POLICY·BRIEF

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Gendered Politics of Health Systems

Transforming the Gendered Politics of Health Systems

What are the root causes and consequences of the gendered politics of health care systems for women and men's health?

Evidence shows various ways in which the health care system can fail gender equity from the perspective of women and men as both consumers (users) and producers (carers). Important barriers are lack of awareness—a lack of knowledge of patients, their families and health care providers about the existence of health problems—and lack of acknowledgement that something should and can be done about the health problem.What are the root causes and consequences of the gendered politics of health care systems for women and men's health?

Health systems tend, for example, to ignore women's over representation as health producers, both in the formal health system and in the informal provision of home care. Further, women are generally more aware of their health needs than men, which make them over represented in the health consumption as well**.** Health sector reforms that take gender into consideration can therefore have fundamental consequences for gender equality in aspects beyond health and wellbeing (WGEKN, 2007).

Considering multiple levels

The various levels of the health care system must be examined to fully understand gender equity. Firstly, the content and structure of the official (authoritative) knowledge in medical and health care courses and curriculums are important, because the knowledge is used to train professionals and is thus applied to clinical practices. Secondly, understanding how the knowledge of both men and women regarding their bodies, health, and illness is produced and how dominant cultural messages about this knowledge is internalised and applied to life is important.

The processes connected with awareness, knowledge and circumstances for realisation of human, patient, female, and reproductive rights in health care system and other systems must be examined at the structural, interpersonal and intrapersonal levels. Aspects of health care institutions, including written and hidden agendas as well as knowledge-power relations, support, neglect, and sometimes abuse rights.

Gender inequality dimensions are interwoven with the power relationships among different health care providers in health care settings. Curing and caring are characteristics of nursing and midwifery that have been used to professionalise women's domestic duties and may influence professional theories and practices. Gender issues are connected to the hierarchy of specialisations among doctors, professional development, and more. Working conditions of women and men in health systems and the balancing working life with private and family life for those within the system should be in focus to develop an understanding of health issues.

Conclusions from Analysis of Existing Practice

The analysis of existing practices finds numerous good practices where health care professionals form the different health care settings and representatives of non-governmental organisations, academics and governmental bodies directly and/or indirectly address the problems of gender in health system.

These good practices aim to develop solutions for the problems of consequences of the gendered politics of healthcare systems for women and men's health from different perspectives and at various levels.

Based on the analysis of existing practices, there are key areas of change needed and key steps to be made in regards to the gendered politics of health systems. There is a lack of existing practices addressing working conditions, status and the health of healthcare professionals, because the health care sector is traditionally based on specific gendered perception and differentiation of curing/caring rules. Regular education and other curricula in medicine and health in general need to be developed to include gender perspective/knowledge.

Good Practice Example 1:

> **Farmers Have Hearts Project, Ireland**
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> The Farmers Have Hearts Project, run at Ireland's National Ploughing Championships, represents a creative approach to targeting cardiovascular screening services outside the traditional primary care setting to a difficult to reach target population group (farmers). The project provides access to a multidisciplinary team of health professionals including health promotion, nurses, public health researchers, dieticians, and physical activity professionals. It aims to create an awareness of cardiovascular disease and the importance of healthy lifestyles in promoting heart health. It identifies participants with risk factors that contribute to cardiovascular ill-health and encourages them to engage in positive health behaviours.

Good Practice Example 2:

> **Girls Health in Styria, Austria**
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> The Austrian Women's Health Centre developed their activities targeting adolescent girls. As recent research data has shown, girls have fewer chances to be healthy and free of ailments than boys, and the self-perceived general health and quality of life of girls decrease drastically during puberty. The Women's Health Centre started ensuring and promoting cooperation, increasing awareness among multipliers and staff of youth facilities, stimulating structural changes and improvements as well as promoting specific services for girls.

Good Practice Example 3:

> **Multidisciplinary Dealing with the Cases of Violence in Nursing in Midwifery Care, Slovenia**
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> Violence against women is target from different perspective in this good practice. This good practice addresses the problem of violence against women in working place. Multidisciplinary treatment of cases of violence in nursing and midwifery care were established by the Working Group for Non-violence in order to comprehensively and effectively assists the nurses and midwives victims of workplace violence.

Existing EU-Level Policy

Council Recommendations on the Inclusion of Gender Differences in Health Policy

The Council Of Europe has recommended that governments of member states should ensure the inclusion of gender aspects of health in the training and continuing education of all health and related medical and social professionals at both undergraduate (medical and nurse training) and continuing education levels (in service training) of all workers including policy makers (Council of Europe, Recommendation CM/rec (2008)1of the Committee of Ministers of Member States on the inclusion of gender differences in health policy (30th January 2008).

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).

Gender Literacy

Gender literacy in a doctor patient relationship is crucial. "Health workers and other professionals for example need to be trained in good communications and listening skills and in how they tailor their communication to meet their patients'. Needs (Kickbush, Wait and Maag 2006). They also need to be aware of how gender influences health outcomes and health seeking behaviour. This requires the integration of gender into the curriculum of health personnel as part of training" (World Health Organisation, Closing the Gap in a Generation- Health Equity through action on the social determinants of health-Final report of the WHO Commission on Social Determinants for Health, 2008).

Steps for Policy Action

1) **Encourage disaggregated data by sex to provide a more complete picture of health**

Women represent a significant proportion of workers in the health services sector where they tend to hold positions that are low paid. The concentration of women in low paid and part-time jobs, their specific working conditions their major responsibility for family care and household work might determine the higher prevalence of stress related disorders in women. The availability of sex-disaggregated data could help to plan, monitor and evaluate successful gender-sensitive interventions in the work place.

Methods for health workforce analysis developed in relation to predominately male employment sectors, should be validated and extended for analyses of women's jobs. Recognise and develop solutions for gender issues at work places. The inclusion of gender and its relevance to the effectiveness of health interventions in the curriculum and continuous training of all health professionals is crucial to better health care for all.

2) **Encourage collaboration between sectors for better policy development**

At the national-level, recognise the need of legislation for strategic solutions and for collaboration among different sectors and policy makers. In collaborative efforts, include civil society and NGOs in the decision-making processes; these groups are often the first to reveal unrecognised problems and to develop new approaches and their expertise should be recognise need for information on healthcare utilisation.

3) **Support health care services and other services to develop gender-sensitive approaches**
Men and women utilise healthcare services in different ways. The use of healthcare services can be substantial at different stages of life: explanations for these differences include differences between men and women in healthcare seeking behaviour and biases in the provision of care to male and female patients. There is very little data available on healthcare utilisation for the EU Member States that is broken down by gender. The data that exists tend to focus on the provision of services, numbers of physicians, number of available hospital beds, etc.

4) **Health information must be consistent, simple and clear. Messages need to be developed and disseminated through multiple media channels and in forms appropriate to local culture, age and gender.** Recognise that media—including specialised journals, guidebooks, scientific books, and reports—plays an important part in the processes of education, raising awareness, and suggesting solutions.

Develop gender competent health information that is disseminated through media that is appropriate for men and women (e.g. the provision of national men's health help-line– e.g. *Mensline Australia*). Include sensitive and on-going education about body, health, rights, with information and methods that hasten empowerment of both boys and girls in school curriculums.

5) **Educate health care providers, experts in public health, and researchers to include gender-sensitive approaches**
Policy effectiveness relies on policy makers understanding the impact of gender differences on health outcomes and patterns of service use. Data availability must be accompanied by appropriate training regarding the use of this knowledge in the various stages of a research project. Policy makers are often confronted with the requirement to take gender considerations into account in the planning, implementation and evaluation of an initiative without having the necessary tools to be able to do so effectively. Researchers must be trained in communicating the gender dimension in research to policy makers more effectively.

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References

1) Abdool S, Garcia-Moreno C, Amin (2010). Gender equality and international health policy planning in: Kuhlmann E and Annandale E (eds.) The Palgrave Handbook of Gender and Healthcare, Basingstoke: Palgrave, 36-55.

2) Council of Europe, Recommendation CM/rec (2008)1of the Committee of Ministers of Member States on the inclusion of gender differences in health policy (30th January 2008)

3) Directorate-General for Health and Consumer Protection (2007). Health Programme 2008-2013 http://ec.europa.eu/health/ph_programme/documents/prog_booklet_en.pdf

4) Kuhlmann E, Annandale E (2010). Bringing gender to the heart of health policy, practice and research, in: Kuhlmann E and Annandale E (eds.) The Palgrave Handbook of Gender and Healthcare, Basingstoke: Palgrave, 1-18.

5) Lin V, L'Orange H (2010). Gender-sensitive indicators for health, in: Kuhlmann E and Annandale E (eds.) The Palgrave Handbook of Gender and Healthcare, Basingstoke: Palgrave, 72-90.

6) Riska E (2010). Women in the medical profession: International trends, in: Kuhlmann E and Annandale E (eds.) The Palgrave Handbook of Gender and Healthcare, Basingstoke: Palgrave, 389-404.

7) WGEKN (Women and Gender Equity Knowledge Network) (2007). Unequal, Unfair, Ineffective and Inefficient Gender Inequity in Health: Why it exists and how we can change it. Final Report to the WHO Commission on Social Determinants of Health work, http://www.who.int/social_determinants/resources/csdh_media/wgekn_final_report_07.pdf .

8) World Health Organization, Closing the Gap in a Generation- Health Equity through action on the social determinants of health-Final report of the WHO Commission on Social Determinants for Health, 2008

9)Wrede S (2010). Nursing: Globalization of a female-gendered profession in: Kuhlmann E. and Annandale, E. (eds) The Palgrave Handbook of Gender and Healthcare, Basingstoke: Palgrave, 437-453.