsuboi K, Dennerstein L; *Prevalence of eating disorders: a comparison of Western and non-Western countries*. Medscape General Medicine; 6: 3: 49. 2004.

is often limited to the under-25s, with older women excluded because bulimia and anorexia nervosa are considered to be a 'young girls' condition ([62]).

Mental Health: Gender determines the power and control men and women have over their lives. It affects their social position, status and treatment in society, and consequently, their susceptibility and exposure to mental health risks. Apart from specifically female conditions such as the experience of perinatal mental health problems, there are clear and consistent differences in the patterns of mental health experienced by men and women. 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 ([63]) with women twice as susceptible as men.

There are gender-specific risk factors for some common mental disorders. For example, women are at much greater risk of experiencing domestic abuse than men. Interpersonal relationships marked by severe and chronic violence result in high rates of depression and anxiety, symptoms of post-traumatic stress, and subsequent difficulty in establishing and maintaining relationships. Women living in poverty and minority women are at heightened risk for victimisation by violence ([64]). Similarly, women living on a low income for an extended period can experience stress, difficulty in personal and family relationships, and can be left feeling isolated and depressed. Individuals most at risk of social isolation and anxiety are female lone parents and retired women living alone ([65]). Women's social roles, particularly as primary carers for children and/or other dependants, can result in 'role overload', where women undertake both employment and household/childrearing responsibilities. This contributes to social isolation and further impacts on mental health.

Gender differences exist in patterns of help seeking for psychological disorder. Women are more likely to seek help from, and disclose mental health problems to, their primary care physician while men are more likely to seek specialist mental health care and are the principal users of inpatient care. Gender bias can also occur in the treatment of psychological disorders. Doctors are more likely to diagnose depression in women compared with men, even when they have similar scores on standardised measures of depression or present with identical symptoms. There may also be differences in access to specific treatments such as psychotherapy or anti-depressants, and in the response to treatments and their outcomes. Female gender is a significant predictor of being prescribed mood altering psychotropic drugs. The disability associated with mental illness falls most heavily on those who experience three or more co-morbid disorders, which is mainly women ([66]).

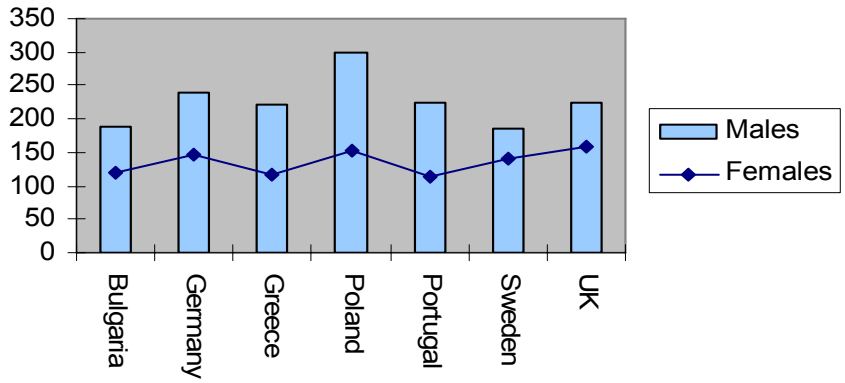
4.2 Selection of some diseases

4.2.1 Cancer: Cancer is a major public health problem in Europe. After cardiovascular disease, it is the second most common cause of death in the EU. In general, cancer

[62]Vanderlinden,J.; UZ health letter 120, 1-9-2001
[63]European Commission: Expert Report *'Actions against depression. Improving mental and well-being by combating the adverse health, social and economic consequences of depression'*, 2004.
[64]World Health Organisation: *Women's mental health – an evidence based review*. Geneva, 2000
[65]Myers, F., McCollam, A., Woodhouse, A., *Resource document on mental health and inequalities in Scotland*. Scottish Development Centre for Mental Health, 2005
[66]Austbury J. Mental Health: 'Gender Bias, Social Position, and Depression', in: Sen. G., A. George, and P. Östlin (eds.) (2002) *Engendering International Health: The Challenge of Equity*. MITPress, Cambridge. See also: Hällström T. 'Gender differences in mental health', in: Östlin P, Danielsson M, Diderichsen F, Härenstam A, Lindberg G (eds). *Gender Inequalities in Health: A Swedish Perspective.* Harvard Center for Development and Population Studies, Harvard University Press, Cambridge 2001.

mortality is higher in men than in women. Four cancers - colorectal, female breast, lung, and prostate - accounted for nearly half of all new cases of cancer diagnosed in 2000. They also account for nearly half of all deaths from cancer in the EU. Cancer causes 35% of all deaths before the age of 65 and amongst children aged 1–14 they are the second leading cause of death ([67]).

Table 7. Deaths from cancer in 2000 (per 100 000 persons) ([68])



Notes: no data available for Belgium

Risk Factors: The majority of cancers can be attributed to the particular environment in which an individual is living, though lifestyle and familial predisposition can also influence the risk of contracting cancer. For women less advantageous work conditions, lower education, and additional stresses that affect lifestyle choices and access to screening and treatment may adversely influence their health behaviours. The cessation of smoking, improvements to diet and physical activity to avoid obesity, the reduction of over-exposure to sunlight, and screening for cancer are all recommended by the 2003 European Code Against Cancer as ways to avoid the disease ([69]).

Breast Cancer: Breast cancer is a prominent cause of death for women aged 35 to 64 years and it is estimated that one in every 12 women will develop breast cancer at some point in their life, with one of the highest rates in Sweden (although this may be attributable to the longevity of Swedish women). Mortality from breast cancer however, is decreasing in many Member States and is partially attributed to the introduction of effective screening programmes ([70]).

Table 8. Breast cancer incidence in women and deaths (all ages) ([71])

	Crude death rate per 100, 000 population	New cases per 100,000 population
Belgium (1996)	48	104.5
Bulgaria (2001)	26.3	82.1
Germany (1998)	42.1	110.1
Poland (1996)	23.9	48.8
Portugal (1993)	28.7	62.2
Sweden (1999)	33.1	140.9
UK (1997)	44.6	125.6

[67]European Commission: *The Health Status of the European Union*. op. cit.
[68]Eurostat. op. cit.
[69]European Community/Europe Against Cancer: *European Code Against Cancer, Version 3*. 2003 http://www.cancercode.org/
[70]European Commission: Report on *Equality between Women and Men*, op. cit.
[71]World Health Organisation: *Atlas of Health in Europe*. WHO, Regional Office of Europe, Copenhagen, Denmark, 2003.

Note: no data for Greece available

Evidence suggests a plethora of risk factors for breast cancer in women. For example, regular use of alcohol increases the risk of breast cancer and each additional daily measure increases the risk of breast cancer by about 10% ([72]). There is also evidence to suggest that alcohol increases the risk more if a woman is on hormone replacement therapy ([73]). According to some studies the height and weight of an individual can affect the risk of breast cancer. A Harvard study showed that higher body mass index (BMI), especially in early adulthood, may be associated with a reduced risk of breast cancer before menopause. As it is not uncommon for overweight women to have irregular or long menstrual cycles, the reduced risk could be the result of irregular ovulation rather than larger body size ([74]).

Colorectal Cancer: Colorectal cancer is the third most common cause of cancer deaths for men and the second for women ([75]). The lowest mortality cluster of countries includes Finland and Greece and the highest mortality cluster includes Denmark and Ireland, with female rates also proving high in Germany. The highest five-year survival rates are reported for Spain, France and the Netherlands, and the lowest for Poland, Slovenia and Hungary. The causes of colorectal cancer are not known, although it is thought there may be a link with a diet high in animal fats and protein, and low in fibre. Dependency on insulin may also be a factor, as type 2 diabetics are more likely to develop colon cancer than people who do not have diabetes ([76]).

Lung Cancer: In 2000, the gender difference in the incidence of lung cancer was 54.1 per 100,000 men and 11.1 per 100,000 women ([77]). In the EU, cancers of the lungs/bronchus are the most common cause of cancer mortality in men and the third most common in women. While the overall incidence of lung cancer mortality is decreasing, it is still increasing for women in most Member States, though decreasing in the UK for women under 65 years of age ([78]). A primary cause of lung cancer is smoking, although pollution and exposure to certain gases/chemicals may play a part.

Cervical Cancer: High rates of cervical cancer can be found in the EU, particularly Eastern Europe ([79]). It is seen most commonly in women over the age of 50. As with many other forms of cancer, researchers are unsure of the exact cause though several risk factors have been identified, such as smoking, early sexual activity, sexually transmitted infections (STIs), human papilloma virus (HPV), age, and lack of access to services.

[72]Key, J., *et al., Meta-analysis of Studies of Alcohol and Breast Cancer with Consideration of the Methodological Issues*. Cancer Causes Control, 2006. 17(6): p. 759-770.
[73]Beral, V.; *Breast cancer and hormone-replacement therapy in the Million Women Study*. The Lancet; 362; 9382; 419-427. 2003
[74]Cancer Help UK: http://www.cancerhelp.org.uk/ . See also: Karin B. Michels; Kathryn L. Terry; Walter C. Willett: *Longitudinal Study on the Role of Body Size in Premenopausal Breast Cancer.* Archives of Internal Medicine, Nov 2006; 166: 2395 - 2402
[75]European Commission: *The Health Status of the European Union*. op. cit p21
[76]Yang, Y-X., Hennessey, S., Lewis, J.D.; *Insulin therapy and colorectal cancer risk among type 2 diabetes mellitus patients*. Gastroenterology, Issue 4, Pages 1044-1050. October 2004. http://www.gastrojournal.org/issues?Vol=127
[77]European Commission: *The Health Status of the European Union*. op. cit. p 20
[78]Ibid p 20
[79]World Health Organisation: *Atlas of health in Europe*. WHO, Regional Office of Europe, Copenhagen, Denmark, 2003.

Table 9. Cervical cancer incidence and deaths (25-64 years) ([80])

	Crude death rate per 100 000 population	New cases per 100 000 population
Belgium (1996)	3.4	9.1
Bulgaria (2001)	8.9	26.7
Germany (1998)	4.7	16.7
Poland (1996)	10.2	19.6
Portugal (1993)	3.8	17.8
Sweden (1999)	3.6	10.0
UK (1997)	4.6	10.8

Note: no data available for Greece

There is much gender-specific data on incidence, prevalence, death rates and five year survival rates due to the introduction of cancer registers and collection of cancer data collection, supported by EUROCARE. However, there is almost nothing on how men and women may be treated differently with the same or comparable cancers.

4.2.2 Cardiovascular Disease (CVD): CVD is a prime example of how a disease can affect men and women in different ways. CVD tends to affect women about ten years later than men, as estrogen has a protective effect for women against heart disease before menopause. Before menopause, women are somewhat protected against heart disease by oestrogen, which increases high-density lipoproteins (HDL, or 'good' proteins) and decreases low-density lipoproteins (LDL, or 'bad' proteins) in cholesterol levels. This advantage disappears with menopause however, and cholesterol levels are higher in postmenopausal women than men at similar ages. The incidence of CVD can therefore increase dramatically for women in middle age. Evidence is growing that lowering blood cholesterol levels can reduce the incidence of major heart attacks in women with heart disease and improve survival in older patients, but guidelines on when and how to reduce cholesterol levels in healthy women have not yet been established. However, a woman who has a stroke or a heart attack - especially when older- is more likely to die than a man. Studies have indicated that women also have a higher rate of repeat attack and heart failure, which in turn leads to increased morbidity ([81]).

Research has suggested that fewer women than men with suspected acute heart attack symptoms are referred for non-invasive tests, and fewer women than men who test positive for heart disease are recommended for further testing and treatment ([82]). Because of the high fatality rate associated with first heart attacks in women, it is important that women with suspected heart attacks are evaluated promptly, carefully and completely. Women can present different symptoms to men, often feeling extremely tired for a period of a month preceding an attack. There also seems to be a higher incidence of unrecognised myocardial infarction in women than in men ([83]). Not all doctors recognise the differing male and female symptoms, and moreover, some women - notably those who are obese - are more likely to have co-morbidity's

[80] World Health Organisation: *Atlas of health in Europe*. Op.cit.
[81] European Heart Network/European Health Management Association/Bristol-Myers Squibb. Op.cit.
[82] Arber, S., McKinlay, J., Adams, A., et al: *Patient characteristics and inequalities in doctors' diagnostic and management strategies relating to CHD: A video-simulation experiment*. Social Science & Medicine 62 (2006) 103–115
[83] de Torbal et al; *Incidence of recognized and unrecognized myocardial infarction in men and women aged 55 and older: the Rotterdam Study*. European Heart Journal 10.1093/eurheartj/ehi707. The European Society of Cardiology, 2006

that mask symptoms of heart disease ([84]). The *European Heart Journal* recently identified gaps in the data available on women, and recommended further research in:

- The effect of female hormones on cholesterol levels
- The effectiveness of aspirin in treating women as opposed to men
- Appropriate prescription of blood pressure medicines to women
- Recommended dosages for women
- Effective methods for motivating lifestyle changes among women ([85])

Risk Factors: Diabetes increases the risk of heart disease more for women than it does for men. Women who have already had a heart attack have double the risk of a second attack if they are diabetic. Reasons for these gender differences are thought to include greater prevalence of other risk factors such as obesity and hypertension in diabetic women ([86]). Stress is another important risk factor for women in cardiovascular disease. Hormonal balance associated with pre-menstrual, post-partum and menopausal changes can also affect chemical vulnerability to stress and depression. The benefits of treating severe hypertension have been demonstrated in both men and women. Evidence of long-term benefits of treating mild to moderate hypertension in women is however still lacking, due to the low rates of inclusion of women in clinical trials. Lifestyle changes such as improved diet, weight control, lowered alcohol intake, sodium reduction, and some dietary supplements may be effective for women.

4.2.3 Sexually Transmitted Infections (STIs): Risk factors for STIs can include lifetime multiple sex partners and a weakened immune system. Women are more vulnerable to STIs biologically, culturally and socio-economically as often their lower social position in society gives them less power in sexual relationships and therefore a high risk of acquiring an infection. The gender stereotypes that accompany this lack of power ensure a greater stigma is attached to becoming infected, which may influence the treatment and severity of the health repercussions from such an infection ([87]).

Trichomononiasis is the most common of the STIs, causing symptoms in approximately 50% of infected women, but data on its prevalence and incidence are limited. It is associated with adverse birth outcomes such as premature delivery, rupture of the membranes, and low birth weight. In men, infection is usually urethral and of short duration, but men easily transmit the parasite to women during the period when they are infected. Vaginal trichomoniasis infections have no systemic complications but there is evidence that it can facilitate the spread of HIV ([88]).

Chlamydia is a common bacterial STI. Women with Chlamydia may not be aware that they are infected, as 70-75% of infected women are symptom free. If left untreated, 20 to 40 percent of women with genital chlamydial infections develop pelvic inflammatory disorder (PID), which can lead to infertility, ectopic pregnancy, and chronic pelvic pain. Recent studies have also linked Chlamydia with increased risk of developing cervical cancer. It can also cause pneumonia and eye infection in children born to infected mothers ([89]).

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[84]Stramba-Badiale, M., Fox, K. *et al*: *Cardiovascular diseases in women : A statement from the policy conference from the European Society of Cardiology*. European Heart Journal (220) 27, 994-1005, doi:10. 1093/eurheartj/ehi819
[85]de Torbal et al, op. cit.
[86]European Heart Network/European Health Management Association/Bristol-Myers Squibb, op.cit. p10
[87]Women's Health Council: *Women and Sexually Transmitted Infections: a gendered analysis.* Dublin, 2006
[88]World Health Organization: *Global Prevalence And Incidence Of Selected Curable Sexually Transmitted Infections.* Geneva. 2001
[89]World Health Organization: *Global Prevalence And Incidence Of Selected Curable Sexually Transmitted Infections*. Op. cit

Table 10. Extrapolated prevalence of Chlamydia in Europe (total population) ([90])

Country	Extrapolated Prevalence
Belgium	152,180
Bulgaria	110,558
Germany	1,212,126
Greece	156,581
Poland	568,034
Portugal	154,766
Sweden	122,241
UK	886,333

Human Papilloma Virus (HPV) is typically spread by direct, skin-to-skin contact during vaginal, anal, or oral sex with someone who has the infection. Despite the potential severity, the health consequences of HPV are often hidden and can occur years after infection. Thus, many people do not know that they are infected or that they are passing the virus on to others. HPV produces genital warts which are suspected of causing the cellular changes that can lead to cervical cancer, though they are commonly regarded as being of low risk with regard to malignancy ([91]). Nevertheless, up to 90 percent of cervical cancer shows evidence of HPV infection. Few EU countries routinely collect surveillance data on infection with genital warts.

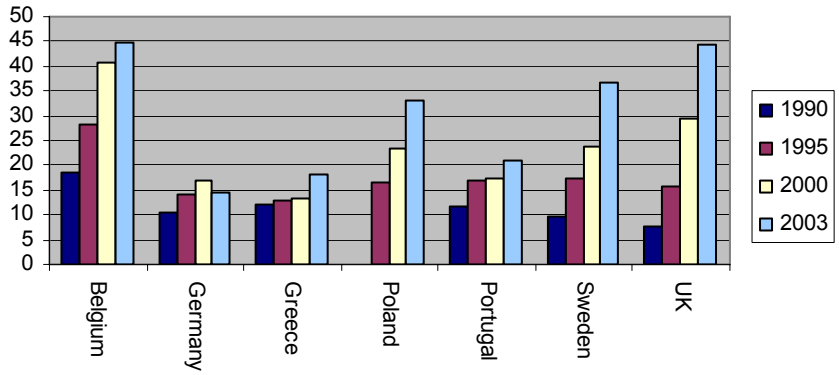
Gonorrhea. Gonorrhoea is a curable bacterial disease that if left untreated can cause chronic pelvic inflammatory disease, infertility, ectopic pregnancy, and chronic pelvic pain in women. Symptoms may be hidden and up to 80% of women and 10% of men are asymptomatic. An eye infection, ensuing from the mother's condition, can lead to blindness in new-born infants. Those infected with gonorrhoea also face greater risk of transmitting or becoming infected with the AIDS virus. Since the mid 1990s an increase in cases of gonorrhoea have been observed in some countries. England and Wales for example, experienced a 35% increase in male cases and a 32% rise in female cases between 1995-97 ([92]).

HIV/AIDS: In the 23 EU countries for which data was reported in 2004 (excluding Italy and Spain), there were 24,184 newly diagnosed cases of HIV representing a rate of 68 HIV infections per million population. Over a third of cases (36%) were females. Thirteen per cent of cases were young people between 15-24 years of age ([93]). Because of biological reasons, women are more vulnerable to HIV infection than men. Moreover, women often are dangerously unaware of the risks of HIV infection and of ways to protect themselves. In many societies, it is the unequal economic, social, and cultural status of women that puts them at greatest risk of infection. They may also lack adequate access to prevention services and methods of contraception. Women who have limited social standing or economic security, or who are involved in coercive or abusive relationships often cannot negotiate abstinence or use of a condom.

[90] Wrong diagnosis: http://www.wrongdiagnosis.com/c/chlamydia/prevaence.htm
[91] Fenton, K A., and Lowndes, C M; *Recent trends in the epidemiology of sexually transmitted infections in the European Union*. *Sex. Transm. Inf.* 2004;80;255-263; doi:10.1136/sti.2004.009415.
[92] World Health Organisation: *Global Prevalence And Incidence Of Selected Curable Sexually Transmitted Infections*. Op. cit.
[93] EuroHIV. HIV/AIDS Surveillance in Europe. Mid-year report 2005. Saint-Maurice: Institut de veille sanitaire, 2006. No. 72. p 6

One effective way to enable women to protect themselves from HIV is to tackle the gender inequalities that put them at risk in the first place. Many prevention programmes need to address HIV/AIDS both as a public health issue, and as a symptom of underlying gender inequality. The implementation of policies and programmes that increase women's access to education and information is essential ([94]). Most effective however, are policies that increase women's status relative to men, and those that increase women's decision-making power in sexual relationships, and these issues need to be taken into account in order for strategies in this area to be successful ([95]). According to UNAIDS, men and women living with AIDS show no difference in survival rates when they are treated equally ([96]).

Table 11. Share of women in newly reported HIV infections ([97])



Notes: no data available for Bulgaria

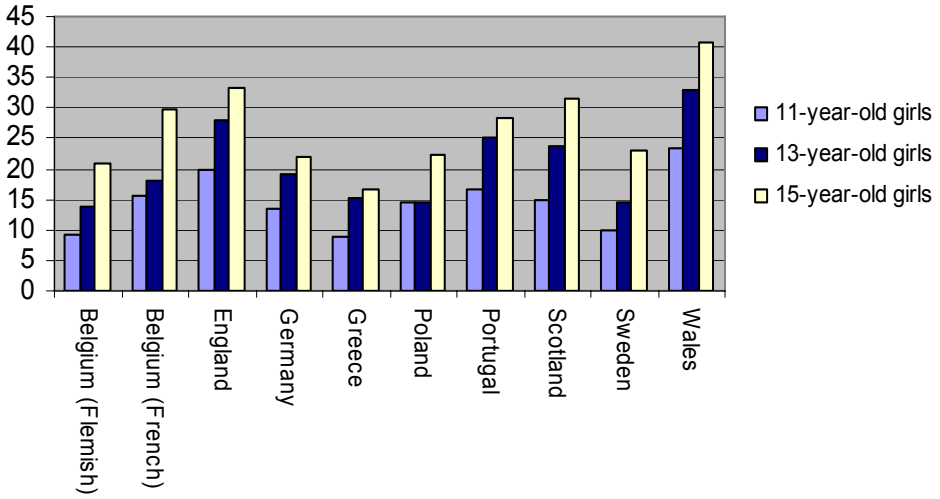
4.3 The Situation of Young Girls: The main data source for this section is the WHO's *Health Behaviour in School-aged Children (HBSC) Study: 2001/2002*, a collaborative cross-national project giving a comprehensive account of the health of adolescents in Europe, and the factors that influence this. It notes that socio-economic factors have a significant influence on health and across all domains children and adolescents from families of low socio-economic position have more health problems than those in high socio-economic position, e.g. in mortality, injury, self-rated health and subjective health complaints, and risk behaviour ([98]).

Self esteem: Adolescence is a time when increasing health inequality becomes apparent. Girls begin to report multiple subjective health complaints more often than boys, with the levels rising with age. With the onset of puberty, girls begin to feel social pressure in areas relating to body image, relations with peers, and school. This process of socialisation can cause girls to be more aware of their physical and emotional state, and to develop a lower threshold for detecting and reporting health complaints. Boys may be less inclined to report health complaints, by wishing to appear 'tough'. This underreporting of health problems may, therefore, be influencing the increased gender differences observed during these years ([99]).

[94]Brown, H.; *Women's Lack of Control Over STI Risks Drives Microbicide Search*. PRB, 2003
[95]Women's Health Council, op. cit.
[96]UNAIDS, UNFPA, and UNIFEM, Women and HIV/AIDS: *Confronting the Crisis*. Geneva and New York, 2004. www.unfpa.org/hiv/women/report/
[97]Gagel S, Niederlaender E.: *Statistics in focus: population and social conditions. HIV and AIDS in the European Union*. Office for Official Publications of the European Communities, Luxembourg. 2005
[98]World Health Organisation/HBSC; *Young people's health in context: Health Behaviour in School-aged Children* (HBSC) study: 2001/2002. Edited by Candace Currie et al. Copenhagen, 2004
[99]World Health Organisation/HBSC, op. cit

Academic achievement is seen to have an immediate effect on self-esteem and general well-being. Those who succeed academically tend to enjoy school, while those who fail tend to feel alienated from it. Low academic and social competence during childhood can affect both current and future health. Girls with negative school experiences report lower general life satisfaction and poorer health significantly more often than girls with positive experiences. The development of young people's self-esteem, self-perception, and health behaviour is heavily influenced by how they perceive their social support and achievement. Self-esteem plays a significant role in health outcomes and high esteem scores tend to predict favourable health outcomes and a lack of somatic and psychological symptoms. Girls with low scores report significantly higher levels of multiple recurrent subjective health complaints ([100]).

Table 12. Girls rating their health as fair or poor (%) ([101])

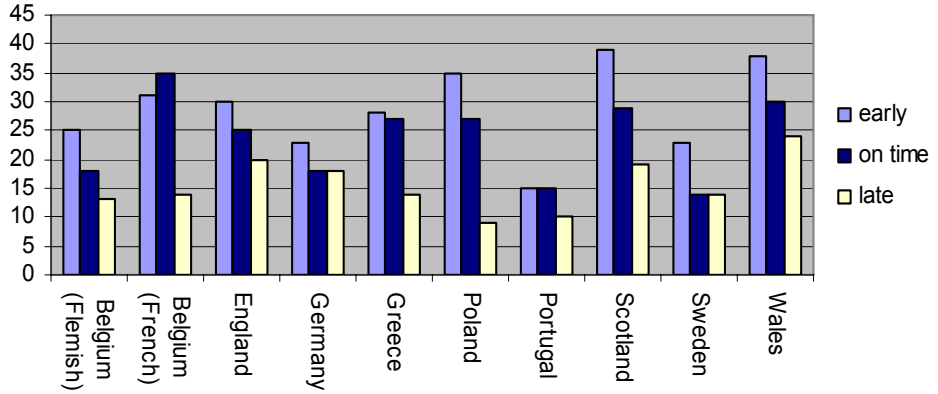


Note: no data for Bulgaria available

Gender differences in health-related behaviour: Health related behaviour is directly related to the wealth, structure, and social support of the family, peers, and the school environment. Young people who perceive their socio-economic position to be high report better health, fewer subjective health complaints, and engage in higher levels of physical activity. Stress-relieving health behaviours such as smoking, dieting, physical activity and alcohol use can be linked to both socio-economic status and health outcomes in adults. This may be related to the effect of lower absolute material standards in more deprived environments, such as bad housing, poor diet and inadequate heating. The low self esteem associated with being poorer than neighbours or other relevant reference groups has also been suggested as resulting in health disadvantage. Lower social position can lead to chronic mental and emotional illness resulting in direct physiological consequences. For girls, early onset of menarche (9-11 years) can also influence behaviour and health. For example, girls who reached menarche by 11 are more likely to say they are too fat than girls who matured on time, or late, and are more likely to engage in dieting/weight control behaviour ([102]).

[100] World Health Organisation / HBSC, op.cit.
[101] Ibid
[102] Ibid

Table 13. Girls engaged in dieting and weight control behaviour, according to onset of menarche, 15-year-olds (%) ([103])

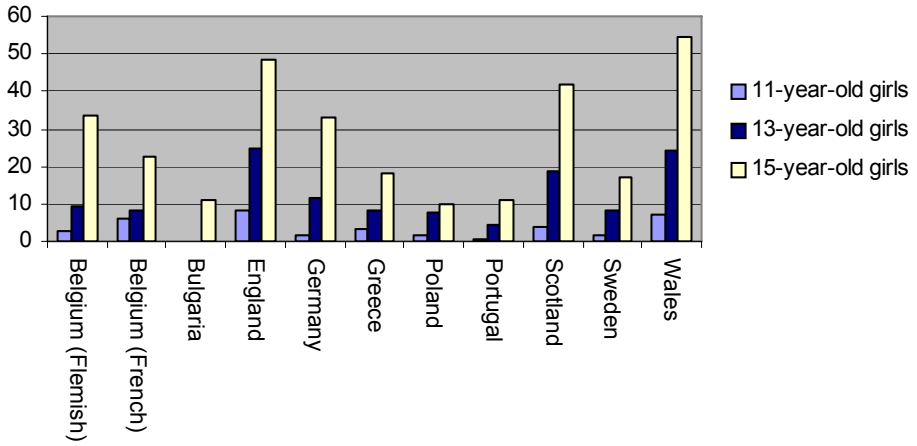


Note: no data for Bulgaria available

It is suggested that girls who mature early are perceived as older and more mature than other girls of the same age and may therefore socialise with older peers. Consequently, they have more opportunity to engage in poor health behaviours and may even come under more pressure to do so. Being younger, they may be more sensitive and malleable in conforming to the ideas of peers. The size of the peer group, as well as its gender mix, has some effect on behaviour. Spending several evenings with friends during the course of a week is associated with higher levels of physical activity, but also higher levels of smoking and alcohol consumption, including drunkenness ([104]).

In a standardised survey among 15-16 year-olds in 1999 it was found that 26% of boys and 22% of girls in Sweden had been drunk at the age of 13 or earlier, while in Greece the rate was 11% and 6% respectively ([105]). We can see from the table below that the number of girls drinking alcohol weekly rises sharply between 11 and 15 years. Whilst these rates are generally not as high as for boys, girls' alcohol consumption is catching up quickly.

Table 14. Girls who drink any alcoholic drink weekly (%) ([106])



[103]World Health Organisation/HBSC; *Young people's health in context: Health Behaviour in School-aged Children* (HBSC) study: 2001/2002. Edited by Candace Currie et al. Copenhagen, 2004
[104]World Health Organisation/HBSC, op. cit
[105]Jernigan, D. H., *Global Status Report: Alcohol and Young People* . World Health Organization, Geneva, 2001
[106] World Health Organisation/HBSC, op. cit

Smoking: Statistics show that about nine out of 10 tobacco users start before they are 18 years old. It is driven predominantly by psychosocial motives such as wanting to look older, needing to relax, feeling rebellious and even as a result of boredom. Girls especially are attracted by the idea that it might control weight gain. Children who smoke frequently have low self esteem, impaired psychological wellbeing, or are poor achievers at school, and tend not to be succeeding according to their own or society's terms ([107]). While boys are more likely to start smoking earlier than girls, smoking rates for girls are overtaking those for boys in many northern and western European countries.

Table 15. Age at onset of smoking for 15-year-olds (years) ([108])

	Ever smokers		Weekly smokers		Daily smokers	
	Girls	Boys	Girls	Boys	Girls	Boys
Belgium (Flemish)	12.9	12.3	12.6	11.9	12.5	11.7
Belgium (French)	12.6	12.1	12.1	11.7	12.0	11.6
England	12.7	12.6	12.2	12.2	12.0	11.9
Germany	12.5	12.3	12.3	11.8	12.2	11.7
Greece	14.0	13.4	13.7	13.0	13.7	12.5
Poland	12.9	11.7	12.7	11.4	12.6	11.4
Portugal	13.2	12.6	13.2	12.3	13.0	12.4
Scotland	12.2	12.4	11.7	12.4	11.6	12.2
Sweden	12.8	12.2	12.1	11.6	12.0	11.7
Wales	12.5	12.6	12.0	11.9	11.8	11.8

Note: Youth smoking prevalence in Bulgaria in 2001 was 28.7% for 15-year-old boys and 26.4% for girls.
Source: WHO, 2003 ([109])

The HBSC/WHO report recommends that countries should consider implementing gender-specific intervention programmes to control smoking. Adolescent girls in particular should be targeted as their smoking behaviour may influence future health. For example, the interaction between smoking and oral contraceptives is thought to increase the risk of cardiovascular disease and affect reproductive health. Smoking in young women may therefore have a significant impact on the developmental and growth environment of the next generation.

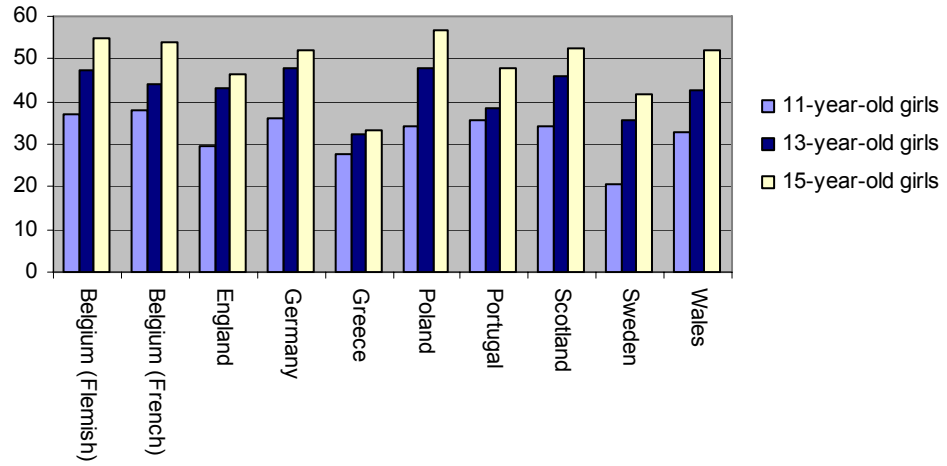
Eating Disorders: It is thought that physical pubertal changes may be an important causal factor in eating disorders. Dealing with difficult transitions, loss, or teasing about weight from friends or family may also trigger eating disorders. Dieting and other weight control methods can be associated with negative physical and psychological outcomes. Those who diet are more prone to irritability, concentration problems, sleep disturbances, menstrual irregularities, growth retardation, delayed sexual maturation and nutritional deficiencies.

Gender differences are seen in the ways in which male and female adolescents evaluate their bodies. Girls tend to view their bodies primarily as a means of attracting others, while boys perceive their bodies as a means of operating effectively in the external environment. Adolescents often find it difficult to classify themselves appropriately in terms of weight. Girls often set their goal not at having normal weight,

[107] Jarvis, M. J.; *Why People Smoke*: British Medical Journal; 328:277 279: 31 January 2004
[108] World Health Organisation country profiles for Tobacco control, 2003: http://www.euro.who.int/document/E80607.pdf
[109] Ibid

but to be overweight, while boys are more likely to perceive themselves as underweight and to engage in weight-gaining and muscle-enhancing activities.

Table 16. Young people dissatisfied with their body weight (%) ([110])



Note: no data for Bulgaria available

Obesity is also a major public health concern in the EU. Among 13 year olds, obesity is highest in girls (between 2-6%) in England, Ireland and Scotland, and in boys (4-9%) in England, Portugal and Wales. Evidence suggests that being overweight during adolescence compromises long-term health, as it is associated with increased mortality, especially from coronary heart disease, arteriosclerosis and colorectal cancer. Again socio-economic background has been shown to have a strong influence here. The promotion of physical activity and reduction of sedentary behaviour may be a better and safer way to manage weight than dieting for young people.

Sexual Behaviour: Sexual behaviour is an important determinant of physical and mental well-being. Unsafe sex can have implications for unwanted teenage pregnancies, fertility, infectious diseases and other reproductive health problems. The improvement of family planning programmes has reduced the number of unwanted pregnancies, but there still is a significant demand for abortion, predominantly among teenagers. The demand for induced abortion is associated with cultural factors, the failure of contraceptive methods, pregnancy resulting from rape, malformation of the foetus, health risks to the mother, and socio-economic circumstances.

Everywhere teenage pregnancy is on the rise. For example, Bulgaria has for some years, had one of the lowest birthrates in the world. It has the highest rate in Europe for adolescent maternity, and a high proportion of low birth weight births - increasing from 5.7 per 100 live births in 1986, to 8.9 per 100 live births in 2002 ([111]). In Belgium in 2003 there was a 4% increase in teenage pregnancy rates compared to those of 2002 and it appears that between a quarter and a third of pregnant teenage girls had planned their pregnancy. '*Jeunesse et Sexualité*' (Youth and Sexuality), a non-profit organisation, note that many of the girls becoming pregnant are having troubles in

[110]World Health Organisation/HBSC, op. cit

[111]Bulgarian Ministry of Health: *Report on the Health of the Nation at the beginning of the 21st century. Analysis of the health care reform.* Sofia, 2004 (Accessed at: http://www.mh.government.bg/programmes) (*in Bulgarian*).

school or at home and view their pregnancy as a part of growing up or as a way to start a new life for themselves ([112]).

There are great differences between ages of first sexual intercourse in the Member States. Early first intercourse is thought to be linked to unplanned, unprotected sex and therefore to a greater risk of unintended pregnancy and STIs. In Mediterranean States, men start their sex lives well before marriage. In Northern countries men and women have their first sexual intercourse at about the same age. Belgium and Germany are characterised by a comparatively late sexual initiation for both sexes. These patterns and trends are important when planning health promotion initiatives and school sex education programmes ([113]).

Sexually Transmitted Infections: Adolescents tend to underestimate, downplay or deny their risks of HIV infection. Feelings of invincibility, combined with the lack of awareness of the consequences of risky behaviour, may make them less likely to take precautions to protect their health and their lives ([114]). Sexually transmitted infections are an important health problem for young girls because of the risk of infertility, ectopic pregnancy, pelvic inflammatory disease, and chronic pelvic pain.

The face of AIDS is increasingly young and women are becoming infected at significantly younger ages than men. Young girls are particularly vulnerable to the sexual transmission of HIV for both biological and social reasons. While both young girls and boys engage in consensual sex, girls are more likely than boys to be uninformed about HIV, to be coerced or raped, or enticed into sex by someone older, stronger, or richer. Increased incidence of HIV/AIDS in young women has also led to an increase in transmission of the virus from mother to child. Today, UNAIDS calculates that more than 50 percent of all new HIV infections around the world occur in children and young people between 10 years and 24 years old. The dramatic spread of HIV/AIDS, particularly in Eastern Europe, means that in Europe as a whole, 30–40% of all reported HIV/AIDS cases are among those under 25 years of age ([115]). Therefore, reaching young people before they become sexually active is key to fighting the epidemic.

Overall, we can see that the discrimination of young girls in healthcare systems can have serious consequences later in life. However, young women who are well prepared to make healthy lifestyle choices related to nutrition, exercise, tobacco, alcohol and drug use, and sexuality, will have enhanced physical and mental health and will almost certainly reduce or avoid major diseases later in life.

[112]Belgium News, Expatica.com, accessed at: http://www.pregnancy-info.net/in_the_news1.html
[113]European Commission: *The Health Status of the European Union*. op. cit
[114]World Health Organisation: *The health of children and adolescents in Europe*. Factsheet EURO/06/05. Copenhagen, Bucharest, 12 September 2005
[115]Ibid

Chapter 5: CONCLUSIONS AND RECOMMENDATIONS

5.1 Future Directions

The promotion of gender equality and equity has been a longstanding theme in the operations of the EU. For example, the European Commission has recently developed a *Roadmap for Equality* between men and women. This outlines six priority areas for EU action on gender equality for the period 2006-2010, including equal economic independence for women and men; equal representation in decision-making; eradication of all forms of gender-based violence and the elimination of gender stereotypes.

Gender equality issues have, until recently, received relatively little attention in public health policies at EU level. However, since the Maastricht and Amsterdam Treaty changes, the EU has acquired a new competence in Public Health. Amongst the priorities identified in the 2004-2008 Programme (e.g. building and improving health information and knowledge, responding rapidly to major health threats, addressing the determinants of ill-health) actions are included to give greater consideration to gender and health. In June 2006 the Council adopted a Conclusion on Women's Health. It was noted that reliable, compatible, comparable data on the status of women's health is essential to improve information to the public and develop appropriate strategies, policies and actions to ensure a high level of health protection, and that gender-specific data and reporting are essential for policy making.

Therefore, the European Parliament's call for a preliminary study on gender related discrimination in the health sector is very timely. However, only by doing an in-depth analysis what is and is not available in terms of gender based data in the health sector will it be possible to move forward. The results of this study should be an important catalyst in identifying needs for comparative disaggregated data collection, gender related health indicators and better targeted funding and research. It should also help to identify ways of how the healthcare systems in Europe could respond with greater sensitivity to varying healthcare needs of women and young girls.

Promoting Gender

Internationally, the empowerment of women has long been a policy goal for development organisations. Gender-equitable organisations review their structures and procedures to increase their accountability and responsiveness to women. For example, UNICEF has used the *Women's Empowerment Framework* ([116]) as a tool for mainstreaming gender throughout its programmes. Other organisations, e.g. BRIDGE ([117]) claim that the successful implementation of a gender policy at programme level is enhanced by ongoing training and feedback; applying equal opportunity policies throughout organisations, and fostering processes of information-sharing and exchange through a close involvement of programme staff in policy development. These organisations also identify a number of weaknesses that occur in the implementation of gender policies which could be avoided in EU policy design.

5.2 Examples of Good Practice in the Countries Studied

[116]UNDP: Strategy for Implementing Gender in Development Policy. New York 1996
[117]BRIDGE: *Putting gender policy into practice: lessons from ACORD*
http://www.bridge.ids.ac.uk/Dgb5.html#ACORD

During the course of this study a number of experts were consulted about gender discrimination in healthcare and their details are included in Appendix 2. Part of their contribution involved describing examples of best practice in relation to women's health in their respective countries. Some of these examples are provided below, though fuller country reports will be available on http://www.eurohealth.ie/eureports

Belgium
Inventory of health policies: Since 2004, the National Council of Women in Belgium has been making an inventory of health policies that affect women. The report includes policy documents concerning contraception, cancer, breast feeding, cholesterol, gynaecology, menopause, osteoporosis, patient rights and pregnancy.

Volunteers support breast awareness: VIVA-SVV boezemvriendinnen is a project in which female volunteers motivate other women, to support and encourage each other to take part in breast cancer screening.

Bulgaria
Eating Disorders: The Ministry of Health is planning to establish special sectors in psychiatric hospitals and develop specialised standards and programmes for treating eating disorders. There is also pressure for the establishment of specialised hospital and day-care centres for continuous treatment after hospital discharge. The National Action Plan on Food and Nutrition and the National Programme and Action Plan on Mental Health have some targets directed to anorexia and bulimia.

Sexual Health in Young People: The Bulgarian Sexual and Reproductive Health Peer Network is part of the 'Strengthening the National Reproductive Health Programme', funded by UNFPA. It involves a comprehensive combined health, sexuality and life-skills educational package for students aged 12-18. Lectures on safe sexual practices, birth control, and HIV/AIDS prevention are delivered across Bulgaria as part of the school curriculum, at youth clubs and in education centres. Other projects on sexual education and health promotion for young girls and women are supported by international organisations like 'Health Promotion Schools', PHARE 'Family Planning Project' and 'Prevention of STDs and AIDS'.

Germany
Domestic Violence: The *SIGNAL Intervention Project to End Violence Against Women* started in 1999 in the emergency room of the Benjamin Franklin University Hospital in collaboration with the Institute of Public Health Sciences at the Technical University. The project raises awareness and uses contact with the patient to initiate prevention and intervention in violence against women. It provides abused women with reliable and appropriate support and treatment. SIGNAL objectives are to:

- Identify violence and enquire about abuse
- Document injuries and health problems for use in legal proceedings
- Assess the danger and develop a safety plan
- Inform and refer victims to counselling programmes and women's shelters.

Nurses and physicians working in emergency departments have undergone training based on these principles. The SIGNAL project has made a considerable contribution

awareness raising on the necessity of health care for women who are victims of domestic violence. A Female Emergency Room Patient's Survey has shown that female patients want the issue of domestic violence to be given more attention within the health care system. They regard questions about violence as a positive move, if asked sensitively and in the context of the medical history protocol. Emergency departments are important first-contact points for women who have experienced violence to receive care, support, and referral to community resources.

Greece

Young Girls: In Greece NGOs fill important healthcare needs. The NGO *Friends of Adolescents-Centre for the Prevention and Healthcare of Adolescents (KEPYE*) functions within the University of Athens and is staffed by academics with training and expertise in adolescent medicine and healthcare. It includes paediatric, endocrinology, psychological support, obesity, gynaecological, child surgery and infectious diseases services and it cooperates with other specialists. This Centre offers advice, diagnosis, preventive and curative treatment to adolescent girls for such problems as anorexia, obesity, menstruation, cervix inflammations, pregnancy and abortion as well as information about contraception and sexually transmitted diseases. The Centre shows considerable sensitivity and tries to adjust the hours, the interviews and the services in a such a way that they can be better accepted by adolescent girls.

Poland

Multi-faceted approaches to women's health: Many health programmes and campaigns have been carried out under the National Health Programme for 1996-2005. Examples include:

- Neural Tube Defect Prevention Programme: supplying folic acid to women of reproductive age in order to prevent congenital defects of the neural tube;
- Educational leaflets distributed as part of the HIV/AIDS prevention programme in schools. Anonymous free testing for HIV/AIDS infection has been carried out in combination with pre- and post-testing counselling;
- The State Agency to Resolve Alcohol-Related Problems has dealt with foetal damage caused by alcohol use by pregnant women and taken steps to preventing this by publishing a brochure on Foetal Alcohol Syndrome;
- The 'Pink Ribbon' breast-cancer-prevention programme has also been conducted in secondary schools.

Portugal

Health Promoting Schools: As part of the European Network of Health Promoting Schools, a project of the European Commission, the Portuguese Network integrates health promotion into every aspect of the school setting (e.g. the curriculum, healthy practices in daily routines, sexual education, improved working conditions, and relationships with community health providers). Significant differences between members and non-members of the network have been observed. Member schools have been integrating sexual education into the whole education process, working in partnership with health professionals (health centres, municipality, NGOs), and developing strategies with parents' and students' associations. Although all schools report a lack of competence in sexual education, this lack is much higher among non-member schools. In 2003, one third of all the student population in the public system were enrolled in one of the schools of the network. Preliminary evaluations indicate that this programme increased pupils' self-esteem and improved relationships between

pupils and staff, and is a fine example of the potential of developing health services in educational institutions.

Sweden

Gender mainstreaming in all policies: Since 1994, there has been a commitment to ensure that a gender equality perspective must permeate all aspects of government policy. At the national level, three main measures have been taken to integrate a gender perspective into every policy area. Firstly, all official statistics have been sex-disaggregated. Secondly, training programmes in gender equality have been held for ministers, press secretaries, political advisers and senior civil servants. Thirdly, all Government commissions of inquiry have been instructed to include a gender impact dimension in their investigations.

Research: The establishment of the Centre for Gender-Specific Medicine at the Karolinska Institutet exemplifies the fact that only through systematic research can an evidence-base for gender-sensitive health care be created (See www.ki.se/cfg).

United Kingdom

Teenage Pregnancy: The Teenage Pregnancy Strategy has set targets to:

- Reduce by 50% the 1998 England under-18 conception rate by 2010
- Achieve a downward trend in the under-16 conception rate by 2010
- Increase to 60% the participation of teenage parents in education, training or employment to reduce their risk of long-term social exclusion by 2010

(See www.dfes.gov.uk/teenagepregnancy)

A Social Model of Healthcare: The Sandyford Initiative is part of NHS Glasgow, and supported by Glasgow City Council. All services are free of charge, and available without the need to be referred by a doctor or another practitioner. The Sandyford Initiative was launched in Glasgow in 2000 when it brought together Centre for Women's Health, Family Planning, The Steve Retson Project (for men who have sex with men) and Genitourinary Medicine. The aim is to provide services using a social model of health. The initiative provides sexual and reproductive health services for women, men and young people in Glasgow, as well as counselling, information and a range of specialist services. It has a website with sections for staff and for service users. This staff part of the site has been specifically designed to provide background information for health professionals, policy makers and other interested parties. There is also a section of the site designed for the public (See www.sandyford.org).

5.3 Emerging recommendations

Generally, equitable social, educational and employment policies are necessary to reduce gender differences concerning health and illness. A number of recommendations have emerged from this project. The European Institute of Women's Health, with its European Advisory Council and affiliated members, urges European and national policy makers, politicians, practitioners, researchers and stakeholders in equitable gender health policies to support these recommendations.

Promoting Gender at European Union Level

- Mainstream health into all relevant EU policies and to include a gender perspective in those policies
- Ensure the Council's Conclusions on Women's Health under the Austrian

Presidency be carried forward during consecutive Presidencies.

- Facilitate Member States, particularly those who have recently joined the EU, to develop effective strategies to address gender-based inequalities, for example with more funding and an exchange of experts
- Increase the number of women in planning and decision-making positions at local, regional, national and EU levels.

Addressing Gender Inequalities Through Health Policy

- Take a more strategic approach to public health policy-making that focuses on the inter-relationship of health and other social determinants that interact with gender, education, living and working conditions, equal opportunity, lifestyle issues and gender roles, for specific population groups
- Examine the existing health inequalities within and between Member States under current and future Public Health programmes and devise strategies to minimise disparities, and ensure equity and equality of treatment and access to care.
- Introduce gender sensitive strands to Public Health programmes in relation to information, health education and promotion, disease prevention and screening
- Take differences in patterns between women's and men's health into account when designing national public health policies to ensure that the health needs of the entire population are included.
- Pay particular attention to marginalised groups of women and men such as the disabled, elderly, migrants, and ethnic minorities.
- Ensure that a gender sensitive approach be included in the training of healthcare professionals who should be educated to give women the same level of care and attention as men.
- Institute equitable policies to avoid that differing healthcare financing options impact on gender inequalities in access to care.
- Ensure that service planning takes account of the cultural and ideological differences that limit women's access to, and utilisation of, services.
- Encourage new Member States to make greater use of structural funds for investing in health, such as supporting implementation of the Council Recommendation on Cancer Screening
- Target information and education campaigns about health and lifestyle choices at young girls of school age in all EU member states.

Research and Data Collection

- Ensure that data (both quantitative and qualitative) showing the impact of health-related issues on women separately from men are collected along the same line at national and EU level to be comparable.
- Promote and strengthen the comparability and compatibility of gender-specific information on health across Member States and at EU level
- Once data are available, set realistic targets for the reduction of major diseases that impact on women and put programmes in place for their achievement
- Address gender imbalances by using both morbidity and mortality rates to inform research, policy and practice.
- Broaden health targets for diseases with high mortality (such as cancer and heart disease) to include diseases with high morbidity (such as arthritis and

osteoporosis).

- Continue the commitment to address sex and gender as an issue for research, under the Seventh Framework Programme.
- Ensure that all EU-funded research projects include a better balance between women and men. Draw up and revise clinical studies guidelines appropriate to women and older people
- Promote multidisciplinary research into the socio-economic determinants of health across the lifespan of women
- Allocate more EU funds under the Seventh Framework Research Programme to disorders which are of little interest to the pharmaceutical and health technology industry, and to disorders which have low prevalence but high levels of disability in women, e.g. fibromyalgia
- Make funds available for research about gender mainstreaming strategies to improve gender equity

Liaising with other Stakeholders

- Ensure the EU Health Portal, in consultation with relevant organisations provides reliable and informative health information for women
- Ensure the EU Health Policy Forum has representation from women's health organisations, who are working at EU level to promote women's health
- Support the exchange of information, experience and good practice between organisations in order to build a rigorous evidence-base on gender-related health issues; a first step is to establish a database of good practice examples
- Support the inclusion of women's health groups in the EU Obesity initiative to reflect the key role that women play as family nutritionists
- Encourage greater collaboration on gender and health issues with international health organisations, such as WHO
- Reinforce the effectiveness of the EU gender equality policies and programmes through the work of new European Gender Institute and ensure that its tasks, functions and budget are set to promote gender equality policies across the EU, including the field of healthcare.

Appendix 1: ACRONYMS

BMI	Body Mass Index
CARE	Health Care Services
CISID	Centralised Information System for Infectious Diseases (WHO)
CVD	Coronary Vascular Disease
DALY	The Disability-Adjusted Life Year
DG RTD	Directorate General for Research
DG SANCO	Directorate General for Health and Consumer Affairs
DIS	Disability Interview Survey
ECHIS	European Core Health Survey
EHSS	European Health Survey System
EIWH	European Institute of Women's Health
EP	European Parliament
ESHIS	European Special Health Surveys
ESS	European Statistical System
EU	European Union
EUIHK	European Union System of Information on Health and Knowledge
GDP	Gross Domestic Product
GIA	Gender Inequality Impact
HES	Health Examination Surveys
HFA DB	European Health for All Database (WHO)
HIS	Health Interview Survey
HMP	Health Monitoring Programme
MDB	European Mortality Database (WHO)
MORB	Morbidity Data
NGO	Non Government Organisation
OECD	Organisation for Economic Co-operation and Development
PHARE	Pologne, Hongrie Assistance à la Reconstruction Economique
PRB	Population Reference Bureau
REVES	International Network on Health Expectancy and the Disability Process (Euro-REVES – European subsidiary)
SILC	The Statistics of Income and Living Conditions
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNIFEM	United Nations Development Fund for Women
UNFPA	United Nations Population Fund
WHO	World Health Organisation

Appendix 2: EXPERT CONTRIBUTORS

Country	*Expert Details*
Belgium	Els Messelis, Higher Institute for Family Sciences, Brussels.
Bulgaria	Albena Kerekovska, Faculty of Public Health Medical University of Varna
Germany	Birgit Babitsch Center for Gender in Medicine, Charité - Universitätsmedizin Berlin Ulrike Maschewsky-Schneider, Berlin School of Public Health, Charité - Universitätsmedizin Berlin
Greece	Constantina Safiliou-Rothschild Executive Council, 50+Hellas Founding Member 50+Hellas
Poland	Maria Wasilewska Ministry of Labour and Social Policy, Chief specialist
Portugal	Vasco Prazeres General-Directorate of Health, Ministry of Health. Julian Perelman, Ceu Mateus, Ana Fernandes National School of Public Health Universidade Nova de Lisboa.
Sweden	Pia Maria Jonsson. Medical Management Centre, MMC Karolinska Institutet, Stockholm.
United Kingdom	Hilary Thomas Centre for Research in Primary and Community Care, University of Hertfordshire. Annie Dillon, NWCI

Appendix 3 EUROPEAN INSTITUTE OF WOMENS HEALTH PROJECT ADVISORY COMMITTEE

Peggy Maguire
Director General, EIWH

Hildrun Sundseth
European Cancer Patient Coalition, Europe

Dr Piroska Östlin
Karolinska Institute, Sweden

Dr Karen Ritchie
Inserm, France

Dr Ineke Klinge
Genderstudies in Health and Healthcare, University Maastricht.NL

Sinead Hewson
Client Focussed Coaching

The opinions expressed in this report do not necessarily reflect the views of individual country experts or project advisory committee.

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