The ENGENDER Project

POLICY BRIEF #3

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Gendered Exposures and Vulnerabilities

Reducing Health Risks for Women and Men by Tackling Gendered Exposures and Vulnerabilities

What role do biological differences and gendered factors play in our understanding of women's and men's differential exposure and vulnerability?
The differences between women and men in health vary in magnitude across various health conditions. Some conditions are determined primarily by biological differences. Others are the result of gendered differences—the manner in which societies socialise women and men, the norms about masculinity and femininity supported by societies, and the power relations that accord privileges to men within society. However, many health differences reflect a combination of both the biological differences and gendered factors. Understanding this interaction is important for reducing health risks in women and men, tackling gendered exposures and vulnerabilities and ultimately addressing gender inequality in prevention, health services and care. (EU-adapted from WGEKN 2007). In the past health research has failed to adequately explore the combination of social and biological sources of differences in men and women's health.

Background
The incidence and prevalence of certain diseases—including breast cancer, osteoporosis and eating disorders—are higher among women than among men. Other diseases, such as lung cancer, affect men and women differently. Some specific diseases related to reproductive organs, like endometriosis and cervical cancer, affect women exclusively (EIWH, 2000; Sandall et al., 2010) while testicular and prostate cancer affect men only. Despite significant advances in the treatment of prostate cancer, it remains a growing problem for men's health, increasing with advancing age. (The State of Men's Health in Europe 2011)

Many of the medical conditions and risk factors of disease that influence the health of men and women are caused by behavioural and social factors (Roy and Chaudhuri, 2010; Edwards, 2010). For example injuries and alcoholism are more prevalent among men.

Significant differences exist between women and men in their health needs and in their access to the relevant resources. These need to be identified. The most obvious differences relate to reproductive characteristics. Women's capacity to conceive and give birth has major effects on their wellbeing; if they cannot control their own fertility or lack the resources to move safely through pregnancy and childbirth, women will be unable to realise their health potential (EIWH, 2011). In the past the health of women was mostly linked to their reproductive function. While reproductive health care must continue to be given the highest priority, women now live many more years past menopause when chronic diseases begin to set in. During the last 50 years, life expectancy has steadily increased for both women and men. Women outlive men on average by six years in Europe. The average life expectancy is 82 years for women, 76 years for men. However, the difference in healthy life years of women is far less - 18 months (Eurobarometer 2007). This means that women spent more of their later years burdened by chronic diseases limiting their activities. Men have an opportunity to catch up with women in living longer but at the same time must ensure that their healthy life expectancy keeps pace.

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The Biological Dimension

The biological sex differences between females and males are relevant for the diagnosis and treatment of various diseases and medical conditions (WHO, 2007; Gardiner et al., 2008; Hart et al., 2011, NCD Alliance, 2011; EIWH, 2011).

Cardiovascular disease (CVD): CVD is the number one cause of death in Europe for both men and women. The incidence of CVD in women increases dramatically in middle age. In the past, CVD was mainly considered a male disease, so research studied men. Recent findings suggest that women experience heart disease differently, which can delay diagnosis (HealthEurope.org, 2010). Therefore, improved prevention, diagnosis and treatment strategies tailored to women are needed (EIWH, 2006).

Diabetes: Women share over half of the diabetes burden with men. The prevalence of diabetes is currently increasing across Europe for both sexes. The disease in women has important consequences for health during pregnancy. Diabetes is associated with a higher rate of coronary heart disease mortality in women compared with men. Women with Type II diabetes are less likely than men to receive measures for prevention and control of cardiovascular disease (NCD Alliance, 2011).

Lung Cancer: Lung cancer is the most common cancer in the world. For women, it is the third most common cancer in Europe after breast and bowel cancer, accounting for 12% of new cases (Cancer Research UK, 2010). While it is the number one cancer for men, it is declining since the 1990s. However, it appears to be on the increase in women. In some EU countries, more young girls are taking up smoking than boys as tobacco companies increasingly target their promotional activities at young girls (WHO 2010).

Osteoporosis: Osteoporosis, the disease of fragile bones, is a major disease burden of women. Hip fractures and their resulting disabilities are especially costly in economic as well as human terms, requiring hospitalisation, rehabilitation and home or long-term care. The WHO calculates that the overall burden of osteoporosis, in terms both of deaths risk linked to the disease and the disability suffered, is greater than for all types of cancer, with the exception of lung cancer (IOF, 2011; EIWH, 1997). Men also get osteoporosis; it is not well recognised.

Smoking: Tobacco use is the single largest cause of avoidable death in the EU, accounting for around 650 000 premature deaths per year (European Commission special Eurobarometer 332/Wave 72.3 – TNS Opinion &Social, May 2010). Smoking related death and illness places an enormous burden on society. 13 million Europeans suffer from diseases, which are related to tobacco smoking. Tobacco products also kill people who do not smoke. Traditionally men have been the heaviest smokers, but women are now catching up. Effective tobacco control policies must target both men and women and stop young people from taking up smoking altogether.

Obesity: Obesity is responsible for a large proportion of the total burden of disease in the WHO European Region (WHO 2007). The prevalence of obesity has risen threefold since the 1980. It has become a pan-European epidemic for both men and women. Obesity is more prevalent in men than in women. It appears that the higher the educational attainment in men the greater the proportion who are overweight. This is the converse in women (The State of Men's Health in Europe 2011).

The Social Dimension

Social differences between males and females interact with socio-economic determinants to influence health. Important social issues with consequences for health include education, employment and family life.

Socio-economic, educational, cultural and ethnicity differences can impact on patterns of behaviour and access to resources. Gender inequities including violence against women, lack of decision-making power, and unfair work divisions all have an impact on health. Fortunately, gender inequities are socially generated and therefore can be changed (WHO, 2008).

The healthcare system may produce gender inequalities, if it does not adequately respond to the needs of men and women by following a model of 'gender neutral' medicine that privileges the needs of men (Klinge, 2007, 2010; Kuhlmann and Annandale, 2010; Lagro-Janssen, 2010; Payne, 2009; Sen et al., 2007).

Gender Roles and Women's Health: Within the household, women often have little support, which may affect their health negatively. Much of the responsibility for childcare, care of older parents and disabled family members continues to fall on women. The time consumed in care giving can lead some women to neglect their own health.

Women entering the labour market normally continue to bear the main burden for childcare and household work, which may affect their mental health. Also, women are typically employed in lower paid, less secure and informal occupations than men (WGEKN, 2007, UNICEF, 2006).

Women are key actors in the health sector both as users and providers of services. However, women remain concentrated in the lower-level health occupations and are a minority among more highly-trained professionals.

Gender Roles and Men's Health: An increasing amount of research is examining hazards of masculinity for health. In many countries, there is a growing gap between male and female life expectancy (Boback et al., 1998; Leon et al., 1997).

The nature of masculinity may be damaging to men's health (Sabo and Gordon, 1993). The workplace often puts men at greater risk than women of dying prematurely from occupational accidents (Waldron, 1995). Less direct pressures lead men to expose themselves to risky behaviour, like smoking, drinking, unsafe sex, and taking up dangerous sports. (Connell, 1995; Kimmel and Messner, 1993; Waldron, 1995; Schofield, 2010; Zeidenstein and Moore, 1996).

EU Institutions & Council Conclusions

European Institute for Gender Equality
The Institute was created in 2006 by the European Parliament and by the Council. The Institute helps European institutions and Member States "in the promotion of gender equality in all Community policies and resulting national policies and in the fight against discrimination based on sex." The Institute also aims to increase awareness about such issues among citizens of the EU (Europa, 2007).

Advisory Committee on Equal Opportunities for Women and Men
In 1981, the committee was created to help the Commission create and implement EU efforts to encourage equal opportunities for men and women (Europa, 2007). It has issued multiple opinions relating to gender and women's health including a 2010 opinion on gender equality policy.

Council Conclusion on Men and Gender Equality
In 2006, the Employment, Social Policy, & Health Council accepted the conclusion of the Finnish presidency to help achieve a more equal society. The conclusions state "There are gender-based differences in health risks in Member States, which are costly in both economic and human terms. Lifestyles, which have a significant impact on health, are influenced by gender-related norms and conceptions that may differ in respect of women and men" (Ministry of Social Affairs & Health, 2006).

Council Conclusions on Women's Health
In 2006 the Austrian EU Presidency adopted the Council Conclusions on Women's Health. The Conclusions invite Member States to collect gender-specific data on health; take initiatives to enhance general and health professionals' knowledge on the relationship between gender and health; promote health and prevent disease taking into account where appropriate gender difference; promote research into the different effects of medicines on women and men, and gender specific health research; and encourage gender mainstreaming in healthcare.

Existing EU-Level Policy, Programmes, & Projects

Framework Programme 7, Directorate General Research & Innovation
The €50 billion programme funds research grants on technological development and demonstration projects from 2007 to 2013. The projects must have "European added value." One of ten areas for research is health (EC, 2007). In the Cooperation Work Programme: Health, "the differences of gender/sex in research (risk factors, biological mechanisms, causes, clinical features, consequences and treatment of diseases and disorders) must be considered where appropriate" (EC, 2011).

Discrimination & Employment
Since 2000, various EU anti-discrimination laws have been passed including legislation to ensure equal treatment of both men and women. This legislation ensures that individuals residing and working in the EU are not discriminated against based on age; disability; gender; race or ethnicity; religion or beliefs; or sexual orientation (DG for Employment, Social Affairs, & Inclusion, 2010).

Beijing Platform for Action & The EU
The EU helped generate the Declaration. In 1995 and 1998 respectively, the Council committed to annually monitoring its indicators and assessing its implementation. The action platform is comprised of twelve concern areas for women's empowerment including health, women's advancement, economy, education, environment, poverty, decision-making, and violence against women (EIGE, 2010).

Roadmap for Equality Between Women and Men 2006-2010
The roadmap is a strategy to achieve gender equality within six priority areas (Europa, 2007). The roadmap states "[w]omen and men are confronted with specific health risks, diseases, issues and practices impacting their health[…] Medical research and many safety and health standards relate more to man and male-dominated work areas. Knowledge in this field should be improved and statistics and indicators further developed. Social, health and care services should be modernised with a view to improving their accessibility, quality and responsiveness to the new and specific needs of women and men" (EC, 2006).

Strategy for Equality Between Men and Women 2010-2015
The Strategy in 2010 and builds from the 2006-2010 Roadmap. It addresses issues concerning women's economic interdependence, equal pay, decision-making equality, and gender-based violence using principles from the European Commission's Women's Charter (Europa, 2007).

Health Programme 2008-2013
The programme started in 2008 and funds over 300 projects that aim to improve EU health security; to promote health and reduce inequalities; and to create and spread health information. This includes improved "measures on the prevention of major diseases and focus on Community added-value action in areas such as gender issues" (DG Health & Consumer Protection, 2007).

"Inequalities experienced in earlier life in access to education, employment and health care as well as those based on gender and cultural background can have a critical bearing on the health status of people throughout their lives. The combination of poverty with other vulnerabilities such as childhood or old age, disability or minority background further increases health risks and vice-versa, ill health can lead to poverty and/or social exclusion."

Report on Reducing Health Inequalities in the EU, Committee on the Environment, Public Health, and Food Safety, 2011

Conclusions from Analysis of Existing Practice

The research and analysis shows that interaction between gender and social determinants of health in Europe frequently lie outside the health policy sector such as social and family affairs, education, communication, human rights, labour market and employment, finance, environment, law and internal affairs. Therefore a firm commitment is needed for a multi-sectoral approach from all policy areas to achieve optimal health and address the needs of all population groups.

The analysis finds that women and men have differential needs. Certain health conditions are sex-specific such as certain types of cancer. These unique needs must be addressed in health promotion and disease prevention messages specifically target women and men. Moreover, health conditions that affect women and men differently must be considered in order to access diagnosis and treatment without bias or discrimination. As a result, tailor-made interventions that address specific needs in health and health care should be developed.

Existing practice addressing work conditions is disaggregated by sex. In order to make systems more responsive to the needs of both men and women, gender biases within certain subsets of healthcare professionals needs to be addressed.

In addition, continuous efforts are required to better understand the interaction between health, gender and other social determinants like education, living and working conditions, equal opportunity, lifestyle issues in order to contribute to more equal health opportunities for all.

More research needs to be conducted in the sex differences in health. Research also needs to explore how men and women experience health and health care from a multi-dimensional perspective. Specifically, more attention should be given to the differences within the groups of men and women. Such groups include but are not limited to single parents in low-status occupational groups, ethnic minorities, unemployed people living in rural areas, and young women and men with coronary heart disease that do not fit the male-tailored health care services.

For the in-depth analysis of good practice as well as more examples of good practice from the ENGENDER Project, please see the policy brief annexes, which are available online at:

Interaction Between Sex & Gender

Gender divisions have direct impact on the health behaviours, exposures, needs and access to care of women and men (Doyal, 2000; Kuhlmann and Annandale, 2010; Payne and Doyal, 2010). For example, women are more likely to seek help from and disclose mental health problems to primary care physicians than men, while men are more likely to seek specialist mental health care and are the principal users of inpatient care. Gender bias also occurs in the treatment of psychological disorders (Austbury, 2002).

Gender divisions thus lead to inequitable patterns of health risk, of access to health services, of use of health services and of health outcomes. Acknowledgment of the interaction between sex and gender can improve healthcare (Klinge and Bosch, 2005). Health research has failed to adequately explore the combination of social and biological sources of differences in men and women's health. Despite considerable progress in recent years at both national and international levels, gender inequalities in health remain in many areas across Europe. Overall, both the differences due to biology as well as the differences due to gender discrimination throughout the wider society must be confronted in order to promote gender equity in health (Doyal, 2000; Annandale and Hunt, 2000; EIWH, 2005; Annandale, 2009).

***Good Practice Example 1*: A Healthier Sweden, Sweden**

A Healthier Sweden is a national campaign in the health sector that takes into account gender differences in health and aims to promote and stimulate physical activities among the entire population and with special focus to vulnerable groups in the society. This campaign also aims at enhancing and promoting good lifestyle behaviours such as healthy eating behaviours assuming equal need for the activities among women and men.

***Good Practice Example 2*: Advocacy of Sexual and Reproductive Rights, Slovenia**

This project is a social and family affairs booklet compiled by NGOs in Slovenia. It is dedicated to different aspects of sexual and reproductive health issues and focuses on the clarification of the most problematic points with suggestions on how to improve the situation. The booklet is meant to inform decision makers and the general public.

***Good Practice Example 3*: Women and Men in Data, Czech Republic**

This publication provides statistical data on the status of women and men in the Czech Republic. This publication is a tool that contributes to the governmental resolution of the promotion of equal opportunities between men and women.

***Good Practice Examples 4:* The Traveller Men's Development Programme, Ireland**

This intervention is specifically designed to target men's health. It is from the health sector and addresses the introduction of the interagency model as a means of working together to enhance and more effectively target services to those communities who need them most.

***Good Practice Examples 5:* Women's Health Centre, Austria**

This Centre aims at influencing policy and promotes action on the social factors that affect women's health and well-being throughout their entire life. It supports a woman-centred approach that respects women's perspectives and experiences, listening to the voices of women not typically heard.

Steps for Policy Action

1) **Prioritise the standardisation of data collection methods in a sex/gender-disaggregated manner across the EU**
   It is crucial to collect data in a format that can easily be processed and interchanged between local, national and EU levels. Good primary data is essential and EU Member States should be encouraged to work to standard templates for data collection. Templates with common indicators, capturing patterns of behaviour and access to resources, which can be utilised by health care delivery organisations and can be channelled through regional and national statistics to the EU level.

2) **Reduce health inequalities by integrating sex and gender-specific data into health policy design and healthcare planning, paying special attention to vulnerable and marginalised groups**
   Discrimination in the healthcare sector must be uncovered and reported.

3) **Make the inclusion of women in clinical trials explicit and the numbers included statistical ly relevant to allow for systematic analysis of sex differences**
   In addition to including women in clinical trials in numbers that match the prevalence of the disease in the general population, stratified analyses should be carried out separately for men and women to take into account the fact that a treatment may not only have a different effect in men and women, but that secondary factors influencing efficacy, treatment adherence and side effects may also be different.

4) **Encourage the European Institute for Gender Equality (EIGE) to include gendered health policy in their work programme**
   The EIGE should not only collect gender-specific socio-economic data but also include gender equality within the health sector.

5) **Combat health inequalities under the current and future Health programmes by introducing gender sensitive strands**
   Suggest strategies to minimise the disparities across the EU and ensure a gender-sensitive approach in relation to information, health literacy, health promotion, prevention and screening programmes.

6) **Encourage Member States to make their health policies and programmes gender-sensitive, paying particular attention to marginalised groups of women and men such as the disabled, elderly, migrants and ethnic minorities**
   Take the difference in health patterns between men and women into account when designing health policies to ensure the health needs of the entire population are met.

7) **Institute policies that encourage healthy active ageing for both women and men, through investing in a lifespan, gender-sensitive approach**
   Ageing is a life-long process where a multi-sectorial "health in all policies" approach converges. It is important to create timely opportunities for prevention, early diagnosis and interventions to avoid much chronic disability and enable older people live independently for as long as possible.

8) **Strengthen stakeholder involvement for the development of gender-sensitive health policy and care**
   Encourage collaborative projects, particularly NGO involvement in policy and care development.

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