CONCLUSION

Time constraints dictated that there should be a quick turn around of information for these country reports. However, not only were some advisors unavailable when the questionnaire was sent, but because of the varying availability of statistics, the task proved far more difficult for some to complete than for others. Many responses arrived too late to be included in early versions of the report to the European Parliament; in addition, despite every expert being sent the same pro-forma, responses and level of detail varied greatly.

Furthermore, questions were interpreted differently, and descriptions were given of governance and systems that proved difficult to compare. Reporting tended to centre on conditions suffered only by women, rather than the disadvantage women experience in diagnosis or treatment of all conditions, or on gender-specific research and the issues this raises.

In all, nearly 100 pages of material was received, not including supporting reports and documents. When added to material already being included for the report, we had around six times the projected size of the final report.

The logistics of preparing the European Parliament report in a short time frame meant that much of the material could not be included. Some results conflicted with data already gathered, but time did not allow for deeper analysis. Lengthy explanations of local governance, culture and socio-economics, which might have shed light on certain types of discrimination, had to be deleted.

Quite often, data was not comparable because it had been drawn from a variety of dated reports. For example, in the 2003 WHO publication describing incidence of, and deaths from, cervical cancer, the data dated from 1993 (Portugal), 1996 (Belgium and Poland), 1997 (UK), 1998 (Germany), 1999 (Sweden), and 2001 (Bulgaria) – a span of eight years. In this time political, economic and social conditions had changed immensely in many of the countries reviewed.

It seems apparent from some of the responses received, that contemporary data is actually available on a localised basis. Differences in language, transcription, governance and software may be making this material difficult to access internationally.

In response to the question asking for an in-depth country overview of three issues from a list of eight common conditions, the break down was as follows[1]:

[1] NB: some responses combined the subjects. They are entered here under separate headings

Condition	No. of reports
• Cancer	7
• Sexually transmitted infections	4
• Smoking	3
• Osteoporosis	3
• Reproductive health	3
• Alcohol	2
• Eating disorders	2
• Drug abuse	-

It has been seen then that the difficulties of gathering timely, comparable information - even in a simple format - are immense. A platform is sorely needed that would allow the linking and exchange of information in a widely – and immediately - accessible format.

We would like to thank all contributors for their excellent work.

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