

Equity in Access to Health Promotion, Treatment and Care for all European Women

Edited by

Vera Lasch, Ute Sonntag, Ulrike Maschewsky-Schneider

We would like to thank the following organisations for funding:
the Hessian Ministry of Higher Education, Research and the Arts
the German Federal Ministry for Family Affairs, Senior Citizens, Women and Youth

Bibliographic information published by Deutsche Nationalbibliothek
The Deutsche Nationalbibliothek lists this publication in the Deutsche Nationalbibliografie;
detailed bibliographic data is available in the Internet at <http://dnb.d-nb.de>.

ISBN (print): 978-3-89958-740-1
ISBN (online): 978-3-89958-741-8
URN: <http://nbn-resolving.de/urn:nbn:de:0002-7414>

2010, kassel university press GmbH, Kassel
www.upress.uni-kassel.de

Cover pictures: www.digitalstock.de The ColorWorld, W. Bulgar, Piktogramme, J. Hausmann
Cover layout: Jörg Batschi Grafikdesign, Kassel
Layout: Marcin Czerwinski
Printed by: Unidruckerei der Universität Kassel

Table of Content

Health Inequalities and Gender – An Introduction <i>Vera Lasch, Ulrike Maschewsky-Schneider & Ute Sonntag</i>	5
Gender Equity in Access to Health Care and Treatment – A Global View <i>Piroska Östlin</i>	15
Beyond Gender Bias: a Methodological Approach for Analyzing Inequalities <i>Margrit Eichler & Mary Anne Burke</i>	31
Gender Based Strategies for Public Health Activism: Tools from Social Epidemiology to Address Inequalities in Women’s Health <i>Julie Cwikel</i>	45
Migrants, Discrimination and Equity in Access to Health Promotion and Health Care <i>Annemiek Richters</i>	63
Social Inequality, Health and Health Care: Gender-specific Patterns in Germany <i>Birgit Babitsch</i>	79
Domestic Violence and Health Care <i>Sabine Bohne</i>	93

Domestic Violence against Women: Health Care Needs and the S.I.G.N.A.L.-Intervention Programme <i>Hildegard Hellbernd & Petra Brzank</i>	119
Equity in Reproductive Health in Central and Eastern Europe: The Hungarian Experience <i>Zsuzsa Györffy, Krisztina László, Szilvia Ádám & Mária Kopp</i>	141
Chosen Women's Health Needs in Central-Eastern Europe: The Situation after the Process of Transformation - The example of Poland <i>Beata Tobiasz-Adamczyk</i>	159
Notes on Contributors	179

Health Inequalities and Gender – An Introduction

Vera Lasch, Ulrike Maschewsky-Schneider & Ute Sonntag

1. Context of the Book

The European Women's Health Network (EWHNET) is proud to present its second book about women and health. After the previous edition "Gender, Health and Cultures – Networking for a better Future for Women within an enlarged Europe", which was published in 2006, this volume concentrates on women's access to health promotion and prevention as well as on women's access to and utilisation of health services.

Referring to the United Nation's year of equal opportunities, the European Women's Health Network organised a European conference in October 2007 which focused on special groups of women, who are disadvantaged in terms of access to health information, proper treatment and health care services. The book focuses on important aspects of the conference.

Several key questions were addressed at the conference. The conference showed what is known about gender inequities in health care services in the European countries and also worldwide. The matter of concern was how inequities in access to treatment and care can be reduced and how gender based health care services could be installed. Also connected with this aspect is the question, how a gender perspective can be mainstreamed in the health care sector.

The conference showed social disadvantages of special target groups and the effects on health, health services and treatment. Migrants, socially deprived women and women who went through domestic violence have special health needs but experience dramatic under- or mistreatment in the health care system. The conference also focused on prevention, health promotion, access to health information by women, and on reproductive health, which is a central aspect of women's health all over the world.

The book takes up these aspects, varying the points of view from global to European to country-specific descriptions.

2. Gender and Health

Despite considerable progress in recent years gender inequalities and inequities in health remain in many regions across Europe. There is still considerable evidence of disparities in access to health care services between both genders. This is in particular true for women who belong to socially disadvantaged groups, such as poor women, migrants and ethnic minority women.

Mapping the differences in the quality of care for women and men is a difficult enterprise, largely because of the lack of studies in this area. Scientific knowledge indicates that gender is a limiting factor for the quality of care women receive and that standards of care are furthermore not equal for men and women. Women are only half as likely as men to undergo cardiac testing for symptoms suggesting heart problems. Therapy and diagnosis of CVD are prominent examples which indicate that both genders receive different types of care, depending on health care services and research priorities. This example underlines the challenge to provide needs- and gender-based health care services.

There are several aspects causing inequality, within health systems and within society, which correlate with gender.

Reproductive Health is a field of differences and inequalities, too. There are consistent indications that gender divisions can be a causal factor limiting the quality of care women receive in delivery of reproductive health services. Providers are often too concerned with controlling women's fertility, especially when it concerns marginalized groups of women such as disabled, poor and/or migrant women, who can suffer adverse effects stemming from the lack of information, cultural insensitivity and degrading treatment. Egg cell trade is a topic for the underprivileged women of poor European countries and for the privileged ones in the western countries in Europe. This shows that research has to give focus to the issues centred upon the accessibility of pre and post natal care.

The ageing process itself is highly gendered and older women are biologically more susceptible to certain disabling diseases including rheumatoid arthritis, osteoporosis and Alzheimer's disease. Deteriorating health is a frequent, though not inevitable, part of the ageing process for both sexes and women make up the majority of the elderly population of the EU. Because of inequalities in income and wealth in earlier life, older women are also likely to have fewer resources at their disposal and are less likely than men to receive assistance from relatives and friends. Due to women's lower participation in the labour market, they receive fewer pension benefits and their economic situation when they retire or become widowed is more precarious than for men. However, gender inequities in health care services differ widely in the European Countries.

Additionally, domestic Violence has varied implications on health care services. Violence against women occurs at all social, economic and cultural levels of society. The consequences of domestic violence are varied and women who are victims of violence are at increased risk of physical injuries, psychosomatic disorders, chronic pain syndromes, depression, suicide attempts, and reproductive health consequences. Women who suffer from domestic violence are also confronted with a health care system which is not equipped to deal with this problem appropriately. Often the consequences for health caused

by violence are not known and treatment is insufficient. In some cases, health care providers in hospitals and many general practitioners are not trained to identify domestic violence, and are not familiar with specialised agencies dealing with domestic violence problems. There is a need for models of good practice for better health care of female victims of domestic violence and on developing proper strategies for training health care providers.

In the field of access to health promotion and disease prevention, public health knowledge is needed on social determinants of health, living conditions of different populations, and why these groups make certain lifestyle choices. We have to know how to target health promotion and disease prevention programs in communities, in particular to women and socially disadvantaged groups. If people and communities are to take responsibility for health, they have to have access to the knowledge, skills and tools to enable them to make confident, healthy choices.

Health information/education is one important part of health promotion and prevention. It must take a lifespan approach from children, teenagers, elderly – it is part of the process of lifelong learning. Women have a keen interest in health information. Easily accessible and easily understandable, high-quality, accurate, reliable, independent from economic interests and up-to-date health and disease information is an essential step towards health literacy to achieve a high level of health protection. In health care appropriate information can improve communication between patients and doctors, leading to improved health status and a sense of being in control. The World Health Organisation (WHO) acknowledges that women are one of the strongest means for improving health in families and communities. Problems in accessing appropriate information about health risks, diseases and care, as well as health promotion services are evident for many women, including poor, underprivileged and migrant women, young girls, and older women.

Health literacy can be a hidden problem because it is often not recognized by policy makers and health care providers. The complexity of health systems, which comes from the nature of health care and public health itself, can cause confusion, even for highly skilled individuals. Different cultural and educational backgrounds between patients and providers, as well as between those who create health information and those who use it, may contribute to problems in health literacy. Cultural differences may also affect the perception of health, illness, prevention and health care, and the lack of mutual understanding of health, illness and treatment, its risks and benefits, has implications for behaviour for both providers and patients.

Gender, education, access to information and health policy are thus highly interlinked. Public health interventions are therefore needed to address the lack of knowledge and health competencies in different population groups; they likewise need to emphasize gendered life situations and the different needs of

old or young. Health information and communication has to be gender sensible and guarantee equity in access for men and women, and all social groups in a society.

3. Equity in Access to Health, Health Services and Health Promotion – A theoretical perspective

Gender differences in health, health care and health promotion have to be considered in each health service and regarding each vulnerable group. Prerequisites, conditions and influencing factors of access to and utilization of health services in both genders, and effects on outcomes of services for men and women must be carefully observed. We want to know: Are health and access to health equally distributed to men and women? Are the health services able to meet the needs of both genders? Does one gender benefit more from health services than the other?

To answer these questions the perspective of public health ethics, the concept of social determinants of health and the theoretical definition of sex and gender have to be considered.

Sex differences are based on natural, biologically implied inequalities between men and women, while gender differences are social inequalities, that can be – but not necessarily are – accompanied by social inequities, social discrimination and social exclusion. This can be explained by an example. Men and women are biologically different in terms of reproductive health and functioning – they are unequal; reproductive services for men and women differ also because both groups have specific needs, implied by biological as well as by social differences (e.g. social roles in a society as pregnant and child bearing humans, as fathers and mothers, male or female child). These differences are not necessarily accompanied by social inequities. Insofar as both genders get the service they need to maintain their health and wellbeing social justice and gender equity is granted.

WHO (1996) provides a clear definition of equity: *“Equity means fairness. Equity in health means that people’s needs guide the distribution of opportunities for well-being. ... This implies that all people have an equal opportunity to develop and maintain their health, through fair and just access to resources for health.”* Equity or inequity in health can thus exist between rich and poor countries, between and within populations, across social classes and ethnic groups, between old and young and different generations, between sick/ disabled and healthy people – and between both genders. To ensure equity in health means not to extinguish inequalities or differences between human beings, but to diminish differences that are unjust, evoked by social inequalities, which are not under people’s control, but can be avoided by public health means.

Not only at a global level, but even in Europe, inequalities exist regarding the organization and economic resources of health systems and health services. Still, we recognize huge differences, that might imply injustice in health care provision across and within European countries – and each gender might not benefit from health services in the same way.

Inequalities exist regarding specific health needs in a population: women in the reproductive age-group need more reproductive health care than men, older people need more care and nursing than younger people and chronically sick people should be a priority group to get vaccination because they are more vulnerable to infectious diseases. When resources in the health system are scarce, the society has to decide where to allocate them: should the system allow equal access to health services for everybody, or should expensive care be only provided for those who pay more? Who decides about the distribution of resources and the provision of services? Which (social or sick or vulnerable) group will receive the best benefit from a service or treatment, and how will this affect the health status of the entire population?

These questions are increasingly at the forefront of social debate since the economic crises has had an enormous impact on the health systems. Solidarity used to be the dominant principle of organization in many health systems – but now it seems to be threatened. Out of pocket payments, individual private health insurance, and reduced entitlement to receive benefits from the health system are not taboo topics any more, and in the meantime the social and health gap between the poor and rich is growing.

Societies can actually benefit from just and fair health systems. Studies show that the more equal a society, the better the health and higher the life expectancy of the entire population. Societies benefit in different ways:

- Inequities in health are unfair and unjust. They stand in contradiction to the constitution of democratic countries, their values, norms and principles of social organization.
- Inequities in health reduce the economic power within countries. The economy and labour market need human resources – healthy people – to fulfil the high demands at the workplace.
- Inequities in health reduce the social coherence within countries. (Chronically) ill people have fewer resources to participate in highly valued activities in a society, such as participation in the workforce, integration into social networks, community involvement, etc. Disadvantages in health are often associated with social and economic disadvantages, social exclusion and even discrimination. Inequities in health can lead to disaggregated societies, which might provoke social conflicts and disturbances.

- To ensure gender equity in health means to preserve and promote the human resources of a society: parents who live in good subjective and objective health conditions are the best resource for the wellbeing and social integration of children and families. Good health of mothers is a prerequisite for healthy and risk free childbearing, child care and family life.
- Inequities are avoidable: effective public health policies are available to improve the health of populations and ensure access to health services. This includes the implementation of health promotion and prevention, community and individual empowerment, access to high quality care, and transparency in allocation of resources within the health system.
- To summarize: reducing inequities means to improve or maintain the social values of a society via solidarity and mutual responsibility.

To answer the question of how to avoid and how to ensure equity in health for both genders, theories about influences on health are needed. The concept of health determinants (Wilkinson, Marmot 2003) is helpful to explain the relationship between social factors and health. Social determinants are defined as: *“The range of personal, social, economic and environmental factors that determine the health status of individuals or populations.”* (WHO 1998) They comprise determinants of the physical environment, the socio-economic environment, personal health practices, capacity and coping skills, and health services (ibid.). They refer to the social conditions under which people live and work, and to the economic and social conditions that influence the health of individuals, communities and jurisdictions as a whole. They determine the extent to which a person possesses the physical, social, and personal resources to identify and achieve personal aspirations, satisfy needs, and cope with the environment. (ibid). Social determinants are influences to health at different analytical levels:

- It is the construction of a society as a whole, that refers to determinants such as economy, class composition, culture, and ethnicity, the construction of the health system and health policies, but also the position of both genders in a society.
- The construction of the society thus has implications for working and life conditions of the population, such as the rate of employment and unemployment, the proportion of single parent families, education and qualification levels in a society, housing conditions, and access to social and health services.
- At the third level, social networks in which people are embedded play an important role. Social networks comprise families, neighbourhood, workplace, leisure time and community networks. Networks can be effective in different ways: they can be supportive or destructive, can

provide coherence and inclusion or divergence and exclusion, they rely on transparency and trust or are ruled by opacity, alienation and distrust, they allow participation of and control by the members of the network or they are based on hierarchical authority and abuse of power.

- The fourth level of influences comprises psychological and behavioural factors. Healthy and unhealthy lifestyles and the subjective and objective resources for healthy behaviour are well known influences. However, psychological resources also play an important role such as cognitive and coping resources, self-esteem and self-efficacy, and psychological health, which is also a resource in itself. Antonovsky's (1987) concept of salutogenesis and sense of coherence is probably the most comprehensive theory to explain health and wellbeing of individuals and populations.

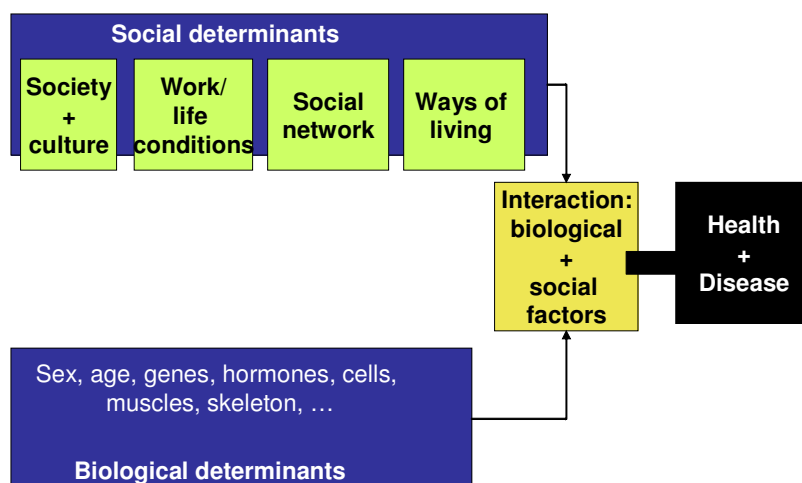


Figure 1: Influences to equity in health – levels of social determinants

Gender is a particular determinant with implications at all levels of determinants. Gender – as the German term ‘Geschlecht’ – has two dimensions, the concepts in English language are expressed by two different terms, defined as ‘sex’ and ‘gender’.

“,Gender‘ refers to a social construct regarding culture-bound conventions, roles, and behaviours for, as well as relations between and among, women and men and boys and girls. Gender roles ... and gender relations ... vary within and across societies, typically in relation to social divisions premised on power and authority (e.g., class, race/ethnicity, nationality, religion).” (Krieger 2003)
“,Sex‘ is a biological construct premised upon biological characteristics enabling sexual reproduction (organs, functions, genes)...“ (ibid). Sex-linked

biological characteristics have an impact on various non-reproductive functions of the organism (e.g. hormones influence the vulnerability to environmental exposure), and they can have an impact on gender and social differences in health (e.g. good looking people seem to be healthier than ugly people).

Gender, as a social determinant of health, interacts with other determinants at all levels. At the society level gender is determined by social status and roles that are defined by norms, tasks and obligations of men and women. Status of men and women is determined by political and community power they have, access to work, money and other material resources. Working and life conditions of men and women are different: they work in separate branches and professions, have culturally determined duties in the family, housing and infrastructure might influence their life and wellbeing in different ways. Networks can be supportive for women, but not for men – and the other way round. We also know that women and men are different regarding psychological health, character, coping capacities, etc.

The concept of health determinants therefore enables public health professionals to identify health disadvantages in the population, between both genders and within each gender group, to understand how gender is correlated with other determinants of health, to develop policies for equity in health via public health interventions and health promotion, and to provide strategies, programs and services for more equity in access to health.

The concept of public health ethics and the theory of social determinants enable public health professionals and scientists to investigate gender differences in health and to identify the specific needs of women in a much easier way by following and answering a whole range of questions:

- What are women's health needs?
- Are health needs different within various groups of women in the population?
- Are women's health needs met by the existing health services?
- Are the health services available for all groups of women in the society?
- Do the various groups of women get the service they need?
- Is the utilization of services appropriate to women's needs?
- Do the different groups of women get the quality of care they need?
- Does the service have the same impact/ effect on the health of women with different needs?

These questions guide our investigative search for more knowledge about gender equity in health as undertaken in this book.

4. Book Structure

The book is structured in two parts. The first gives an overview of the topic of inequalities from three points of view, an epidemiological one, a methodological one and a strategic one. *Piroska Östlin* takes up the global perspective and describes facts and figures in the whole field of gender equity in access to health care world wide. She shows demand-side and supply-side barriers and discusses why health care systems in many countries are unable to adequately deliver on gender equity in access to health care. *Margrit Eichler and Mary Anne Burke* present a methodological contribution for analysing inequalities. After Margrit Eichler had developed the instrument “gender based analysis”, this approach has been widened and other aspects of power were added. They design the BIAS FREE Framework, which addresses multiple forms of discrimination people experience based on the intersection of social hierarchies, such as sexism, racism, ableism, ageism, and how these affect people’s overall health and well-being. The article by *Julie Cwikel* describes gender based strategies for public health activism grounded on the social epidemiology. She proposes to combine social epidemiological research and intervention methods together with gender-based sensitivity and analysis to develop effective strategies to address health challenges in women’s health.

The second part of this book focuses on specific target groups which are treated inadequately and inequitably, and explores the situation in different countries. *Annemiek Richters* shows that migrant women are confronted with a lack of and discrimination in access to health promotion and health care services. But she does not stop here. She discusses the ambiguity of discrimination and demonstrates how to combat this discrimination in health care. Social inequality of women is the topic of *Birgit Babitsch’s* article. She shows that social inequality has many faces. The article explores the structures and characteristics of social inequality of women.

Violence against women occurs at all social, economic and cultural levels of society. The consequences of domestic violence are varied and women who are victims of violence are at increased risk of physical injuries, psychosomatic disorders, chronic pain syndrome, depression, suicide attempts, and reproductive health consequences. Women who suffer from domestic violence are confronted with a health care system which is not equipped to deal with this problem appropriately. *Sabine Bohne* introduces the international discussion about domestic violence as a form of human rights violations. She describes prevalence studies and the health outcome of violence. She ends with recommendations of the World Health Organisation how to strengthen the health care sector response to violence against women. Here, *Hildegard Hellbernd and Petra Brzank* present a joint and concrete approach to domestic violence, through the well publicised German project S.I.G.N.A.L. They describe the guidelines and the implementation process of the project.

Beata Tobiasz-Adamczyk describes the situation of women in Central-Eastern Europe, their health needs and their access to health information. The situation after the process of transformation in Poland serves as an example. Reproductive health is a very important health aspect for women. Reproductive health in Eastern Europe is discussed by *Zsuzsa Györffy, Krisztina László, Szilvia Ádám and Mária Kopp* in this book. They describe the Hungarian experience and compare reproductive health indicators such as fertility rates, abortion rates, pregnancy health and complications in Hungary with other European countries. They widen their view towards psychosocial aspects and work conditions of women.

The editors hope that this book will enlighten the debate on equity in access to health. The intention is to give health workers and policy planners a range of relevant arguments in order to improve the situation of women in their field of intervention.

Dezember 2009 Dr. Vera Lasch, Prof. Dr. Ulrike Maschewsky-Schneider, Dr. Ute Sonntag

References

Antonovsky, A. (1987): *Unravelling the Mystery of Health. How people manage stress and stay well.* Jossey Bass: San Francisco.

Krieger, N. (2003): Gender, sexes, and health: what are the connections – and why does it matter? In: *International Journal of Epidemiology* 32: 652-657.

WHO (1996): *Equity in health and health care.* Geneva.

WHO (1998): *Health Promotion Glossary.*

Wilkinson, R. and Marmot, M. (2003): *Social determinants of health. The solid facts.* Second edition. WHO Europe.

Gender Equity in Access to Health Care and Treatment – a Global View ¹

Piroska Östlin

”In order to ensure that women and men of all ages have equal access to opportunities for achieving their full health potential and health equity, the health sector needs to recognize that they differ in terms of both sex and gender. Because of social (gender) and biological (sex) differences, women and men face different health risks, experience different responses from health systems, and their health-seeking behaviour, and health outcomes differ.”

World Health Organization (2008: 8)

Introduction

In an ideal world, women and men should be treated equally by health care systems when they share common needs, and when their needs are different, these differences should be addressed in an equitable manner. Evidence from low-, middle- and high-income countries suggests that we have a long way to go before we can even start knocking on the door of such an ideal world. Gender inequities are endemic in health care systems globally. In part, this reflects the lack of sufficient attention to the differential needs of women and men due to both biological and social factors in the planning and provision of health care systems. It also reflects more general gender inequalities in society that impact on the equitable access to health care services.

The purpose of this chapter is to illustrate the ways in which gender² influences inequities in access to health care and treatment. The manifestations of these inequities in relation both to the demand-side and supply-side dimensions of access to health services are described in the first part of the chapter. As we will see, demand-side factors, such as awareness (knowledge about the existence of the health problem) and acknowledgement (recognition that something should and can be done about the health problem) are important prerequisites for seeking care and treatment in the first place. Moreover, evidence will be provided to show that the supply-side dimensions of access to health care and treatment, including availability, affordability and acceptability, are often influenced by the gendered politics of health systems. In the second

¹ This chapter expands on the work of the Women and Gender Equity Knowledge Network of the WHO Commission on Social Determinants of Health (Sen et al. 2007).

² “Gender refers to socially constructed distinction between women and men based on differences in access to resources and knowledge, social roles, divisions of labour and occupational segregation, power relations and hierarchies of authority and decision making, and socially sanctioned and enforced norms regarding identity, personhood, and behaviour” (Sen et al. 2002: 33).

part, I will provide some possible explanations for why health care systems in many countries are unable to adequately deliver on gender equity. The final part of the chapter draws together a number of recommendations about actions that can be taken to address gender based inequities in access to health services and lists a number of good practices from all over the world.

I. Gender Based Barriers to Equitable Access to Health Care and Treatment

Gender inequity in access to health services and treatment is pronounced in low- and middle-income countries, but it is prevalent in high-income countries too. These inequities often reflect two conceptually distinct dimensions: (1) unfair accommodation of the biologically specific health needs of women and men and (2) biased health care services arising from unfair gendered power relations and not from biological differences between women and men (Östlin et al. 2001).

The most obvious and striking expression of the failure to adequately address women's biologically specific needs is the persistence of extremely high rates of maternal mortality in many parts of the world despite the widespread knowledge as to how to prevent such disasters. More than half a million women die each year from maternal causes (WHO 2005). 99% of these deaths occur in low- and middle income countries. Health systems do not always address adequately men's biologically specific needs either: due to the tendency to interpret biological reproductive capacity as something that exclusively belong to women, health systems may fail to meet men's need for reproductive health information and services, often to the disadvantage of both women and men (Ringheim 2002).

As mentioned in the introduction, gender relations may impact on the demand-side factors of health care utilization as well as on the supply-side dimensions:

Demand-side Barriers to Access and Use of Health Services

Women themselves and their families in poor settings sometimes are not aware of the existence of a health problem, as these are seen as normal and natural outcomes related to female biology or women's everyday activities. Chronic pain, depression and reproductive tract infections are examples of health problems that are often ignored (Iyer 2005; George 2007).

Even though women are aware of their health problems, they may not acknowledge them, because they fear adverse reactions from the family, community and unsympathetic health care providers. This can affect all women but especially unmarried women with sexually transmitted infections who may be highly stigmatised by the negative reaction from health care providers, or

young women with e.g. tuberculosis who fear that the public acknowledgment of their illness would lead to poorer chances for marriage (Iyer 2005; Long et al. 2001). The unwillingness to acknowledge health problems may occur also among men in both low- and high income settings. Masculine norms of men and boys as being invulnerable may influence their health seeking behaviour, contributing to unwillingness to seek help or treatment when their physical or mental health is impaired (Barker et al. 2007). For example, UK based studies have found that men consistently ignored symptoms of illness (e.g. for testicular lump) and avoided seeking help from health services (Galdas et al. 2004).

In highly patriarchal societies, equitable utilization of health care may be strongly affected by the unwillingness of families to invest in the health of women and girls, especially in poor households. Due to preferential allocation of resources to male health needs, women and girls may be unable to access health care services. As a result, girls are likely to receive more home-based care than boys and also more likely to suffer from outright neglect of their need for health care and treatment (Ahmed et al. 2002). For example, in China, India, Nepal and Pakistan, under-five child mortality in girls exceeds that of boys. According to WHO, this disparity is particularly noticeable in China, where girls have a 33% higher risk of dying than their male counterparts. These inequities are thought to arise from the preferential treatment of boys in family-health care-seeking behaviour and nutrition (WHO 2003). As has been shown in India, poor families may ration their scarce resources preferentially to boys and men relative to girls and women leading to higher rates of non-treatment or discontinuation of treatment among women and girls (Iyer et al. 2007).

Equitable access to health care services is affected in several countries also by restrictions on women's physical mobility, unequal control over financial resources in households, and unequal decision making (Sen et al. 2007). For example, in many African countries, such as Burkina Faso, Senegal, Nigeria, Malawi, Cameroon, Morocco, Ethiopia, Zambia and Lesotho, more than half of the women cannot decide themselves about own health care (CSDH 2008).

Many of the demand side gender-based barriers among women in poor settings may be present also among immigrant women in Europe in addition to barriers such as cultural differences between them and health care providers, discriminatory attitudes towards them and language difficulties. Several European studies (e.g. from the Netherlands, Portugal and Sweden) have found an underutilization of health care services among immigrant women (Dias et al. 2008; Wamala et al. 2007; Stronks et al. 2001) These studies indicate, that the interplay between gender and immigrant status can be important in relation to the demand for and access to health care, even in high-income countries with universal health insurance.

Supply-side Barriers to Access and Use of Health Services

Important supply-side barriers to access health care services for both women and men is related to availability in terms of geographical location of the health care facilities, medicines and drugs, opening hours and waiting time to appointment. There is evidence from both high- and low income countries, that opening hours of health care facilities may be a greater barrier for men to access health care and treatment, due to difficulties to get there during working hours. For example in the UK, there was a request to extend surgery opening hours of general practitioners in order to increase men's access to services (Wilkins 2007). One study in Pakistan showed that men's adherence to tuberculosis treatment was deteriorated by their fear to forego income or even risk losing their jobs due to the daily treatment (Khan et al. 2005). Women working in homes, by contrast, were more able to substitute for one another and avoid high time costs of attendance.

There is mounting evidence mainly from high-income countries pointing at gender inequities in access to certain technologies or treatment for the same disease. A recent study from Sweden revealed medically unjustified differences in the availability of examination and treatment for women and men (Smirthwaite 2007). In general, women had less access to: dialyses and kidney transplantation, referrals for bronchoscopy, operations for knee and hip arthritis, cataract operations, certain areas of cardiovascular care, light therapy related to psoriasis and eczema, special stroke units, and to new and more expensive medication. Moreover, the same study found that women had to wait a longer time for an appointment with general practitioner in case of both acute and non-acute medical conditions.

While in some low-income countries even the most basic equipments for obstetric care are unavailable, in other countries there seems to be an over-utilization of e.g. Ceasarean sections. For example, the number of Ceasarean sections per 1,000 live births is more than 300 in Italy to compare with less than 150 in the UK, Sweden and Czech Republic (EIWH 2006). The significantly higher utilization of Ceasarean sections in Italy compared to other European countries cannot be medically justified – Italian women are not different biologically from other women. In fact, both in terms of maternal mortality and infant mortality Italy has worse records than e.g. Sweden. The overuse of the technology is rather the result of the increased demand for the service from Italian women, probably encouraged by scaremongering propaganda from for-profit health care providers about possible negative consequences of vaginal delivery for baby's and own health, and for impaired or painful sexual life after delivery.

Lack of economic resources is an increasingly important barrier for poor people to utilize health care services. For example, out-of pocket expenditures for public and private health care services and drugs drive many families into

poverty, especially in developing countries (Whitehead et al. 2001; Gilson et al. 2007). Women are disproportionately affected as they have less access to household resources and require more preventive reproductive health services (Hanson 2002). Under the counter payments, referring patients from the public service to their own private clinic, making patients pay for drugs and supplies that should be provided free, recommending unnecessary interventions which they can charge for are examples of abusing users of services (Govender and Penn-Kekana 2008). Informal payments for health care are widespread also in most countries in Central- and Eastern Europe (Szende & Johr Culyer 2006; Falkingham 2004; Gaal & McKee 2004; Ensor 2004). A study from Hungary found that people with lower income paid proportionally more for public health care through informal payments compared to people with higher income (Szende & Johr Culyer 2006).

Gender inequality may also be manifest in the ways women and men are treated by the health care systems. Evidence suggests that both female and male health care providers may be gender biased in their perception of patient preferences and problems (Govender & Penn-Kekana 2008). Negative and judgmental attitudes towards poor patients in general and poor women in particular may prevent women in some cultures from using health care services (George 2007). Women in these settings are not always treated with respect by health care providers. Privacy and confidentiality are not always ensured and information about treatment options is not always provided. There is even growing evidence on how women, also those undergoing labour, may be abused by health care staff physically, verbally and economically (Govender & Penn-Kekana 2008; Freedman 2005; Kim & Motsei 2002).

In some cultures, social-cultural norms and practices restrict social and physical contact between women patients and male providers (Govender & Penn-Kekana 2008). Thus, lack of female doctors – itself a reflection of gender bias in educational opportunity – may in some contexts be a serious barrier for women to access health care and treatment. For example, women seeking antenatal care in Saudi Arabia and Thailand highly preferred female doctors (Nigenda et al. 2003).

II. Why are Health Care Systems in many Countries unable to adequately Deliver on Gender Equity in Access to Health?

Although the antecedents of gender inequities often need to be tackled within the broader social and economic arena, the role of health care systems in redressing gender inequities in health and preventing future gender-based inequities remains critical. As we have seen in the previous section, gender-based inequities in access can be observed everywhere, but these are particularly consistent and pervasive in many middle- and low income countries. We could

also see that gender inequalities may have an impact on men's access to health care and treatment, but the impact on women and girls are more pronounced, due to their lower social position and less decision making power both as consumers and providers of health care services. Moreover, due to their greater need for preventive services for contraceptives, cervical screening and other diagnostic tests and for curative treatment for reproductive morbidity, women in most countries have more interactions with health systems than men.

The following factors are of key importance in understanding why health care systems in most countries are unable to adequately address gender inequities in access to health care and treatment:

1. Health systems may pay insufficient attention to the different needs of women and men in planning and providing health services. For example, health services for women often focus on reproductive functions and important women's health issues, unrelated to their reproductive role, tend to be shortchanged. Institutional indifference and lack of awareness of women's and men's specific health needs are reflected in the design of budget lines, supervision systems, staffing patterns, drug allocations and training curricula, which do not take this into account (George et al. 2005).
2. Equitable utilization of health care is strongly affected by gender inequalities in society. The root causes of gender inequalities all over the world are the gendered power relations that place women in subordinate positions in a remarkably consistent and pervasive manner. The gender power relations are manifest among other things in 1) unequal access to and control over financial resources, 2) strongly defined gender-based divisions of labour, also within health systems, 4) unequal restrictions of physical mobility in some cultures, and 3) unequal decision making at all levels (Sen et al. 2007). Many of these inequalities cannot be tackled by health systems. Policies in sectors such as the labour market, social services or education are crucial for addressing gender inequalities, because these policies have direct and indirect impacts also on the use of health care services.
3. Powerful global and international trends in health care reform result in fundamental consequences for equitable access to health care and treatment. The objective of health sector reform in many countries has been to improve the efficiency, equity and effectiveness of the health sector. Gender analysis of health sector reform programmes suggests that many of the reforms may affect women differently than men, due to their respective positions as users and producers of health care. However, the consequences of health care reforms for gender equity – particularly in access to health care – are seldom taken into consideration when designing fundamental changes to health care systems (Östlin 2005).

There is mounting evidence that health sector policies, such as the introduction of user-fees and private insurance schemes, escalating costs for medicines, rapid decentralization of responsibilities without corresponding devolution of authority and requisite human, institutional and financial resources have in many countries led to difficulties in providing affordable, accessible and equitable health services. These reforms have affected women's access more because of their greater need for health care due to reproductive functions, their greater social, cultural and financial vulnerability and their greater involvement both as users and providers of health care within the formal as well as informal care system (Neema 2005; Standing 2000).

III. What can Health Systems do to Improve Gender Equity in Access to Health Care and Treatment?

As mentioned in section II, the role of health care systems in redressing gender inequities in health and preventing future gender-based inequities remains critical. Although, many of the root causes of gender inequalities that have an impact also on health care utilization must be tackled by a variety of sectors, the health care sector can do a lot to improve gender equity in access to care and treatment, or at the least, it can prevent that health sector policies and programmes do not exacerbate inequitable access even further. In the short term, the health sector may be a promising entry point for gender equity-oriented policies and interventions and for preventing impoverishment due to health care expenses.

The Women and Gender Equity Knowledge Network, in its final report to the WHO Commission on Social Determinants of Health, has identified a number of good practices within health systems that have demonstrated positive effects on gender equity in access to health care and treatment (Sen et al. 2007). Based on the evidence collected, the report lists a number of recommendations about action priorities within the health sector (Box 1).

BOX 1: Recommendations of the Women and Gender Equity Knowledge Network Regarding what Health Systems can do to Improve Gender Equity in Health

Transform the gendered politics of health systems by improving their awareness and handling of women's problems as both producers and consumers of health care, improving women's access to health care, and making health systems more accountable to women

Action priorities:

- Provide comprehensive and essential health care, universally accessible to all in an acceptable and affordable way and with the participation of women: ensure that user fees are not collected at the point of access to the health service, and prevent women's impoverishment by enforcing rules that adjust user fees to women's ability to pay; offer care to women and men according to their needs, their time and other constraints.
- Develop skills, capacities and capabilities among health professionals at all levels of the health system to understand and apply gender perspectives in their work.
- Recognize women's contributions to the health sector, not just in the formal, but also through informal care. Women as health providers in auxiliary, volunteer and informal care need multiple linkages to formal and professional sectors: training, supervision, acknowledgement and support, functioning referral systems linking them to drugs, equipment and skilled expertise.
- Strengthen accountability of health policy makers, health care providers in both private and non-private clinics to gender and health. Incorporate gender into clinical audits and other efforts to monitor quality of care.

Source: Sen, Östlin and George (2007)

Good Practices to Improve Women's and Men's Access to Health Care

The removal of physical, financial and cultural barriers for utilization of health care services is a key measure for addressing gender-based inequities. For example, many countries, including South Africa and Sri Lanka, provide free maternal and infant services. Available evidence creates a strong case for removal of user fees and provision of universal coverage for pregnant women, particularly for delivery care (Witter et al. 2007). Some countries, where gender taboos limit women's mobility and interaction with male care providers, have introduced innovative programmes to increase women's possibility to access health care. For example, Pakistan's 'Lady Health Workers' programme provides door-to-door service for women whose mobility is constrained. As a result, uptake of services was increased, adoption of contraceptives was improved as well as community health in general (Douthwait & Ward 2005). In the European context, the extension of surgery opening hours of general practitioners in order to increase men's access to services in the UK (Wilkins 2007), can serve as an example of good practice. Immigrants in Sweden have the right to a translator, when visiting health care facilities, which may decrease the language barrier.

Establishing multipurpose clinics is also a good way of increasing access to health care. For example, integrating family planning services, reproductive health services and maternal and child health services increased women's access to care considerably as they were able to access various services at one occasion and in the same facility. Moreover, integrating STI (Sexually Transmitted Infection) prevention with reproductive health services instead of separate STI services can help to ensure privacy and reduce stigma, as has been the case in rural Ghana (Mayhew 2000).

Male-friendly services are rare both in low- and high income countries, although these may increase men's access to health care, especially to reproductive health services. Such services can be promoted through separate waiting areas, male service providers, separate examination rooms and male only clinics (Govender & Penn-Kekana 2008). The Pro familia's Clinica Para El Hombre in Colombia represents one of the most successful attempts to increase men's access to comprehensive reproductive health services through the introduction of men-only clinics. Quality of care and gender-sensitive patient-provider interactions are central to the delivery of services. Staff are trained on personal and cultural beliefs about masculinity, and are encouraged to reflect on their personal attitudes regarding gender and how gender impacts on their interactions with patients. The clinics are supported by the Association for Voluntary Surgical Contraception. Information about these male-only clinics is dispersed through radio announcements, magazine advertisements, and newspaper articles. An interesting observation has been the importance of ensuring privacy and confidentiality from the patients' perspective (Goldman 1987). This good practice should be followed also by countries in Europe.

Gender equity in access to health services can be improved also by developing skills, capacities and capabilities among health professionals at all levels of the health system to understand and apply gender perspectives in their work. Transforming medical curriculum is a key measure for building capacity of health care providers in gender analysis and responsiveness, as has been done in many places, both in low- and high income countries, such as India (Kerala), Argentina, Canada, the Netherlands and Sweden (Verdonk et al. 2005; Verdonk et al. 2006, Westerståhl et al. 2003). However, there are many more innovative approaches to gender sensitization of health care providers. For example, The Health Workers for Change project, which has been implemented in five African countries, Argentina and Pakistan, provides a space for providers to examine how gender and other social issues impact on their lives. More over, the programme provides training on gender-sensitive interpersonal communication (Vlassoff & Fonn 2001). Another good practice is introducing training programmes for PHC (Primary Health Care) nurses to help them acknowledge women's health needs and problems related to domestic violence, as has been implemented successfully in South-Africa. (Kim & Motsei 2002).

Measures to strengthen accountability of health systems to citizens are important for safeguarding access, quality and acceptability of health care services and treatment (Murthy 2008). For example in India, the citizens' Campaign Against Sex Selective Abortion uses several innovative strategies to monitor private health clinics' and providers' adherence to the Pre-natal Testing and Diagnostic Act. They use pregnant women who are part of the campaign to bring those private clinics and providers who disclose the sex of the child or conduct sex selective abortions to book, while protecting the right of women to abortion on other grounds. They also demand a list of private clinics registered with the district and state authorities under the Act, and provide a list of un-registered clinics to the government to take appropriate action. Where their representatives sit on district committees, they are able to ensure that action is taken against unregistered clinics (Gupte 2003). A community based monitoring system in Uganda resulted in improved quality of care by providers, increased number of beds for women increased and user-fees were removed, which benefited women in particular (Uganda Debt Network 2002).

One example of the most comprehensive attempts to integrate gender equality into health policies and programmes, also those related to access to care and treatment, comes from Stockholm County Council in Sweden. According to the Swedish Health and Medical Services Act (Ministry of Health and Social Affairs 1982: 763), good health and equal access to high quality care – regardless age, sex, geographic area, social status, or ethnic background – are important goals for health and health services. County councils are obliged to ensure that health care is available to all members of society and to provide a high standard of general health care for everyone on equal terms. This is ensured in the Stockholm County Council by the following measures:

- Gender equality policy document for Stockholm County Council (SLL 2006)
- Guidelines for decision-makers within the health sector as to how to integrate gender into steering documents concerning e.g. personnel policy; budget; health plans and public health
- Mechanisms for senior management support and accountability, gender sensitive budgeting and human resource policy, capacity building in gender and health issues, well functioning and regular monitoring and evaluation
- Sex-disaggregation of all health statistics and gender analysis of data
- Research, development of all activities and education within the health field must involve men and women on equal terms and have a gender perspective (co-operation with the Karolinska Institutet)

In order to ensure effective implementation of the measures above, gender equality education/training was provided for more than 600 managers and teachers between 2004 and 2007 in collaboration with the Karolinska Institute. Evaluation of the capacity building showed that the training was very much appreciated by participants, it increased participants' knowledge and awareness about gender equality and health and it increased motivation of managers to work with gender issues.

Concluding Remark

Although gender inequity in access to health care services is pervasive and persistent everywhere, it can be changed through effective leadership, well designed health policies and programs, and institutional incentives and structures. The innovative and effective actions within health systems described in section III, illustrate that equitable access to health care can be achieved by relatively straightforward and cost-effective measures. Although health systems have an important role in addressing gender inequities in health, it is important to emphasize that many of the root causes of gender inequalities cannot be tackled by the health sector alone. There is a need for multi-sectoral policies and actions, where the health sector is only one, but a very important, stakeholder in ensuring that both men and women can develop their full potential for a flourishing life in good health.

References

- Ahmed, Syed Masud, Alayne M. Adams, Mushtaque Chowdhury and Abbas Bhuiya (2002): Gender, socioeconomic development and health-seeking behaviour in Bangladesh. In: *Soc Sci Med* 51: 361-71.
- Barker, Gary, Christine Ricardo and Marcos Nascimento (2007): *Engaging Men and Boys to Transform Gender-Based Health Inequities: Is There Evidence of Impact?* Geneva: World Health Organization and Instituto Promundo.
- Commission on Social Determinants of Health (2008): *Closing the gap in a generation. Health equity through action on the social determinants of health. Final report.* Geneva, World Health Organization.
- Dias, F. Sónia, Milton Severo and Henrique Barror (2008): Determinants of health care utilization by immigrants in Portugal. In: *Health Services Research* 8: 207. Open Access paper. www.biomedcentral.com/1472-6963/8/207
- Douthwaite, Megan and Patrick Ward (2005): Increasing contraceptive use in rural Pakistan: an evaluation of the Lady Health Worker Programme. In: *Health Policy Plan* 20: 117-23.
- Ensor, Tim (2004): Informal payments for health care in transition economies. In: *Social Science and Medicine* 58: 237-246.
- European Institute of Women's Health (2006): *Women's Health in Europe. Facts and Figures Across the European Union.* Dublin: European Institute of Women's Health.
- Falkingham, Jane (2004): Poverty, out-of-pocket payments and access to health care: evidence from Tajikistan. In: *Social Science and Medicine* 58: 247-258.
- Freedman, P. Lynn (2005): Achieving the MDGs: Health systems as core social institutions. In: *Development* 48: 19-24.
- Gaal, Peter and Martin McKee (2004): Informal payment for health care and the theory of 'INXIT'. In: *International Journal of Health Planning Management* 19: 163-178.
- Galdas, M. Paul, Francine Cheater and Paul Marshall (2004): Men and health help-seeking behaviour: literature review. In: *Journal of Advanced Nursing* 49 (6): 616-623.
- George, Asha (2007): *The outrageous as ordinary: primary health care workers' Perspectives on accountability in Koppal district, Karnataka State, India.* Institute of Development Studies. Brighton: Sussex University.
- George, Asha, Aditi Iyer and Gita Sen (2005): *Gendered health systems biased against maternal survival: preliminary findings from Koppal, Karnataka, India.* Brighton IDS Working Paper No 23.
- Gilson, Lucy, Jane Doherty, Rene Loewenson and Victoria Francis (2007): *Challenging Inequity Through Health Systems. Final Report of the Knowledge Network on Health Systems for the WHO Commission on Social Determinants of Health.* Centre for Health

Policy at the University of the Witwatersrand, South Africa, EQUINET and the Health Policy Unit of the London School of Hygiene and Tropical Medicine, UK.

- Goldman R. (1987): Male-only clinics: a success story from Columbia. In: AVCS-News 25 (1): 5.
- Govender, Veloshnee and Loveday Penn-Kekana (2008): Gender biases and discrimination: a review of health care interpersonal interactions. In: Global Public Health, Supplement 1, 3 (2): 90-103.
- Gupte, M. (2003): A Walk Down Memory Lane: An Insider's Reflections on the Campaign Against Sex-Selective Abortions. Masum, Pune, India.
- Hanson, Kara (2002): Measuring up: gender, burden of disease, and priority setting. In: Gita Sen, Asha George and Piroska Östlin (eds.) Engendering international health: the challenge of equity. Cambridge, MIT Press.
- Iyer, Aditi (2005): Gender, caste, class, and health care access: Experiences of rural households in Koppal district, Karnataka. Trivandrum: Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Sciences and Technology.
- Iyer, Aditi, Gita Sen and Asha George (2007): The dynamics of gender and class in access to health care: Evidence from rural Karnataka, India. In: International Journal of Health Services 37 (3): 537-554.
- Khan M.A., Walley J.D., Witter S.N., Shah S.K. and Javeed S. (2005): Tuberculosis patient adherence to direct observation: Results of a social study in Pakistan. In: Health Policy Plan 20: 354-365.
- Kim, Julia and Mmatshilo Motsei (2002): "Women enjoy punishment": attitudes and experiences of gender-based violence among PHC nurses in rural South Africa. In: Soc Sci Med 54: 1243-54.
- Long, Nguyen Hoang, Eva Johansson, Vinod K. Diwan, and Anna Winkvist (2001): Fear and social isolation as consequences of tuberculosis in VietNam: a gender analysis. In: Health Policy 58: 69-81.
- Mayhew, H. Susannah (2000): Integration of STI Services into FP/MCH Services: Health Service and Social Contexts in Rural Ghana. In: Reproductive Health Matters 8: 12-124.
- Ministry of Health and Social Affairs (1982): The Health and Medical Services Act. Stockholm.
- Murthy, K. Ranjani (2008): Strengthening accountability to citizens on gender and health. In: Global Public Health, Supplement 1, 3 (2): 104-120.
- Neema, Stella (2005): The impact of health policies and health sector reform on the readiness of health systems to respond to women's health needs, with special focus on reproductive health, reproductive rights and HIV/AIDS. UN Division for Advancement of Women (DAW) Experts Group Meeting. Bangkok, Thailand.

- Nigenda, G., Langer, A., Kuchaisit, C., Romero, M., Rojas, G., Al-Osimy, M., Villar, J., Garcia, J., Al-Mazrou, Y., Ba'aqueel, H., Carroli, G., Farnot, U., Lumbiganon, P., Belizan, J., Bergsjö, P., Bakketeg, L. and Lindmark, G. (2003): Women's opinions on antenatal care in developing countries: results of a study in Cuba, Thailand, Saudi Arabia and Argentina. In: *BMC Public Health*: 317.
- Östlin, Piroska (2005): What evidence is there about the effects of health care reforms on gender equity, particularly in health? Copenhagen: World Health Organisation, Regional Office Office, Health Evidence Network (HEN).
- Östlin, Piroska, Asha George and Gita Sen (2001): Gender, health and equity: the intersections. In: Timothy Evans, Margaret Whitehead, Finn Diderichsen, Abbas Bhuiya and Meg Wirth (eds). *Challenging Inequities in Health: From Ethics to Action*. New York. Oxford University Press: 175-189.
- Ringheim, Karin (2002): When the Client Is Male: Client-Provider Interaction from a Gender Perspective. In: *International Family Planning Perspectives* 28 (3): 2002.
- Sen, Gita, Asha George and Piroska Östlin (2002): Engendering Health Equity: A review of research and policy. In: Gita Sen Asha George and Piroska Östlin (eds.): *Engendering International Health – the challenge of Equity*. Cambridge, MIT Press: 1-33.
- Sen, Gita, Piroska Östlin and Asha George (2007): Unequal, Unfair, Ineffective and Inefficient -Gender Inequity in Health: Why it exists and how we can change it. Final report of the Women and Gender Equity Knowledge Network to the WHO Commission on Social Determinants of Health. Bangalore: Indian Institute of Management and Stockholm: Karolinska Institutet.
- Stockholms Läns Landsting (2006): Jämställdhetspolicy för Stockholms läns landsting [Gender Equality Policy For Stockholm County Council] (In Swedish). Stockholm: SLL.
- Smirthwaite, Goldina (2007): (O)jämställdhet i hälsa och vård – en genusmedicinsk kunskapsöversikt. (Gender inequities in health and health care). Available in Swedish with English summary. Stockholm: Sveriges Kommuner och Landsting.
- Standing, Hilary (2000): Gender impacts of health reforms. The current state of policy and implementation. Asociación Latinoamericana de Medicina Social Meeting. Havana, Cuba.
- Stronks Karien, Anita C. J. Ravelli and Reijneveld S.A. (2001): Immigrants in the Netherlands: equal access for equal needs? In: *J Epidemiol Community Health* 55 (10): 701-707.
- Szende, Agota and Anthony Johr Culyer (2006): The inequity of informal payments for health care: The case of Hungary. In: *Health Policy* 75: 262-271.
- Uganda Debt Network (2002): The community Based Monitoring and Evaluation System (CBMES) Pilot Test in Kamuli District. Uganda: Uganda Debt Network.
- Verdonk P., Mans L.J. and Lagro-Janssen A.L. (2005): Integrating gender into a basic medical curriculum. In: *Med Educ.* 39: 1118-1125.

- Verdonk P, Mans L. and Lagro-Janssen T. (2006): How is gender integrated in the Curricula of Dutch medical schools? A quick scan on gender issues as an instrument for change. In: *Gender and Education*. 18: 399-412.
- Vlassoff, Carol and Sharon Fonn (2001): Health Workers for Change as a Health Systems Management and Development Tool. In: *Health Policy and Planning* 16: 47-52.
- Wamala, S.P., Merlo, J., Boström, G. and Hogstedt, C. (2007): Perceived discrimination, socioeconomic disadvantage and refraining from seeking medical treatment in Sweden. In: *Journal of Epidemiology and Community Health* 61: 409-415.
- Westerståhl, Anna, Maria Andersson and Margareta Söderström (2003): Gender in medical curricula: Course organizer views of a gender-issues perspective in medicine in Sweden. In: *Women Health* 37: 35-47.
- Whitehead, Margaret, Göran Dahlgren and Timothy Evans (2001): Equity and health sector reforms: can low-income countries escape the medical poverty trap? In: *Lancet* 358: 833-836.
- Wilkins, David (2007): Getting It Sorted: identifying and implementing practical solutions to men's health. Editorial. In: *The journal of Men's Health & Gender* 2: 13-16.
- Witter, Sophie, Arhinful Daniel Kojo, Kusi Anthony and Zakariah-Akoto Sawudatu (2007): The experience of Ghana in implementing a user fee exemption policy to provide free delivery care. *Reproductive Health Matters*. Online publication. Publication date: 1 November 2007.
- World Health Organization (2008): Strategy for integrating gender analysis and actions into the work of WHO. Department of Gender, Women and Health. Geneva, World Health Organization.
- World Health Organization (2005): The World Health Report 2005: make every mother and child count. Geneva, World Health Organization.
- World Health Organization (2003): The World Health Report 2003: shaping the future. Geneva, World Health Organization.

Beyond Gender Bias: A Methodological Approach for Analyzing Inequities

Margrit Eichler & Mary Anne Burke

Introduction

Recognizing and eliminating gender bias remain extremely important tasks for health research. Without doing this, diagnoses may be wrong (as in the case of heart attacks) and treatment may be inappropriate, leading to a failure to heal, when it is possible, and sometimes to avoidable deaths (Eichler 1998). However, recognizing and eliminating gender bias alone does not avoid all of these problems. Similar statements can be made concerning ignoring the effects of race (Smedley et al. 2003) or disability (Albrecht, Seelman and Bury 2001) or any other social hierarchy. In other words, all types of social hierarchies may lead to problems similar to those generated by gender bias. All women and men belong to more than one social hierarchy. We, the authors, for instance, are female, well-educated with good jobs, white, heterosexual, and getting older. That puts us in the lower echelon of the gender hierarchy, the higher echelons of the class, race and sexual orientation hierarchies, and toward the lower echelon of the age hierarchy.

In this paper, we present a framework that is derived from GBA (see Eichler, Fuchs and Maschewsky-Schneider 2000; Fuchs et al. 2002) but that allows us to deal with biases that derive from all social hierarchies (see Burke & Eichler 2006).

What is the BIAS FREE Framework?

The *BIAS FREE* Framework is a new, rights-based tool for identifying and eliminating biases deriving from social hierarchies in research, legislation, policies, programs, service delivery and practices. It is aimed at creating solutions for building equitable, more inclusive societies based on respect, equality, human rights and the full participation and benefit of all people. *BIAS FREE* stands for **B**uilding an **I**ntegrative **A**nalytical **F**ramework for **R**ecognizing and **E**liminating **I**n**E**quities. The *BIAS FREE* Framework addresses multiple forms of discrimination people experience based on the intersection of social hierarchies, such as sexism, racism, ableism, ageism, etc. and how these affect people's overall health and well-being.

For whom is the BIAS FREE Framework?

The *BIAS FREE* Framework has been developed to help researchers, professors, students, policy-makers, the media, community members and others recognize when biases exist and to identify means to eliminate them.¹

Rights-based: The *BIAS FREE* Framework is premised on the inviolability of human rights and on the equal entitlement of all people to be treated with respect. The Framework derives from the understanding of health as a human right and uses a rights-based model of health and well-being. Health (physical, mental, social and spiritual well-being) is seen as fundamentally tied to human rights and social equality (see Burke et al. 2000). Specifically, it rests on the following three basic assumptions:

1. Health policies, programmes and practices have an impact on human rights.
2. Violations or lack of fulfillment of human rights have negative effects on health (physical, mental, social and spiritual well-being).
3. Health and human rights act in synergy. Promoting and protecting health requires explicit and concrete efforts to promote and protect human rights and dignity; greater fulfillment of human rights necessitates sound attention to health and its societal determinants. Paying attention to the inter-relationship between health and human rights may help to re-orient thinking about major global challenges to health and to broaden human rights thinking and practices.

The Framework is designed to draw the users' attention to the structural and organizational determinants of health, to assist them in identifying biases in health research that derive from various social hierarchies, and in to remove the biases, to the degree possible.

Addresses multiple biases: The Framework addresses not just gender biases but deals with multiple biases and how they intersect and compound one another. People are not just people. The human rights abuses they experience cross many ,isms'. They may be women or men, boys or girls, or transsexuals. They can be of colour, of a particular religion, gay, disabled, poor and sometimes all these at once. Understanding their situations in terms of human rights is complex. Racism, sexism, ageism, ableism, heterosexism etc. are deeply embedded in modern society. They result in overt discrimination that negatively affects the lives of many women and men. While these overt biases are challenging to overcome, even more problematic are the biases that remain hidden and deeply entrenched in these various ,isms'. The *BIAS FREE*

¹ The *BIAS FREE* Framework is applicable not just to research, but also to legislation, policies, programmes, service delivery and practices. It is also transferable to any and all policy sectors – not just health, and speaks to the needs of high- and low-income countries alike. However, we are here going to concentrate on research.

Framework draws attention to both the overt and hidden form of bias that derive from these various social hierarchies.

An integrative approach: The *BIAS FREE* Framework is 'integrative' in two ways: First, it aims to combine, co-ordinate and consolidate into a unified whole the various analytical lenses that researchers, policy makers, students, community members and others have had to apply in the past to avoid sexism, racism, ableism, classism, casteism, ageism and endless other 'isms' in their work. It provides a single, comprehensive and integrative tool for exploring and removing the compounding layers of bias that derive from any social hierarchy. This is because the *BIAS FREE* Framework is built on the understanding that the roots of discrimination – the logic of domination – are common to all 'isms of domination'. Understanding this basic conceptual interconnection among all systems of oppression is the key to unlocking them. Second, it recognizes that health research is a global public good and that as such all people have an equal claim to the health research process and its benefits, regardless of their sex/gender, ability, race or other social characteristics.

Innovative: To date, there is no other approach that integrates critiques of sexists, racist, ableist, heterosexist, ageist and other types of biases derived from other social hierarchies (e.g. those based on religion, language, geographical location, etc.) and that proposes solutions to overcome these problems. The impact is, therefore, potentially enormous.

What does the BIAS FREE Framework do?

The *BIAS FREE* Framework provides guidance for initiating a process of democratizing hierarchies, whether these are based on gender, race, disability, age, or other factors. Nineteen analytical questions challenge users to detect biases in their research, legislation, policies, programmes, service delivery and practices. However, the Framework is not only a *tool* of intellectual analysis. It helps in identifying and analyzing a problem and its causes and in finding real solutions to those problems. The Framework engages users in a *methodology* that empowers people to participate in a process of challenging and transforming the social hierarchies to which they are subjected. It does so by asking questions – all answers are provided by the users of the Framework. All problems and all solutions are therefore identified by people within their particular situations and cultural settings.

The *BIAS FREE* Framework has been rigorously constructed, is written in neutral language and approaches bias in a logical way. It provides a safe non-confrontational way to examine issues, and because of this eases the tensions that often arise in these situations. Thus the tool has potential for widespread application.

How does the BIAS FREE Framework work?

The *BIAS FREE* Framework's set of 19 thought-provoking questions are aimed at discovering if social hierarchies are at work in research (or any of the other areas in which it can be applied), and if so, if they are producing bias. The questions in the Framework probe the particular nature of the problem and the biases that may arise from them so that appropriate solutions can be applied to the identified problem. If no biases are found, the researcher or policy-maker can proceed to the next stage of their work. If a bias is found, the Framework points to appropriate solutions that may be taken to address the particular bias problem identified.

The 19 questions stimulate discussion and soul-searching among people using the Framework. As people apply the Framework, they begin to be able to identify biases in their institutions and lives and to put a name to them. Once they identify the correct problems, they can begin to work towards resolving them. In the process, people using the Framework begin to see the world through "new eyes", begin to internalize the values that underpin the Framework, and to change their attitudes and practices. This in turn leads to a more thoughtful and critical reflection on attitudes and practices, and ultimately to a process of personal and structural transformation and broad social change focused on human rights and equity.

For example in a hospital in Costa Rica, patients were treated as objects prior to the application of the *BIAS FREE* Framework. As they re-visited their vision and mission, hospital staff realized the need to become more inclusive and to treat people as 'human beings' deserving of dignity not as mere 'objects'. Doctors gave up their hierarchical approach and followed a more democratic approach by listening to the patients and caring for them as individuals with specific needs and problems. Hospital staff treated patients with dignity, empathy and respect. Patients were happy with this and contented that their voices were heard and taken seriously. In turn, the doctors reported greater job satisfaction (Eichler and Burke forthcoming; MacDonald Quiceno 2008).

Theoretical and Conceptual Underpinnings

The *BIAS FREE* Framework is anchored in 25 years of published research by the two principal investigators. The Framework is theoretically based, drawing upon the voluminous research on sexist, racist and ableist biases. It synthesizes insights from several bodies of research literature that are usually not considered together.

The Framework is also systematic, comprehensive and open-ended: It is systematic in that it identifies each step within the research, policy or other application and requires an iterative approach – it is not applied once, but

iteratively throughout the entire process. It is comprehensive in so far as we have, in the past 5 or 6 years, found no problem that we could not assign to one of our categories – but, should a new type of problem emerge, we would integrate it into the Framework, given that it is open-ended.

The Framework is rigorously constructed, building upon a number of key concepts, including *hierarchy*, *equity*, *equality* and *objectivity*. These are defined in the box below.

Hierarchy is a vertical social system in which people are ordered on a continuum of power that determines access to resources such as: Power and decision-making, health, education, income, employment, the media, etc. It results in different social outcomes, including wealth/poverty, inclusion/exclusion, being listened to/being ignored and discounted, higher or lower social status and shorter or longer life expectancy. Social hierarchies may be built on sex/gender, ability, age, sexual orientation, class, caste, language, socio-economic status, race/ethnicity, religion, Aboriginal status, immigrant status, geographical location, etc. (Barker 2005; Blasiotti, Westbrook and Kobayashi 2001; Chen & Wellman 2005; Denzin 2005; Lollar 2001; Pfohl 2005)

Equity is the *process* of being fair to all people, respectful of differences, and free from discrimination. Such fairness, respect and freedom may require compensatory measures to compensate for historical and social disadvantages that prevent people from non-dominant groups operating on a level playing field. The guiding principle of equity is to create equal outcomes for all people. Sometimes this means *different* treatment to compensate for historical disadvantages, since treating everyone identically can perpetuate rather than remedy inequality. At other times, it does mean *same* treatment, to address discriminatory practices (Status of Women Canada 1996).

Equality is the *outcome* reached through equity. It means that all people can equally realize their full human rights and potential to contribute to national, political, economic, social, cultural and personal development. The concept of equality recognizes that despite equality in law – *de jure* equality – structural and systemic discrimination continue to result in the perpetuation of unequal treatment and access to opportunities based on where someone is located in a social hierarchy. Achieving actual equality – *de facto* equality – requires measures to correct historical imbalances, to eliminate discrimination and exclusion, and to ensure that equality and inclusion are built into the design and implementation of services, supports, funding allocations, programs, policies and legislation. Equality ultimately means that society values equally the similarities and differences among all people and the varying roles they play (Status of Women Canada 1996).

Objectivity is often confused with value-freedom, a confusion that already Max Weber tried to lay to rest (Weber 1977). Minimally, the decision to conduct – or not to conduct – research on a topic rests already on a value judgement. Therefore, research cannot, in principle, ever be value-free. We use a specific approach to objectivity that is derived from the philosopher Longino. Usually, objectivity (or lack thereof) is seen as being located within a particular piece of research or a

particular researcher. By contrast, Longino (1993) understands objectivity as a quality of a scholarly community. She identifies four criteria that must be met if a scholarly community, for instance, epidemiology or psychiatry, wishes to claim that their research is objective:

1. Recognised avenues for criticism: Avenues for presentation of criticism must be the same as those for “original research”.
2. Community response: Critique by a wider “scientific” community must include people with experiential expertise as acknowledged members of the community and their participation must be actively sought. This means that all stakeholders are engaged as active participants in critical discussions.
3. Shared standards: There needs, of course, to be agreement on substantive principles about what counts as knowledge and what are acceptable social values. However, these standards themselves must be open to criticism by appealing to other standards.
4. Equality of intellectual authority: This requires that arguments must be evaluated on the basis of the agreed upon criteria, rather than on the status of the person(s) making them. Dissenting voices must not only *not be discounted*, but must be actively *cultivated*. Knowledge and objectivity are outcomes of social interactions and, hence, are located not in individuals but in communities.

Each hierarchy results in types of discrimination that are specific to that hierarchy. Racism, sexism, ableism, casteism, classism, etc. all take very different forms. They also vary by historical period, by segment of society, etc. and they intersect. Nevertheless, the **logic of domination** which underlies them is the same. It is this fact that makes it possible to create a set of questions that are useful for identifying biases in all social hierarchies.

Warren (1993), a feminist philosopher, has identified three aspects which, together, result in a logic of domination:

1. 'Up-down' thinking which places higher value, status or prestige on what is “up” rather than on what is ‘down’.
2. Disjunctive pairs in which the disjuncts are seen as oppositional rather than as complementary, and as exclusive rather than as inclusive, and which place higher value, status, prestige, on one of the pair.”
3. A structure of argumentation which leads to a justification of subordination.

For example, if we regard being rational vs. being emotional as being of higher value, we are treating it in an up-down manner. If we argue that men are rational and women are emotional, we treat rationality and emotionality as a disjunctive pair which is oppositional rather than complementary and always

present in both females and males. Finally, if we argue that because men are rational and women are not, and that, because rationality is of higher value than emotionality, it is therefore justified that men dominate women, we have engaged in an argument that justifies subordination.

Such logic of domination underlies all justifications for hierarchies, regardless of the type of hierarchy (whether based on sex, race, disability, religion, language etc.) and regardless of what trait is selected as being the important difference. The logic is the same. It is this fact that made it possible to develop an approach which is applicable not only to gender but to all other types of social hierarchies.

The Bias Triangle

The bias triangle represents the theoretical core of the Framework. Bias problems exist because there is a hierarchy.



Fig. 1: The Bias Triangle

The existence of a hierarchy results in 3 specific problems. Sometimes, research or policies etc. simply result in *maintaining an existing hierarchy*, such as a gender, age, or heterosexist hierarchy. This is what we refer to as the **H Problem: *Maintaining an existing hierarchy***. However, bias problems also take two other specific forms: the **F Problem: *Failing to examine differences*** and the **D problem: *Using double standards***. Failing to examine differences is usually referred to as gender insensitivity when the hierarchy we are dealing with is sex/gender. Unfortunately, this is often taken as the only problem. When

that is the case, we may inadvertently cement gender differences rather than eliminate them.

Let us consider a very simple example. For a long time, there were no official spaces where people could change their babies' diapers in airports and in other public spaces. Since it was mostly women who travelled with babies, failing to provide such spaces was a problem that required examining the different needs of female and male travellers and to accommodate them (an F problem). The introduction of spaces for changing diapers in women's washrooms was therefore a welcome innovation when it happened. However, by placing these spaces in women's washrooms only, it cemented the notion that changing diapers was something only women did – which is fortunately no longer true. Having no changing spaces available for men was therefore based on a double standard (a D problem). Making diaper changing spaces available to both women and men is the obvious solution to this problem – a practice which is now fortunately fairly widespread.

When we fail to examining differences, we fail to notice and address the different circumstances and needs of people. When using double standards, we fail to notice and address the similarities between people. Where differences exist, the solution is to accommodate them by treating people differently, where needs are the same, the solution is to treat people the same.

So how do we know with which type of bias problem we are dealing? We find the answer by asking which approach will reduce the hierarchy. If treating people differently reduces the hierarchy, then we are dealing with what we call the F problem. If treating people the same reduces the hierarchy, then we are dealing with what we call the D problem.

Here is a simple example. In China, we were told, rural youths need lower grades than urban youths to qualify for entrance into some universities. Given that this reduces the existing hierarchy between urban and rural youths in terms of access to higher education, this is a solution to an F problem. However, some provinces require higher grades for women to enter university. Given that this maintains the existing gender hierarchy, this is a double standard that should be abolished. The same practice – requiring different entrance grades, in one instance reduces a hierarchy, in the other maintains it.

Always asking simultaneously about the differences (to ascertain whether the F problem applies) as well as the similarities between people (to probe for the D problem) within the context of a hierarchy is therefore a self-corrective process. All three potential problems must always be examined in order to come up with a comprehensive understanding of a situation. Failing to address the hierarchy (the H problem) that gave rise to the situation in the first place, may result in reinforcing the hierarchy. A very basic way of maintaining a hierarchy consists in denying its very existence. Henry et al. call this “the discourse of denial.”

(Henry et al. 2000: 26). The effect of such denials is to reinforce the hierarchy, since what does not exist cannot be effectively addressed.

Underlying the Framework is a 3-dimensional matrix: The type of hierarchy (e.g. sex, race, age), the type of problem (H, F and D problem), and the type of application (research, legislation, policy, programme, service delivery, practice). Each of the various hierarchies always intersects with the other two aspects, each of the applications has a number of components and each of the problems has several sub-problems. The question for each of the problems is based on the definition of the problem.

The three basic questions read as follows:

H – Is dominance of one group over the other in any way justified or maintained?

Solution: Situate the problem within a human rights framework, in which equality is an underlying value. Point out the discrepancy between this value and the inequalities among groups of people that result from the hierarchy.

F – Is membership in a non-dominant/dominant group examined as socially relevant?

Solution: Establish the relevance of group membership within a given context. Once relevance is established, accommodate differences in ways that reduce the hierarchy.

D – Are non-dominant and dominant groups treated differently?

Solution: Provide the same treatment to members of dominant and non-dominant groups whenever this increases equity.

Each of these three main questions is further subdivided into a number of questions that help to identify the nature of the problem. Each problem is preceded by a concept that describes the problem (e.g. objectification, decontextualization, underrepresentation or exclusion), such that we can move towards a common understanding of the meaning of the terminology used for each problem. The question that follows is the definition of the concept, and serves to identify the problem. For the 19 questions that make up the Framework, see the appendix.

Using the Framework

Given space restrictions, we can here give only a few selected examples. For a complete set of examples for each type of problem, see Burke and Eichler

(2006).² Often, a particular study may have multiple problems that manifest in different phases of the study. For example, a large-scale study in the United States that used male doctors as subjects made global headlines in 1989 with its findings that preventive use of Aspirin reduced first heart attacks by 44% (Physicians' Health Study Website 2005). As a result of the reported findings, preventative Aspirin regimens quickly spread. A later, large-scale Women's Health Study found that Aspirin has no preventive effect for first heart attacks in women, although it did show a preventive effect on first strokes for women, especially those over the age of 56 (Ridker et al. 2005). "This is the exact opposite of what we see in men," according to study researcher Paul Ridker, MD (Peck 2005).

An application of the *BIAS FREE* Framework to the original Aspirin study reveals that the *research methods* were gender insensitive in that they failed to examine and account for differences between the sexes (an example of an F1 problem), the *conclusions* were over-generalized from men to women (an F3 problem), and the *whole study* was derived from a male perspective (dominant perspective) (an H3 problem) that contributed to ignorance about or indifference to the possible biological differences in response to a drug between men and women.

In contrast, most research on reproductive health issues and on everything related to parenting is conducted on women only, even though men have separate and different reproductive health issues and typically also have a longer reproductive span than women. Internationally, fertility is measured by the number of children per woman. An application of the *BIAS FREE* Framework would point to the exclusion of men from this research as a double standard because of the under-representation or exclusion of men from research that is relevant to them (a D3 problem).

Depending on where we start our analysis, different questions will guide us to the recognition of a problem. In other words, there is more than one way to approach the issue and sometimes more than one correct answer. The issue is, therefore, not to find "the" correct answer to a problem but to recognize that there is a problem and to deal with it appropriately.

The Framework also alerts us to hierarchies within hierarchies. For instance, people with disabilities tend to be treated as less valuable than people who are 'temporarily able-bodied' (given that most of those who will grow old will eventually experience some disabilities). Within the disabled community, however, people with physical disabilities are usually treated as more valuable than people with cognitive disabilities (a F4 problem).

² Available on the internet at http://www.globalforumhealth.org/Site/002__What%20we%20do/005__Publications/000__All%20publications.php

Problems may appear in any component of a research, policy or other process. For instance, in the Aspirin study mentioned above, problems appeared at the level of data analysis, data interpretation and conclusions drawn.

An example of a bias problem at the conceptual level is the manner in which people in poor countries are often identified as *'non-compliant'* with prescribed medical treatments. A detailed case study of a young Haitian man who was labelled as 'non-compliant' documented how he and his family made heroic efforts to comply with the treatment but that lack of money—in spite of the fact that the family sold half of its land—distance from the medical center without adequate transportation to it, and other such structural factors made it impossible for him to comply more fully (Farmer 1997). This is an example of victim blaming (H 7) as well as pathologization (H 5).

Conclusion

This has been a simple and abbreviated presentation of the *BIAS FREE* Framework with a few very simple examples of how to use it in research. The Framework distinguishes among a number of complex and interrelated problems, identifying the roots of the problems and pointing the way to appropriate and responsive solutions. For researchers committed to doing the best possible research, the Framework presents a valuable and useful tool. Recognizing and avoiding biases derived from social hierarchies is a necessary, albeit not sufficient, aspect of good research.

When used consistently, the Framework can be a powerful means of re-shaping questions and answers not just in research, but also in legislation, policy, programmes, service delivery and everyday practices. The Framework helps to identify where inequities exist, and as such is a powerful tool for challenging the status quo and getting at deeper structural issues.

Because the *BIAS FREE* Framework provides a safe non-confrontational way to examine issues, it is a useful tool for undertaking the preparatory work needed to begin challenging the status quo, particularly where it is firmly entrenched. In this case, more than a simple *pro forma* application of the Framework is needed. Once there is a real commitment to equity the *BIAS FREE* Framework is a tool for effecting real change and broad social transformation.

References

- Albrecht, Gary L., Katherine D. Seelman and Michael Bury (eds.) 2001: *Handbook of Disability Studies*. London: Sage.
- Barker, Chris (2005): *In the shadow of cultural imperialism: Television and national identities in the era of globalization*. In: M. Romero and E. Margolis (eds.): *The Blackwell Companion to social inequalities*. Malden MA: Blackwell Publishing.
- Blasiotti, Ellen Liberti, John D. Westbrook and Iwao Kobayashi (2001): *Disability Studies and electronic networking*. In: G. L. Albrecht, K. D. Seelman and M. Bury (eds.): *Handbook of Disability Studies*. London: Sage.
- Burke, Mary Anne, Michael Bach, Ron Coleman, Craig McKie and Gail Stewart (2000): *Dynamic model of health*. Available from www.cwhn.ca/resources/health_model/Dmodel.pdf.
- Burke, Mary Anne and Margrit Eichler (2006): *The BIAS FREE Framework. A practical tool for identifying and eliminating social biases in health research*. Geneva: Global Forum for Health Research.
- Chen, Wenhong, and Barry Wellman (2005): *Minding the cyber-gap: the Internet and social inequality*. In: M. Romero and E. Margolis (eds.): *The Blackwell Companion to social inequalities*. Malden MA: Blackwell Publ.
- Denzin, Norman K. (2005): *Selling images of inequality: Hollywood cinema and the reproduction of racial and gender stereotypes*. In: M. Romero and E. Margolis (eds.): *The Blackwell Companion to social inequalities*. Malden, MA: Blackwell Publ.
- Eichler, Margrit (1998): *Offener und versteckter Sexismus. Methodisch-methodologische Anmerkungen zur Gesundheitsforschung*. In: Arbeitskreis Frauen und Gesundheit im Norddeutschen Forschungsverbund Public Health (eds.): *Frauen und Gesundheit(en) in Wissenschaft, Praxis und Politik*. Bern: Verlag Hans Huber.
- Eichler, Margrit, Judith Fuchs and Ulrike Maschewsky-Schneider (2000): *Richtlinien zur Vermeidung von Gender Bias in der Gesundheitsforschung*. In: *Zeitschrift für Gesundheitswissenschaften* 4: 293-310.
- Eichler, Margrit and Mary Anne Burke, forthcoming: *Dynamics of change: From GBA to the BIAS FREE Framework through a transformative experience in Costa Rica*. In: Ulla Walter and Brigitte Neuman (eds.): *Gender in prevention and health promotion: Policy, research and practice*. Vienna: Springer Verlag.
- Farmer, Paul. 1997. *Social scientists and the new tuberculosis*. *Soc. Sci. Med.* 44 (3):347-358.
- Henry, Frances, Carol Tator, Winston Mattis, and Tim Rees. 2000. *The Ideology of Racism*. In *The colour of democracy. Racism in Canadian society*. Toronto: Harcourt and Brace Canada.
- Fuchs, Judith, Kris Maschewsky and Ulrike Maschewsky-Schneider (2002): *Zu mehr Gleichberechtigung zwischen den Geschlechtern: Erkennen und Vermeiden von Gender*

- Bias in der Gesundheitsforschung. Deutsche Bearbeitung eines vom kanadischen Gesundheitsministerium herausgegebenen Handbuchs, erarbeitet von Margrit Eichler et al., Dezember 1999. Blaue Reihe. Berlin: Berliner Zentrum Public Health.
- Lollar, Donald J. (2001): Public health trends in disability. In G. L. Albrecht, K. D. Seelman and M. Bury (eds.): Handbook of Disability Studies. London: Sage.
- Longino, Helen (1993): Essential tensions – phase two: Feminist, philosophical, and social studies of science. In: L. M. Antony and C. Witt (eds.): A Mind of One's Own: Feminist Essays on Reason and Objectivity. Boulder: Westview Press.
- MacDonald Quiceno, Jessica (2008): A case study of the application of The BIAS FREE Framework for the elimination of gender bias in the process of transforming the Women's Hospital in San José, Costa Rica: documentation of the experience. Geneva: Global Forum for Health Research.
- Peck, Peggy (2005): Aspirin won't prevent 1st heart attack in women. WebMD Medical News 2005 [cited June 11 2005]. Available from www.medicinenet.com/script/main/art.asp?articlekey=46164.
- Pfohl, Stephen (2005): New global technologies of power: Cybernetic capitalism and social inequality. In: M. Romero and E. Margolis (eds.): The Blackwell Companion to social inequalities. Malden, MA: Blackwell Publ.
- Physicians' Health Study Website (2005): Physicians; Health Study 1. Harvard University 2005 [cited June 11 2005]. Available from <http://phs.bwh.harvard.edu/phs1.htm>.
- Ridker, P.M., N.R. Cook, Lee I.-M., D. Gordon, J.M. Gaziano, J.E. Manson, C.M. Hennekens, and J.E. Buring (2005): A randomized trial of low-dose Aspirin in the primary prevention of cardiovascular disease in women. In: New England Journal of Medicine (352): 1293-1304.
- Smedley, Brian D., Adrienne Y. Stith, Alan R. Nelson, Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, Board on Health Sciences Policy, and Institute of Medicine of the National Academies (eds.) (2003): Unequal treatment. Confronting racial and ethnic disparities in health care. Washington, D.C.: National Academies Press.
- Status of Women Canada (1996): Gender-based Analysis. A guide for policy-making. Ottawa:: Status of Women Canada.
- Warren, Karen J. (1993): The power and promise of ecological feminism. In: M. E. Zimmerman, J. B. Callicott, G. Sessions, K. J. Warren and J. Clark. Englewood Cliffs (eds.): Environmental philosophy. From animal rights to radical ecology: Prentice Hall. Original edition, 1990.
- Weber, Max (1977): 'Objectivity' in social science and social policy. In: T. McCarthy (ed.): Understanding and social inquiry. Notre Dame: University of Notre Dame Press.

Gender Based Strategies for Public Health Activism: Tools from Social Epidemiology to Address Inequalities in Women's Health ¹

Julie Cwikel

Women's health is one of the areas that challenge medicine and public health to address both the biological factors of the individual and the macro, embedded social, religious and cultural factors that dictate gendered roles, statuses, expectations, exposures and access to resources, both general and health-related². There are several universal facts relevant to women's health: 1) women's fecundity; 2) women's constricted access to power, decision-making, political clout and economic resources in most societies, as compared to men; 3) women's longer life expectancy, as compared to men and 4) poorer health status than men in terms of disability, morbidity and chronic illness on (Ashford & Clifton 2005; Buvinic, Médict, Fernández & Torres 2006; education) 1995; Stern 1996; Verbrugge & Wingard 1987). These facts create three types of health inequality: 1) poorer socio-economic position which shapes the determinants of health such as nutritional status, self-esteem, distribution of work load, access to safe water, housing and the ability to live without fear of violence 2) unequal access to education that limits women's ability to recognize symptoms and act on them to protect health status 3) unequal access to quality health care to treat health conditions and problems (Abu-Duhou, Liping & Manderson 2003; Astbury 2001; Buvinic, Médict, Fernández & Torres 2006; Williams 2002).

Recognizing that promotion of women's health are the result of a series of macro conditions, such as discriminatory gender roles and division of labor, limited economic resources and political power coupled with increasing globalization of media, markets and services has emphasized the need for the development of strategies for public health activism to address these health challenges. Effectively addressing health inequalities is not solved through one or two quick, sectoral interventions but requires action on many fronts and levels. There is an urgent to empower women and men, lay persons and professionals at the group, community, regional and national levels with empirically-based, effective strategies (Assai, Siddiqi & Watts 2006; Astbury 2001; Cottingham, Fonn, Garcia-Moreno et al. 2001; Filippi et al. 2006; Freedman et al. 2005; Krieger 2001; McKinlay 1990; Perkins 1995;

¹ An earlier version of this paper was presented at EWHNET, Berlin, Oct 7, 2007

² Definitions: 'Sex' refers to the biological classification of individuals as either male or female, while 'gender' refers to the socially and culturally prescribed roles that men and women hold in a given society and the balance of power and resources between them. Gender is also an individual's self-representation as male or female that is shaped by exposure to cultural, social and economic interactions and expectations and reinforced by experiences with the environment.

Prilleltensky 2003; Stein 1997; Wallerstein 2006). These strategies have developed in a variety of professions and approaches to health including: health promotion, community psychology, human rights, economic empowerment and development, public health, education, participatory action research, nursing, social work, and community organizing (Barten, Mitlin, Mulholland, Hardoy & Stern 2007; Campbell & Murray 2004; J. Cwikel 2008; J. G. Cwikel 2006; Estacio 2006; Garcia-Moreno, Heise, Jansen, Ellsberg & Watts 2005; Geronimus 1992; Hamand 1996; Kar, Pascual & Chickering 1999; Laurence & Weinhouse 1997; Lopez-Carlos & Zahidi 2005; Moane 2003; Travers 1997; Warren, Markovic & Manderson 2006; Watts, Williams & Jagers 2003).

Public health activism has been shown to be effective in preventing or combating (for example): poverty, partner-violence, HIV risk factors, tobacco use, female genital mutilation (FGM), high risk sexual behaviour and maternal mortality and creating access to better health care for low income, migrant or immigrant women, in both developing and developed countries (Assai, Siddiqi & Watts 2006; Barten, Mitlin, Mulholland, Hardoy, & Stern 2007; Birenbaum-Carmeli 1995; Breckenridge & Mulroney 2007; Bustamante-Forest & Giarratano 2004; Chatterjee 1998; J. Cwikel 1999; Cwikel 2008; Ernster, Kaufman, Nichter, Samet, & Yoon 2000; Frohmann 2005; Gala 1997; Hamand 1996; Hatashita, Hirao, Brykczynski, & Anderson 2006; Kar, Pascual & Chickering 1999; Kim et al. 2007; McGovern 2007; Pronyk et al. 2008; Rana et al. 2007; Schusterman & Hardoy 1997; Toubia & Sharief 2003; Travers 1997). A detailed description of the full range of these strategies, which for the remainder of the paper will be termed "public health activism" is beyond the scope of this paper. Interested readers are referred to the papers and books listed above. However, all of these strategies form the tools, methods and concepts of social epidemiology which is the focus of the remainder of this paper (Cwikel 2006; Krieger 2001).

As a social epidemiologist and community activist and drawing on my experiences as the founder and director of Israel's only academic center on Women's Health Studies at Ben Gurion University of the Negev, I want to share some of my insights and experiences from 10 years of work honing these strategies in the "real world". The Negev, the southern region of Israel, is the most sparsely populated region in the country. It includes a culturally heterogeneous population of Jews from the former Soviet Union, Ethiopia, East and West Europe, North Africa, and North and South America, as well as a large Bedouin (formally nomad), Arabic-speaking Muslim population. The Negev region is characterized by higher rates of unemployment, more difficult economic circumstances and a higher proportion of immigrants in the population than the central and northern regions of the country.

The Center was established 10 years ago with mandate to provide an umbrella organization to conduct multidisciplinary research, collect protocols from health promotion efforts so that it would be possible to learn from field

experience and develop new health promotion efforts and training programs. The research and community health promotion programs that operate in the Center are based on collaboration with the Soroka University Medical Center and other government and non-governmental agencies throughout this area. The guiding models used in the Center are derived from feminist theories on health and health status e.g. (Abu-Duhou, Liping & Manderson 2003; Ashford & Clifton 2005; Krieger 2003; Krieger & Gruskin 2001; Mohanty 2005; Narrigan, Jones, Worcester & Grad 1997; Orbach 1978; Reinhartz 1992; Verbrugge & Wingard 1987; Wingood & DiClemente 2000; Wingood, Scd, & DiClemente 2000; Zierler & Krieger 1997) The tools we use for research, however, derive from social epidemiology (Cwikel 2006).

This paper will briefly present the principles of social epidemiology (Cwikel 2006). This article then outlines seven lessons derived from Social Epidemiology which can be used to develop gender-based strategies for public health activism. These lessons are:

1. Use SOCEPID model as heuristic to move from research questions to public health activism
2. Differentiate between health challenges according to the population in question
3. Become familiar with the terminology in order to facilitate multi-disciplinary work
4. Learn to move between paradigms in both research and program planning.
5. Build research and health promotion programs with cultural sensitivity
6. Remember how public health advances were made in the past – and tailor your strategies accordingly
7. Incorporate new models, theories and strategies into women's health promotion.

Introducing Social Epidemiology

I vividly remember studying for my Ph.D. at the University of Michigan's School of Public Health in Ann Arbor in the early years of the HIV epidemic. I had come to public health with an activist background derived from experience as a social worker working with diverse populations. When I heard two of my professors (Prof. Larry Brilliant and Prof. Jill Josephs) talk about social epidemiology in the context of the HIV epidemic that was unfolding, I felt I had finally found my calling. Social epidemiology seemed the perfect vehicle to combine between empirical research and social activism in health. I asked them where the textbook was and was told "There is no textbook – no one really knows what social epidemiology is". Propelled by this apparent lacuna in theory

and practice, I invested 12 years of intensive work to produce ‘Social Epidemiology: Strategies in Public Health Activism’ (www.publichealthactivism.com). The thrust of the approach encourages researchers and practitioners to move from public health research to practical applications that address issues such as gender-equity in health care³.

There are a range of strategies suitable for gender-based public health activism. They need not be bound by a single set of theories and approaches to what constitutes public health activism, but can on experience and examples from North and South American, Europe, Africa, South East Asia and Pacifica. Portraits of significant researchers and their contribution to social epidemiological theory relevant to women's health such as Ignaz Semmelweis (1818-1865)⁴ (Cwikel 2006:131-134) and Alice Stewart (1906-2002)⁵ (Cwikel 2006:460-466) also provide personal case examples of public health activists in action.

Defining Epidemiology and Social Epidemiology

The word *Epidemiology* derives from three Greek roots – *epi* (among) – *demos* (the people) – *logos* (the theory) meaning the study of factors and conditions that afflict the people and shares the same Greek root as *Epidemic* (Cwikel 2006: 6) The tools of epidemiology developed first from infectious diseases and in the past 50 years also from studies of chronic illness such as cancer and heart disease.

The definition of social epidemiology is:

Social epidemiology is the systematic and comprehensive study of health, well-being, social conditions or problems, and diseases and their determinants, using epidemiology and social science methods to develop interventions, programs, policies, and institutions that may reduce the extent, adverse impact, or incidence of a health or social problem and promote health (Cwikel 2006: 4).

This definition is considerably broader and more applied than other definitions of social epidemiology which maintain that social epidemiology is “*the branch of epidemiology that studies the social distribution and social determinants of states of health*” (Berkman and Kawachi 2000: 6). In addition, according to this approach, social epidemiology is also:

⁷ In the meantime, an edited volume on essays on social epidemiology appeared in 2000 which reviewed data on specific social determinants of health (Berkman & Kawachi, 2000).

⁴ Hungarian gynecologist and researcher, Semmelweis demonstrated that physicians who did post-mortems infected women birthing in the Vienna General Hospital and caused high rates of maternal mortality from puerperal fever. He instituted washing procedures which in part reduced this rate.

⁵ Dr Stewart, an English physician and epidemiologist who demonstrated the connection between fetal X-rays and childhood leukemia. Her academic career suffered due to her "whistleblowing".

1. Evidence-based using current research methods
2. Culturally appropriate and builds culturally sensitive health promotion efforts.
3. Can incorporate social factors can be on both sides of the equation: social determinants of health AND the social condition we want to study, e.g. domestic violence, depression, gender inequality
4. Integrates qualitative & quantitative data collection
5. Suitable for hard to access populations such a women living and working illegally in a country, infected with HIV or other sexually transmitted infections, lesbian or transgender.
6. Addresses complicated social/health problems and encourages effective health promotion.
7. Based on biopsychosocial and salutogenic models of health with a focus on what keeps people healthy not just what makes them sick, thus emphasizing the importance in investing in prevention and not just in *"putting out health-care fires"*.
8. Emphasizes learning from successes and failures in healthcare (Cwikel, 2006:4-22)

Roots of Social Epidemiology and Public Health Activism

Current social epidemiology developed from public health, social medicine and practice of visionaries like Rudolf Virchow (1821-1902).⁶ Virchow was Germany's father of cellular pathology, an early social epidemiologist who proposed a model of "multifactorial disease causality". He felt that epidemics were affected by social conditions (political power, economic insecurity etc.). An activist, he was involved in the Medical Reform movement of 1848, helping to clean up Berlin, and using principles of urban design to create a 'healthy city' (Cwikel 2006: 111, 127-128). Virchow was also part of the group of medical reformers of 1848 (Rudolf Virchow, Salomen Neumann, Rudolph Leubuscher) who first outlined activism principles for social epidemiology including scientific surveys of the relationship between social conditions and health and the establishment of government public health agencies (Rosen, 1958, 1993: 230-233).

Other early activists include the husband-wife teams of Sidney and Emily Kark and their students John and Margaret Cassel, Zena Stein and Mervyn Susser. This group together forged principles for preventive medicine and established community health centers in South Africa working with black South

⁶ The conference took place at the Campus named for Rudolph Virchow.

Africans. They were forced to leave South Africa during the onset of apartheid (Cwikel 2006: 135-139) and were eloquent witnesses to the impact of discrimination and social exclusion on health.

Seven Lessons for developing gender-based strategies for Public Health Activism

1. SOCEPID MODEL – step-by-step process for public health activism (Cwikel 2006: 168) (See Figure 1 below)

A heuristic was developed to delineate the steps needed to move from identifying a health or social problems (like gender inequity) and then proceed to public health activism. It consists of three stages – 1) developing a conceptual framework which draws on qualitative methods such as key informant interviews, clinical observations, field experiences and incorporates cultural sensitivity 2) integrating research and data based on the epidemiological triangle of agent, host and environment (Cwikel 2006: 50-51) 3) moving from empirical findings to new programs, policies, further research and materials to debrief and disseminate among interested parties. This model has been used to guide research on: women's heart health, trafficked women who are exploited in the sex industry and reducing excess maternal mortality. The word SOCEPID is used to emphasize these steps as below:

- S – Synthesis of social issues – whose problem is this?
- O – Observations and qualitative data
- C – Cultural awareness in designing research, collecting data and developing interventions
- E – Epidemiological triangle (host, agent, environment) as the basis for analyzing Empirical data –. Incorporating these stages leads to:
- P – Policies & Programs
- I – Ideas for future research
- D –Debrief & Disseminate the findings

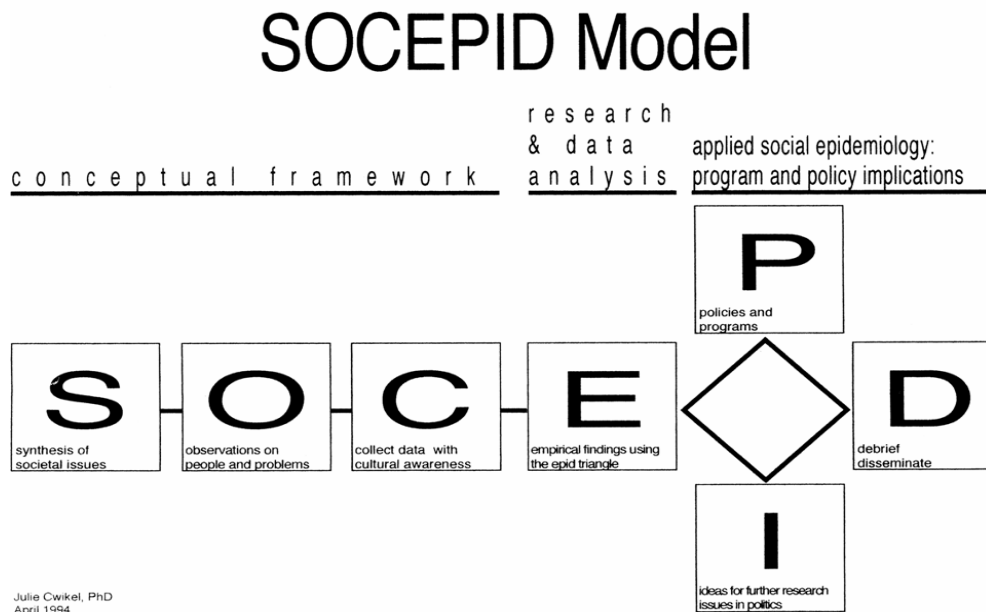


Figure 1: The Socepid Model

2. Differentiate between Women's Health Challenges According to the Population in Question

Part of developing culturally sensitive research and programme planning for promoting gender equality is based on recognizing that women's health challenges are not the same in developing nations, in stable Western-economies and among the sub-populations of inequality and discrimination that live on the margins of the developed countries without adequate access to health and human resources. According the World Health Organization, we can divide health challenges into three major groups (Yach, Mathews, Buch, 1990:508; Cwikel 2006: 347).

- Challenges of poverty (developing world): infectious disease, malnutrition, violence and war, diseases related to exposure to elements such as poor housing, inadequate protection from storms and ecological disasters. These problems particularly affect children and women.
- Challenges of industrialization (developed world) that relate to lifestyle: CHD, cancer, psychiatric illnesses and adverse and long-term effects of toxic exposures such as air pollution, smoking, water and marine pollution. These affect the health of men and women to a similar degree.
- Challenges and conditions of social instability and stigma: STDs, unwanted pregnancies, drug use, crime and the health problems of 'invisible populations' including trafficked women, illegal immigrants, gay persons, and persons living with disabilities. These are populations that are hard to reach out to in the development of community health programs and some of these populations include high proportions of women.

Social epidemiology provides tools to address the health challenges of these three different groups of women. For example, promoting Safe Motherhood and preventing excess maternal mortality is a health challenge that is concentrated in the developing world (Cwikel 2008: 19). Using a feminist approach to health promotion is exemplified by policies and programs needed to develop heart disease prevention programs for women (Cwikel 2006: 347; Mokuau, Hughes, & Tsark 1995; Young, Cunningham & Buist 2005). Finally, within developed countries women who have been trafficked across international borders for work within the sex industry can be found and represent the challenges of an ‘invisible population’ that require services from the health, welfare and police protection agencies but often are too frightened or intimidated to access them (Hoban, Gordon, & Maltzahn 2003; Zimmerman et al. 2008).

3. Become Familiar with the Terminology in Order to Facilitate multi-disciplinary Work

An issue that mystifies students and researchers alike is finding the parallels and differences between terms and concepts that regularly pop up in the literature. The ‘new public health’, ‘social determinants of health’, ‘upstream public health’ are examples of these sometimes confusing terms which have all been used to describe social epidemiology. Social capital, social support, social networks are all terms that are used to describe overlapping characteristics of the social environment where people live and work.

Quoted in the book is the story attributed to the medical sociologist, Irving Zola about the physician who describes his work through a parable (McKinlay 1990). On the banks of a river he jumps into the stream at the cry of a drowning man, pulls him to shore, applies artificial respiration and just as he gets the guy to breathe, another cry, and jumps in again and again, without ever getting the chance to “*see who the hell is upstream pushing them all in*” (Cwikel 2006: 88). Thus, upstream public health looks at the distal, macro, social factors such as health resources, advertising, organization of medical care, political factors that affect the health of individuals, groups and populations. These are all similar terms but often used as though they were different.

By contrast, the downstream practice of medicine, psychology, social work, nursing and many other allied health professions works with patients and clients on a one-by-one basis. This is when we focus on the proximate, micro and individual risk and protective factors that differentiate people. We should remember that each one represents a population with problems that are similar affected by macro, upstream factors. When we focus on the micro we often lose track of the macro issues and visa versa. It is important for those who deal in big numbers to remember that each case represents a person, a child or a family. A better understanding of the terms, concepts and ‘lingo’ used in each professional

group will increase the chances that we can build multidisciplinary teams that will be able to work effectively together.

4. Learn to Move Between Paradigms in both Research and Program Planning

Like understanding the lingo, learning to identify paradigms in research is essential in order to promote creativity and innovation to meet today's health challenges. It is imperative that we become aware of the predominant paradigm in the topic of our research and try to think "outside of the box" to find new ways to conceive of, conduct and apply research. Thus, for example, many researchers have been stuck with working either in qualitative or quantitative research methods without venturing into the new combinations of qualitative and quantitative research designs known as 'mixed methods'. Considered the 'third paradigm' in research, mixed methods designs allows researchers the options of choosing research methods in order to address challenging research questions, create richer data sets and develop more practical research findings (Mendlinger and Cwikel 2008: 281). The SOCEPID model incorporates both ways of inquiry and thus is aptly suited to applications for addressing health inequalities. So, for example, an intervention in South Africa used micro-finance and gender issues education to address HIV risk, prevention of intimate partner violence and poverty and documented its success using a combination of both qualitative and quantitative methods to capture the richness of the intervention program (Kim et al. 2007; Pronyk et al. 2008).

In another example, excess maternal mortality is the greatest health inequality in the world, since 99% of it is concentrated in the developing countries (Cwikel 2008: 22). It is estimated that as much as 3/4 of these 600,000 annual deaths could be prevented if what is currently known were applied in the countries with the highest rates of maternal mortality. Some developing countries have done very well in reducing maternal mortality and others have made no progress at all. Learning from those countries that have been successful in reducing maternal mortality shows that both distal and proximate causes need to be addressed. Distal causes such as the unequal distribution of wealth and resources, a conservative political agenda, low priority given to women's health care, inadequate medical facilities and a shortage of trained professionals and rampant gender inequality relating to access to health care services are implicated in this health inequality.

Proximate causes are also important in reducing excess maternal mortality. These include: lack of attended births by trained medical professionals, lack of transportation for emergency situations (a healthy woman can bleed to death in two hours), unwanted pregnancy, early marriage, and blocked social opportunities for women such as education and social development. Only by

addressing both distal and proximate causes is progress on this important health goal possible (Cwikel 2008: 28-32).

5. Build Research and Health Promotion Programs with Cultural Sensitivity

One of the most robust findings in social epidemiology is that social class as measured by parameters such as socio-economic status, achieved education, and inherited social class has a profound effect on all health outcomes, regardless of whether we are talking about infectious disease morbidity or mortality from chronic illness such as cancer (Antonovsky 1967: 31; Cwikel 2006: 78-79; House et al. 1990: 383). Another finding that has been often shown is that this relationship between social class and health is much stronger within countries than between countries. Countries with the same average per capita income may distribute the nation's wealth in different ways to either reduce relative poverty between groups or increase the gaps between the 'haves' and the 'havenots' (Wilkinson, 1992: 1083).

As indicated in the section on health challenges above, within specific sub-groups there are different health challenges as well as ways of relating to health relative to other values such as religion, political affiliation, connections with family and extended family (Cwikel 1999). Health is a value that is culturally embedded as therefore it is essential that any program that tries to address social or health inequalities must incorporate this understanding. Sometimes the point of entry for health promotion interventions is through church or religious organizations or through the intervention of religious or spiritual leaders. For example, those raised in a Western democratic world view feel that polygamy is a serious breach of women's rights for self-determination. For women who live in societies where polygamy is common, such as Arab-speaking Bedouin women of the Negev of Israel, according to their world view, to live as a single, divorced mother is a far worse option. In these societies, considered 'high context' by virtue of the emphasis on the collective rather than on the individual, it is important to understand how health is valued relative to other values as respect for elders and the tribe (Cwikel 1999: 100).

In addition, each ethnic group has its unique way of expressing distress, physical and emotional pain. Some are very likely to see help of health care professionals, other groups less so. Only personal and in-depth knowledge of the target group allows the development of culturally sensitive health promotion that reflects the health risks, concerns and protective factors in each culture and culture. For example, in the Hawaiian and Pacific Islanders culture, large body size is considered a mark of royalty, prestige and a reason for respect (Mokuau et al. 1995: 48). Thus, developing programs to promote heart health and prevent diabetes with these populations must take this into consideration. Therefore, a

heart health promotion project for Hawaiian women integrated culturally accepted foods such as fish, taro (a starchy tuber) and tropical fruits and organized them around extended family meals and social gatherings.

While it is acceptable and culturally appropriate for women to exercise in the open air and at the workplace in China, this is not the case in all cultures. For example, while group exercise is acceptable for Israeli Jewish women, it is not culturally appropriate for Bedouin women to exercise in the open as women are typically chaperoned and don't appear in public on their own. In another example from our work with Bedouin women struggling with poverty and single parenthood (usually from widowhood), we found that they used a variety of materials such as clay and weaving and familiar items from their lifestyle such as palm trees, the wind and animals from their herds as their 'idiom of distress' to express pain that would ordinarily be somatized in physical complaints (Huss & Cwikel 2008: 140-142). As health educators from outside their culture, it is necessary to learn their 'idiom' and to be able to understand their way, through art materials which can speak 'loudly' through the medium of art work as a way to express their concerns.

6. Remember how Public Health Advances were made in the Past – and Tailor your Strategies accordingly

Once we have research results that we can organize into a comprehensive picture of the health issue at hand using the epidemiological triangle (agent, host, environment), we are in the position to translate these findings into applied social epidemiology, i.e. health promoting programs, interventions with specific populations and health policies. It helps to remember that advances in public health in the past were made in the following ways:

- Eradicating a noxious agent (e.g. eliminating FGM, eliminating high dowry prices, cleaning up environmental contaminants, eradicating small-pox, polio and River blindness, purifying water in order to prevent cholera)
- Separating susceptible hosts from noxious agents (e.g. use of barrier methods to prevent STD infection, removing violent partners from home to prevent intimate partner violence, building shelters and temporary housing to provide shelter for populations in war or disaster areas)
- Increasing host resistance to noxious agents (e.g. education in general and health education in particular, training of health professionals from various ethnic groups, improving social capital in a specific community, teaching teens to say 'no' to drugs, alcohol and high risk sexual behaviors)

- Reinforcing elements in the environment that prevent agents from affecting susceptible hosts (e.g. better reproductive health services, laws to prevent honor killings, dowry death, better health policy to ensure access to services, special health care services for hard to access populations, developing effective law enforcement practices to stem the tide of women being trafficked across borders for exploitation in the sex industry).

When these four strategies are combined with an analysis based on the epidemiological triangle, many options and opportunities for research and program development to address health inequalities become apparent.

7. Incorporate New Models, Theories and Strategies into Women's Health Promotion

The book outlines a number of new public health strategies that are effective in addressing public health challenges such as gender inequity. While beyond the scope of this chapter to give details of all of them, it might be helpful to at least mention:

- Individual models of behaviour change for health promotion (Cwikel 2006: 273-292; (Cwikel 1999; Kar, Pascual, & Chickering 1999; Warren, Markovic, & Manderson 2006)
- Participatory action research and other strategies of community intervention (Cwikel 2006: 294-308; Barten, Mitlin, Mulholland, Hardoy, & Stern 2007; Purdey, Adhikari, Robinson, & Cox 1994; Rodriguez 1999; Shannon et al. 2008; Travers 1997)
- Media advocacy (Cwikel 2006: 293, 480; Campbell & Murray 2004; Mackenzie, Chapman, Salkeld, & Holdin, 2008; Manguyu 1995; Shannon et al. 2008; Yach 2000)
- Coalition building (Cwikel 2006: 396-397; Bigby, Ko, Johnson, David, & Ferrer 2003; Kar, Pascual, & Chickering 1999; Lythcott, Green, & Kramer Brown 2003; McGovern 2007)
- “Stepped programs” for reaching complex goals. Health promotion works best when we have specific data for the target population and we set a specific number of public health goals based on research and with a set of time targets and empirical indicators for reaching the goals. An example of this can be drawn from work to promote Safe Motherhood in developing countries. One of the predictors of excess maternal mortality is the rate of women birthing without the attendance of a qualified health care professional (Rasch 2007: 167). Globally, there are great variations in the rate of skilled attendance at childbirth, with the lowest being in sub-

Saharan Africa (48%). So, a stepped program would be to set a goal as follows: If 0-25% births attended, aim for 50-75%, if 50-75%, then aim for 100%. This is one of the effective methods that were used in the countries that have successfully reduced excess maternal mortality (AbouZahr 2003; Filippi et al. 2006; Rana et al. 2007). This same type of approach can be used with all determinants of excess maternal mortality such as: young age at marriage, access to reproductive health services, lack of education for women, and access to transportation to emergency health care during pregnancy.

When we combine social epidemiological research and intervention methods together with gender-based sensitivity and analysis, we are able to develop a range of effective strategies to address health challenges in women's health. This might allow us to make further progress toward gender equality in health, in Europe and world-wide.

References

- AbouZahr, C. (2003): Safe motherhood: a brief history of the global movement 1947-2002. *Br Med Bull*, 67, 13-25.
- Abu-Duhou, J., Liping, Y. and Manderson, L. (2003): *Gender sensitivity and gender-based analysis in women's health development: Historical outlines and case studies of best practice*. Kobe Japan: WHO Kobe Centre.
- Antonovsky, A. (1967): Social class, life expectancy and overall mortality. In: *Milbank Mem Fund Q*, 45(2): 31-73.
- Ashford, L. and Clifton, D. (2005): *Women of our world*. Washington, D.C.: Population Reference Bureau.
- Assai, M., Siddiqi, S. and Watts, S. (2006): Tackling social determinants of health through community based initiatives. In: *BMJ*, 333(7573): 854-856.
- Astbury, J. (2001): The state of the evidence: gender disparities in mental health. In: M. C. de Mello, T. Bornemann and I. Levav (eds.): *Mental health: A call for action by World Health Ministers: 73-92*. Geneva: World Health Organization.
- Barten, F., Mitlin, D., Mulholland, C., Hardoy, A. and Stern, R. (2007): Integrated approaches to address the social determinants of health for reducing health inequity. In: *J Urban Health*, 84 (3 Suppl): 164-173.
- Berkman, L. F. and Kawachi, I. (eds.). (2000): *Social Epidemiology*. Oxford: Oxford University Press.

- Bigby, J., Ko, L. K., Johnson, N., David, M. M. and Ferrer, B. (2003): A community approach to addressing excess breast and cervical cancer mortality among women of African descent in Boston. In: *Public Health Rep*, 118 (4): 338-347.
- Birenbaum-Carmeli, D. (1995): Maternal smoking during pregnancy: social, medical, and legal perspectives on the conception of a human being. In: *Health Care Women Int*, 16 (1): 57-73.
- Breckenridge, J. and Mulroney, J. (2007): Leaving violent relationships and avoiding homelessness – providing a choice for women and their children. In: *N S W Public Health Bull*, 18 (5-6): 90-93.
- Bustamante-Forest, R. and Giarratano, G. (2004): Changing men's involvement in reproductive health and family planning. In: *Nurs Clin North Am*, 39 (2): 301-318.
- Buvinic, M., Médici, A., Fernández, E. and Torres, A. C. (2006): Gender Differentials in Health. In: D. T. Jamison, J. G. Breman, A. R. Measham, G. Alleyne, M. Claeson, D. B. Evans, P. Jha, A. Mills and P. Musgrove (eds.): *Disease Control Priorities in Developing Countries*. New York: Oxford University Press: 195-210.
- Campbell, C. and Murray, M. (2004): Community Health Psychology: Promoting Analysis and Action for Social Change. In: *J Health Psychol*, 9 (2): 187-195.
- Chatterjee, M. (1998): Women's struggle against poverty: the SEWA story. In: *Health Millions*, 24 (6): 12-15.
- Cottingham, J., Fonn, S., Garcia-Moreno, C. et al. (2001): *Transforming health systems: gender and rights in reproductive health*. Geneva: World Health Organization.
- Cwikel, J. (1999): Changing health behaviors in populations in transition. In: R. Israelowitz and Y. Friedlander (eds.): *Transitions: Russian, Ethiopian, and Bedouin People in Israel's Negev Desert*. Aldershot, UK: Avebury Publications: 91-102.
- Cwikel, J. (2008): Lessons from Semmelweis: A Social Epidemiologic Update On Safe Motherhood. In: *Social Medicine*, 3 (1): 19-34.
- Cwikel, J. G. (2006): *Social epidemiology – strategies for public health activism*. New York: Columbia University Press.
- Council on Graduate Medical Education (1995): *Fifth report: women & medicine: physician education in women's health*. Washington, D.C.: U.S. Department of Health & Human Services, Public Health Service.
- Ernster, V., Kaufman, N., Nichter, M., Samet, J. and Yoon, S. Y. (2000): Women and tobacco: moving from policy to action. In: *Bull World Health Organ*, 78 (7): 891-901.
- Estacio, E. V. (2006): Going Beyond the Rhetoric: The Movement of Critical Health Psychology towards Social Action. In: *J Health Psychol*, 11 (3): 347-350.

- Filippi, V., Ronsmans, C., Campbell, O. M., Graham, W. J., Mills, A., Borghi, J., et al. (2006): Maternal health in poor countries: the broader context and a call for action. In: *Lancet*, 368 (9546): 1535-1541.
- Freedman, L. P., Waldman, R. J., de Pinho, H., Wirth, M. E., Chowdhury, A. M. and Rosenfield, A. (2005): Transforming health systems to improve the lives of women and children. In: *Lancet*, 365 (9463): 997-1000.
- Frohmann, L. (2005): The Framing Safety Project: photographs and narratives by battered women. In: *Violence Against Women*, 11 (11): 1396-1419.
- Gala, C. (1997): Empowering women in villages: all-women village councils in Maharashtra, India. In: *Bull Concern Asian Sch*, 29 (2): 31-45.
- Garcia-Moreno, C., Heise, L., Jansen, H. A., Ellsberg, M. and Watts, C. (2005): Public health. Violence against women. In: *Science*, 310 (5752): 1282-1283.
- Geronimus, A. T. (1992): The weathering hypothesis and the health of African-American women and infants: evidence and speculations. In: *Ethn Dis*, 2 (3): 207-221.
- Hamand, J. (1996): Working for change in the Arab world. Advocacy for reproductive health: Arab world. In: *Plan Parent Chall* (1): 5-7.
- Hatashita, H., Hirao, K., Brykczynski, K. A. and Anderson, E. T. (2006): Grassroots efforts of Japanese women to promote services for abused women. In: *Nurs Health Sci*, 8 (3): 169-174.
- Hoban, E., Gordon, E., & Maltzahn, K. (2003): *"We've been to war together": Experiences of trafficked women in the Australian social, legal and political system. Report to the Myer Foundation*. Melbourne: International Social Service, Project Respect, Good Shepherd Youth and Family Service.
- House, J. S., Kessler, R. C. and Herzog, A. R. (1990): Age, socioeconomic status, and health. In: *Milbank Q*, 68 (3): 383-411.
- Huss, E. and Cwikel, J. (2008): Embodied drawings as expressions of distress among impoverished single Bedouin mothers. In: *Arch Womens Ment Health*, 11 (2): 137-147.
- Kar, S. B., Pascual, C. A., & Chickering, K. L. (1999): Empowerment of women for health promotion: a meta-analysis. In: *Soc Sci Med*, 49 (11): 1431-1460.
- Kim, J. C., Watts, C. H., Hargreaves, J. R., Ndhlovu, L. X., Phetla, G., Morison, L. A., et al. (2007): Understanding the impact of a microfinance-based intervention on women's empowerment and the reduction of intimate partner violence in South Africa. In: *Am J Public Health*, 97 (10): 1794-1802.
- Krieger, N. (2001): Theories for social epidemiology in the 21st century: an ecosocial perspective. In: *Int. J. Epidemiol.*, 30 (4): 668-677.

- Krieger, N. (2003): Genders, sexes, and health: what are the connections – and why does it matter? In: *Int J Epidemiol*, 32 (4): 652-657.
- Krieger, N. and Gruskin, S. (2001): Frameworks matter: ecosocial and health and human rights perspectives on disparities in women's health--the case of tuberculosis. In: *J Am Med Womens Assoc*, 56 (4): 137-142.
- Laurence, L. and Weinhouse, B. (1997): *Outrageous practices : how gender bias threatens women's health*. New Brunswick, N.J.: Rutgers University Press.
- Lopez-Carlos, A. and Zahidi, S. (2005): *Women's empowerment: measuring the global gender gap*. Geneva Switzerland: World Economic Forum.
- Lythcott, N., Green, B. L. and Kramer Brown, Z. (2003): The perspective of African-American breast cancer survivor-advocates. In: *Cancer*, 97 (1 Suppl): 324-328.
- Mackenzie, R., Chapman, S., Salkeld, G. and Holding, S. (2008): Media influence on Herceptin subsidization in Australia: application of the rule of rescue? In: *J R Soc Med*, 101 (6): 305-312
- Manguyu, F. (1995): Women's health, rights are vital for development. In: *Network*, 15 (3): 28-29.
- McGovern, T. (2007): Building coalitions to support women's health and rights in the United States: South Carolina and Florida. In: *Reprod Health Matters*, 15 (29):.119-129
- McKinlay, J. B. (1990): The case for refocussing upstream: the political economy of illness. In: P. Conrad and R. Kern (eds.): *The sociology of health and illness*. New York: St. Martins Press: 502-516.
- Mendlinger, S. and Cwikel, J. (2008): Spiraling between qualitative and quantitative data on women's health behaviours: a double helix model for mixed methods. In: *Qual Health Res*, 18:.293-280(2)
- Moane, M. G. (2003): Bridging the Personal and the Political : Practices for a Liberation Psychology. In: *American Journal of Community Psychology*, 31(1/2), 91.
- Mohanty, C. T. (2005): Under Western eyes: feminist scholarship and colonial discourses. In W. K. Kolmar and F. Bartowski (eds.): *Feminist theory* (2nd ed.). Boston: McGraw Hill: 372-379.
- Mokuau, N., Hughes, C. K. and Tsark, J. U. (1995): Heart disease and associated risk factors among Hawaiians. In: *Health & Social Work*, 20 (1): 46-50.
- Narrigan, D., Jones, J. S., Worcester, N. and Grad, M. J. (1997): Research to improve women's health: an agenda for equity. In: S. B. Ruzek, V. L. Olesen & A. E. Clarke (eds.): *Women's Health: Complexities and Differences*. Columbus, Ohio: Ohio State University Press.
- Orbach, S. (1978): *Fat is a feminist issue: A self-help guide for compulsive eaters*. New York: Berkley Books.

- Perkins, D. D. (1995): Speaking truth to power: empowerment ideology as social intervention and policy. In: *Am J Community Psychol*, 23 (5): 765-794.
- Prilleltensky, I. (2003): Understanding , Resisting , and Overcoming Oppression : Toward Psychopolitical Validity. In: *American Journal of Community Psychology*, 31 (1/2): 195.
- Pronyk, P. M., Kim, J. C., Abramsky, T., Phetla, G., Hargreaves, J. R., Morison, L. A. et al. (2008): A combined microfinance and training intervention can reduce HIV risk behaviour in young female participants. In: *Aids*, 22 (13): 1659-1665.
- Purdey, A. F., Adhikari, G. B., Robinson, S. A. and Cox, P. W. (1994): Participatory health development in rural Nepal: clarifying the process of community empowerment. In: *Health Educ Q*, 21 (3): 329-343.
- Rana, T. G., Chataut, B. D., Shakya, G., Nanda, G., Pratt, A. and Sakai, S. (2007): Strengthening emergency obstetric care in Nepal: The Women's Right to Life and Health Project (WRLHP). In: *Int J Gynaecol Obstet*, 98 (3): 271-277.
- Rasch, V. (2007): Maternal death and the Millennium Development Goals. In: *Dan Med Bull*, 54 (2): 167-169.
- Reinharz, S. (1992): *Feminist methods in social research*. New York: Oxford University Press.
- Rodriguez, R. (1999): The power of the collective: battered migrant farmworker women creating safe spaces. In: *Health Care Women Int*, 20 (4): 417-426.
- Rosen, G. (1958,1993): *A history of public health*. Baltimore: Johns Hopkins University Press
- Schusterman, R. and Hardoy, A. (1997): Reconstructing social capital in a poor urban settlement: the Integral Improvement Programme in Barrio San Jorge. In: *Environment and Urbanization*, 9 (1): 91-120.
- Shannon, K., Kerr, T., Allinott, S., Chettiar, J., Shoveller, J. and Tyndall, M. W. (2008): Social and structural violence and power relations in mitigating HIV risk of drug-using women in survival sex work. In: *Soc Sci Med*, 66 (4): 911-921.
- Stein, J. (1997): *Empowerment and Women's Health: Theory, Methods, and Practice*. London: Zed.
- Stern, P. N. (1996): Conceptualizing women's health: discovering the dimensions. In: *Qualitative Health Research*, 6 (2): 152-162.
- Toubia, N. F. and Sharief, E. H. (2003): Female genital mutilation: have we made progress? In: *Int J Gynaecol Obstet*, 261-251, (3) 82.
- Travers, K. D. (1997): Reducing inequities through participatory research and community empowerment. In: *Health Educ Behav*, 24 (3): 344-356.

- Verbrugge, L. M. and Wingard, D. L. (1987): Sex differentials in health and mortality. In: *Women Health*, 1.145-103 ,(2)2
- Wallerstein, N. (2006): *What is the evidence on effectiveness of empowerment to improve health?* Copenhagen, Denmark: World Health Organization [WHO], Regional Office for Europe, Health Evidence Network.
- Warren, N., Markovic, M., & Manderson ,L. (2006): Typologies of rural lay-health advocacy among rural women in Australia. In: *Women Health*, 43 (4): 27-47.
- Watts, R. J., Williams, N. C. and Jagers, R. J. (2003): Sociopolitical development. In: *Am J Community Psychol*, 31 (1-2): 185-194.
- Wilkinson, R. G. (1992): National mortality rates: the impact of inequality? In: *Am J Public Health*, 82 (8): 1082-1084.
- Williams, D. R. (2002): .Racial/ethnic variations in women's health: the social embeddedness of health. In: *Am J Public Health*, 92 (4): 588-597.
- Wingood, G. M. and DiClemente, R. J. (2000): Application of the theory of gender and power to examine HIV-related exposures, risk factors, and effective interventions for women. In: *Health Educ Behav*, 27 (5): 539-565.
- Wingood, G. M., Scd, and DiClemente, R. J. (2000): Application of the theory of gender and power to examine HIV-related exposures, risk factors, and effective interventions for women. In: *Health Educ Behav*, 27 (5): 539-565.
- Yach, D., Mathews, C. and Buch, E. (1990): Urbanization and health: methodological difficulties in undertaking epidemiological research in developing countries. In: *Soc Sci Med*, 31 (4): 507-514.
- Yach, D. (2000): Partnering for better lung health: improving tobacco and tuberculosis control. In: *Int J Tuberc Lung Dis*, 4 (8): 693-697.
- Young, L. E., Cunningham, S. L. and Buist, D. S. (2005): Lone mothers are at higher risk for cardiovascular disease compared with partnered mothers. Data from the National Health and Nutrition Examination Survey III (NHANES III). In: *Health Care Women Int*, 26 (7): 604-621.
- Zierler, S. and Krieger, N. (1997): Reframing women's risk: social inequalities and HIV infection. In: *Annu Rev Public Health*, 18: 401-436.
- Zimmerman, C., Hossain, M., Yun, K., Gajdadziev, V., Guzun, N., Tchomarova, M., et al. (2008): The health of trafficked women: a survey of women entering posttrafficking services in Europe. In: *Am J Public Health*, 98 (1): 55-59.

Migrants, Discrimination and Equity in Access to Health Promotion and Health Care

Annemiek Richters

1. Introduction

In multicultural societies migrant or ethnic minority groups frequently belong to the socially disadvantaged groups that systematically experience worse health, have a worse health status and are exposed to greater health risks than more socially advantaged groups. One of the factors that may contribute to such health disparities is a lack of access to health promotion and health care services. Most studies about ethnicity related health differences have been done in the United States. It is during the last decade that a slowly increasing number of such studies have been conducted in European countries. In this chapter I will present some results of a selection of these studies, starting with studies of self-perceived 'not good' health among different ethnic groups, to be followed by studies on ethnicity related disparities in access to health promotion and health care. Access to health care services in this chapter includes: a) being acquainted with the various health care services that are available; b) making use of these services, and c) being provided with adequate care by these services. Where this access is unjust or unfair I will use the term inequity. I thereby take note of the observation by Geiger (2006) that the term equity carries a stronger connotation of moral concern than the term disparities or the even more neutral term differences. It places such phenomena more clearly in broader social contexts of differentiation by race, ethnicity, social class, and gender, which entails differences in power, privilege, and resources, and the different life experiences and life opportunities that result.

My moral concern in this chapter will gradually narrow down to discrimination in relation to ethnic differences in the context of health care. With the use of case studies I will examine ethnic discrimination as a barrier to access to adequate care, which may contribute to inequity in health outcomes. The case studies to illustrate the issues at stake have been selected from research undertaken by Partners for Health – a European project aimed to identify and fight discrimination against migrants in health care –, observations made by Dutch medical students during their internships¹, and anthropological studies representing the perspective of patients. I will end by summarizing the toolkit for combating discrimination in health care, as developed by Partners for Health. Throughout the chapter I will pay special attention to female migrants and thus focus on the intersection of gender and ethnicity.

¹ Students deliver reports of their observations and their own experiences regarding care delivered to migrant patients at the end of their internships for the purpose of discussion of intercultural care issues in a subsequent teaching session.

2. Ethnicity Related Health Differences in Europe: a Selection of Examples of Results of Epidemiological Studies

Differences in self-reported Health

My impression gained from the literature to date is that most surveys done in Europe of ethnic differences in health and access to health care are carried out in Britain. Where evidence exists, it shows that the overall health experience of ethnic minority groups is worse than that of the White British population. This does not necessarily mean that the self-reported health of the White British population scores highest, if a differentiation is made between ethnic groups. In a census done in 2001 among a population living in England and Wales, the sample population was subdivided in 16 ethnic groups. The White British group scored as number 5 in the ranking from self-reported good to bad health. The Chinese people reported the best overall levels of good health and Pakistani and Bangladeshi people the highest levels of poor health. These disparities cannot be explained entirely by reference to class or poverty (Equalities Review 2007: 74).

While taking notice of survey results regarding differences in self-reported health between ethnic groups, we have to take the issue of the validity of these results into account. For instance, language problems and cultural differences regarding what is 'good' and 'not good' 'health' may cause a culturally determined information bias regarding 'not good health' and 'good health'. The objective health status may be different from the reported self perceived health status, as is shown, for instance, in research done by Wimmer-Puchinger et al. (2006). They focused in their studies in the nineties on differences in self-reporting on well-being between three ethnically different groups of women in Austria. The well-being of women born in Turkey was reported as worse than the well-being of women born in Austria and of women born in the former Yugoslavia. In terms of objective health status, the Turkish women also scored lowest. However, native Austrian women scored a little higher on objective health status than women from the former Yugoslavia.

Another differentiation that can be made in self-reported general health status among migrants is between generation and literacy, as was done by Bekker and Lhajoui (2004) in a sample of Moroccan Berber speaking women in the Netherlands. After controlling for age, having a job, and having an employed partner, the first generation literates reported significantly better health compared with the illiterates of the first generation. No differences were found in health condition between the literate group of the first generation and the literate group of the second generation, even after controlling for age, number of children, and marital status. The results of this study underline the importance of offering migrants optimal access to opportunities and facilities that can improve their literacy and reading ability. Regarding access to health care, however, next to general literacy and health literacy, health skills are needed. A study by

Jonkers et al. (2009) found that not only poorly educated but also highly educated migrant women had low health skills in the interaction with health care providers during their pregnancy and delivery, which contributed to unsatisfactory health care and the maternal morbidity of the women concerned. Some of these women were not confident enough to ask for medical information about diagnosis and treatment. Others were not assertive enough to ask for the necessary medical attention for their maternal complaints and to do so in time. One well-educated woman who could speak English fairly fluently explained her modest attitude in communicating with her care providers, by hinting at fear for discrimination. She said in an interview with the researcher: *“They (doctors) really hated us (referring to herself and her husband). I have to challenge the doctor. But I was new here. I try to respect the way things are here”*.

Differences in Access to Health Care Services and Health Promotion

One of the many factors contributing to ethnic disparities in self-perceived and objective health status may be a lack of access to health promotion and health care services. This lack of access can be considered as a risk factor for bad health. However, whilst studies show that access to care is often distributed unequally according to ethnic and cultural lines, it is not always the native White population that accesses services most. For instance, women who migrated from Turkey to Austria use general practitioners and gynaecologists relatively more than native Austrian women, but go less to dentists. They make more use of general check ups, but less use of breast cancer screening and cervical cancer screening. Wimmer-Puchinger et al. (2006) conclude from their own and other similar studies on female migrants and health care that the current inadequate health care for migrant women manifests itself in a lack of care in the areas of prevention and health education and an abundance of care in the context of medication and diagnostic procedures.

Also, in The Netherlands attendance rates of breast cancer screening and cervical cancer screening are lower among at least the larger groups of first generation migrant women than among native Dutch women. Visser et al. (2005) conclude from the fact that the detection rate of breast cancer among women born in non-western countries is low, that a passive attitude towards the low attendance is justified. One could also argue, however, that every woman in the Netherlands, regardless of ethnicity, has the right to be informed about available curative as well as preventive health services. From this perspective, efforts should be made to improve health education for ethnic minority women.²

² A women's health care centre in Leiden, the Netherlands, as well as the municipal health services in this area shared this opinion and did all they could to reach Moroccan-Dutch women with information about the relevance of breast-cancer screening. However, they did so with little success. They therefore asked for an exploratory study to find out the reasons for the failure of their health education efforts. One outcome of the subsequently conducted study, supervised by myself and a colleague, was that the women concerned were not able to read the information sent to them by regular mail, and another was that the women had a culturally different conception of the meaning of prevention (Richters & Van Vliet 1999).

This is certainly justified regarding cervical cancer screening, since the incidence of cervical cancer is higher among women born in non-western countries than among native Dutch women (Signaleringscommissie Kanker 2006).

Since there are indications that the cross-cultural validity of self reported data on utilisation of health care is suboptimal, Stronks et al. (2001) linked survey data on utilisation to an insurance register concerning people aged 16-64. The survey study focused on possible differences between first generation ethnic minority groups and the native Dutch population in the use of a broad range of health care services after controlling for health status. Only the largest migrant groups were included. With one exception, migrant groups proved to be more likely to consult a general practitioner and to use prescribed drugs than the native population. In contrast, the ethnic differences in the case of hospital admission, contact with outpatient specialists, contact with physiotherapists and other paramedics are much smaller and less consistent. The inequality in utilisation that was found was not accounted for by the lower socio-economic position of migrant groups alone. This implies, according to the authors, that an individual's ethnic background in itself may be a factor that affects the utilization of health care. What remains unanswered in their study is whether differences in health care consumption between ethnic groups lead to a worse health outcome among ethnic minority groups, and what the factors are that contribute to the inequality in accessibility of services.

Stirbu et al. (2006) explored the quality of the health care system and its role in influencing mortality of the large migrant groups in the Netherlands by examining ethnic variations in 'avoidable' mortality. The result of this study was that mortality risks varied greatly by cause of death and ethnic origin. Migrant women, for instance, experienced a higher risk of death from maternity-related conditions. The overall conclusion of the study is that substantial differences in mortality for a few 'avoidable' conditions suggest opportunities for quality improvement within specific areas for the health care system targeted to disadvantaged groups. Zwart et al. (2008) found in a nation-wide survey that not only maternal mortality but also severe maternal morbidity is higher among some of the migrant groups living in the Netherlands than among native Dutch women. Substandard care was found in 39 of a subset of 63 women (62%) through clinical audit. The authors conclude from this finding that reduction of severe maternal morbidity seems a mandatory challenge. The qualitative study by Jonkers et al. (2009) – to which I already referred above – on the patient perspective on the morbidity at issue, points out that the required morbidity reduction can partly be achieved on the side of obstetric care givers by more sensitivity to context-related social factors that affect health complaints by migrant women, and by stimulating participation of migrant patients in the medical decision-making process. Another recommendation is that migrant women with a low level of health knowledge should be empowered by

education about the danger signs in pregnancy and by information about the specific preferences and policies of obstetrics in the Netherlands and the importance of adopting an assertive patient role in health care. I have already mentioned above that perceived discrimination on the side of the patient perspective may be a factor which hinders access to appropriate care.

3. Discrimination in Access to Health Care Services

Studies from around the world show that there are a myriad of potential barriers in access to health care services among ethnic minorities. They can be identified at patient level, provider level, and health care system level (Scheppers et al. 2006). In the following section, I will identify and discuss some of these barriers under the label of discrimination. After some introductory remarks, I will narrow my focus to discrimination within the interaction and communication between health care provider and patient and address the question of whether the discrimination that takes place at this level leads to inequity in quality of health care and possibly, also in inequity of health outcomes.

The essence of discrimination lies in the fact that an individual is judged and treated unfair only on the basis of belonging to a particular category or group. Discrimination may lead to exclusion from health care all together or from a good quality of care. Non-discrimination is, therefore, an important consideration in the pursuit of equity of health outcomes and equity in the delivery of health promotion and health care.

Potentially, there may be a considerable difference between what is classified as discrimination in a legal sense and what is commonly referred to as discrimination in an everyday context, including the context of health care services. The core of 'everyday discrimination' is that it is often concealed and hidden behind official non-discriminatory policies. Discrimination can take many forms, to be distinguished in direct and indirect, explicit and implicit, open and hidden, conscious and unconscious, intended and unintended, formal and informal, institutional/structural and incidental, collective and individual, active and passive forms, any or all of which can overlap. They are intertwined and play at all levels of health institutes and health care settings (Van Dongen 2003).

Partners for Health conclude, based on a few studies conducted in the context of their European project³ that open, direct and deliberate institutional discrimination, which is unmistakably prohibited by existing laws, seems rare nowadays in large parts of Europe. This may still be otherwise in the United States. Hobson (2001) in a report on a study on racial discrimination in health care in this country gives examples of dramatic racist remarks made by health

³ Research results were presented during a conference held in 2004. See at www.salutepertutti.org.

care workers to their patients. For instance, one respondent in his study reported that during a breast biopsy, she asked for a sedative because of her low tolerance for pain. The nurse replied, *“You people accepted pain as part of slavery because you tolerate pain so well”*. How do we know that discriminatory remarks of this severity are not made in European health care settings? And what is the extent of less dramatic and more implicit forms of discrimination? According to Partners for Health, in large parts of Europe, most discrimination in health care takes place unconsciously and is not intended. More in depth studies are needed to confirm or refute this finding.

What seems to be rare at least in most Western European countries is outright denial of access as was the case in, for instance, South Africa. During the apartheid era in this country health care was deeply permeated by racial discrimination that was legitimated by law. Racially segregated services led to racially unequal delivery of health care. Ambulances, for instance, were only permitted to carry patients of a specific intended racial group, even in emergencies. Because ambulance services for blacks were grossly inadequate, both in quality and quantity, this usually resulted in inferior care and entirely preventable deaths. The reverse also occurred, with ambulances designated as ‘black’ refusing to take critically ill white patients (Baldwin-Ravagan 1999).

Incidences of outright denial to care in the Netherlands occasionally do exist, for instance in the case of illegal migrants. Even though by law they are entitled to the necessary care, this is sometimes withheld from them. The question is whether this happens because they are migrants or only because, regardless of their ethnicity, they cannot pay. A clear case of denial of care in which ethnic discrimination plays a role seems to me the rejection to treat a patient by a physician who says: *“If you do not want to shake hands, you better find another doctor”* (reported by medical student). Not wanting to shake hands with an doctor of the opposite sex for cultural reasons is used here as a reason to deny the patient access to care. In the Netherlands a medical doctor is supposed to have an open attitude to patients, regardless of their ethnic background, culture and philosophy of life. But what to think of a case in which the physician says to a patient: *“If you do not speak Dutch, we cannot have a trust relationship, therefore you better leave”* (reported by medical student). Is discrimination at issue here? I think it is. The patient is clearly denied access to care. In the case at hand, the physician should have tried to create a trust relationship with the patient with the help of a professional translator.

4. The Ambiguity of Discrimination

While in my opinion the cases presented above are examples of direct discrimination, not everyone may agree. The argument for disagreement may be that migrants have the duty to adapt to Dutch society. That includes learning the

Dutch language. But what if a patient worked for years in the Netherlands as a ‘guest labourer’ in long strenuous work shifts, and never got the opportunity to learn Dutch? Another issue to consider is whether what patients perceive as discrimination that prevents them from receiving adequate care can be objectively verified as being discrimination.

In a study of the quality of gynaecological and obstetric care as perceived by migrant women (Richters 2003), Turkish-Dutch women said to the Turkish-Dutch interviewer speaking in Turkish:

- *“I do not know for sure, but I think that the fact that I am not easily referred to the hospital is perhaps related to discrimination.”* (patient)
- *“A Dutch woman for instance has an appointment of sometimes half an hour, but if a Turkish person has an appointment with the doctor, she does remain in the doctor’s office five or at the most ten minutes.”* (patient)
- *“I hear from other women that the gynaecologist does not pay so much attention to his patients. They tell me that they think that the gynaecologist has a denigratory attitude towards them or looks down upon them because they do not speak Dutch.”* (Turkish-Dutch migrant health educator)

It is likely that the self-perception of these women of being discriminated is fed by societal prejudices regarding migrants they are continuously confronted with. Female Surinamese-Dutch patients who participated in the same study as the Turkish-Dutch women just quoted, characterized Dutch society’s prejudices regarding migrants as follows: *“You have people and you have allochthones”*⁴; *“They are after all just allochthones”*; *“It is no more than scum”*; *“They are allochthones, they do not understand that anyhow”*.

Empirical studies in which the interaction between physician and migrants has been observed confirm what the Turkish-Dutch women said about their treatment. A review by Schouten and Meeuwesen (2006) of fourteen of such studies revealed that there are major differences in doctor-patient communication as a consequence of patients’ ethnic backgrounds. Doctors behave less affectively when interacting with ethnic minority patients compared to White patients. Ethnic minority patients are also less verbally expressive; they seem to be less assertive and affective during the medical encounter than White patients. These findings are similar to what Meeuwesen et al. (2006) found to be the case in Dutch clinical practices. What proves difficult to identify in medical encounters is discrimination, because it is frequently such a subtle and multidimensional process. Since discrimination is often a subjective experience

⁴ In the Dutch language a dichotomy is made between autochthones and allochthones. The latter refers to persons from non-Dutch descent, ‘the others’, or people who differ from native Dutch people.

as well as a sensitive issue, it is also problematic to measure it in a quantitative way.

A clear example of self perceived discrimination is the following: a young man of Turkish descent is asked by the physician whom he consults as part of his medical history whether he uses drugs or alcohol. The patient, who does not speak Dutch very well, thought that the doctor accused him of drugs and alcohol abuse. After the short exchange of words, the patient leaves the office smashing the door behind him and sits down in the waiting room, with an attitude of *'how did that doctor get it into his head of accusing him of something like that!'* (reported by medical student).

Medical students report miscommunication due to language problems as the most common problem they encounter in medical care for migrant patients. The young man quoted above did show his indignation of what he perceived to be discrimination. How many more patients misinterpret what is said to them and perceive the misinterpreted words as discrimination, but keep silent about their feelings and do not show any sign of them? We do not know.

5. Direct and Indirect Discrimination

While it is not always clear whether discrimination is at stake, it is also not always clear what kind of discrimination is at stake. An important distinction to make is the one between direct and indirect discrimination. Direct discrimination refers to unequal treatment and care in equal circumstances, while indirect discrimination refers to equal treatment and care that has negative consequences for people belonging to specific groups.

Examples of direct discrimination reported by some of the 45 medical students who participated in one of my teaching sessions are the following:

- *“When seeing a difficult name they (the doctors) are already not taking the patient seriously before even having seen them.”*
- *“As the day progresses and the number of non-Dutch speaking patients increases, the more irritated the doctor becomes and the less patience he or she has with this patient group.”*
- *“You often see that, because of a language barrier, patients are not fully informed about a diagnostic or treatment procedure, but they nevertheless go along with what the physician decides for them.”*
- *“An emergency care nurse reacted to others regarding a woman from Somali by saying ‘Quite hysterical. She (the Somali woman) says that she vomits blood. This, of course, is total nonsense.’ It turned out that this patient had an incomplete abortion.”*

- *“What I noticed is that ‘discrimination’ is quite common in health care. When a migrant patient comes with what is interpreted as a vague complaint, this is identified as ‘typical allochthonous medical history’. What is meant is that there is a broad array of complaints with often very ‘unclear physical causes’. Thus the presentation of complaints of people with other cultures is often clearly different from the Dutch way.”*

These quotes from medical students’ reports indicate that discrimination may be more common than we tend to think.

Another example of direct discrimination is non referral of migrant patients for heart conditions or for in vitro fertilisation (IVF) in equal circumstances. But what do equal circumstances mean here? When a migrant woman has the same desire for children and is in the same medical condition as a native Dutch woman, but does not speak any Dutch, is it then discrimination if she is not referred for IVF treatment? That treatment may be complicated by language and communication difficulties and may, for that reason, have a less effective outcome than the treatment of a Dutch speaking woman.

An example of indirect discrimination is hospitalization of a Muslim woman in a non-segregated ward. Even though she is treated like other patients on the ward from the perspective of her care providers, this women may nonetheless experience the care she receives as a disaster, which may have negative consequences for her health.

Another example is the care for infibulated women giving birth. An anthropological study of this care conducted by Johansen (2006) in Norway revealed that birth routines that may be efficient in reducing fear and pain and em-powering for Norwegian women during birth, may, however, be experienced as abandonment and lack of care by Somali women. For instance, out of respect for what they considered to be a taboo practice, the health workers in this study dealt with the infibulation in silence, rarely discussing it with the women. Most health workers had strong negative emotions about infibulation, which may cause increasing detachment from the Somali women giving birth. Although these women may expect more supportive touch than Norwegians, they may receive less because of the negative feelings of the health workers. The study leaves the question open whether the emotional detachment of health care workers negatively affected the outcome of the pregnancy of the Somali women and their future reproductive health behaviour.⁵

Again, other examples of indirect discrimination are the use of diagnostic procedures in mental health care that are not appropriate for all ethnic groups, and the use of a standard dose of medicine that should have been adjusted for

⁵ Wimmer-Puchinger et al. (2006) found in Austria that because of feelings of shame, little knowledge of medical risks, and the dominance of male gynaecologists, women who were infibulated usually do not seek reproductive health care.

people of certain ethnic groups because of possible biological differences between ethnic groups regarding the reaction to medicines. Is this discrimination or simply ignorance/lack of knowledge?

6. The Opaqueness of Discrimination

Let me give some more examples of the difficulty to determine whether a certain treatment is discriminatory. The cases presented are reported by medical students.

A patient in burka was referred by her general practitioner to the outpatient department of cardiology because of chest pain during physical exertion. The female assistant in charge of making electro cardiograms (ECGs) asked the patient to expose the upper part of her body so that she could put the ECG stickers on her body. The patient refused. When the male cardiologist asked the same and despite the language barrier tried to make clear that the heart is situated in the chest and that the chest had to be exposed for a proper examination, and that the woman could only be treated after that examination, she again refused. The patient was subsequently sent home without having been treated. One could argue that the cardiologist complied with the patient's wish. On the other hand, perhaps more effort could have been made to explain the procedure with the help of a professional translator.

A child needs an emergency examination and treatment. The father of the girl demands a female doctor. However, a female doctor was not available. The father decided to take his daughter to another hospital. In this case, the lack of access to the care the father wanted led to shopping behaviour. Was this physician's behaviour – not responding to the beliefs of the father that it is improper for his daughter to be examined by a male physician – indirect discrimination?⁶

What to say about unnecessary medical procedures and tests? A specialist who does not want to lose time by trying to overcome difficult language and communication barriers, summarized his policy as follows: "A small language barrier is a large one, people who can not speak go into machines (referring to machines for CT scans)". Another specialist said: "With such people (referring to people with Arabic background) I know beforehand that I will have a CT scan made, even though that will not show anything particular".

Is it thus discrimination when general practitioners more easily refer migrant patients to specialists than native Dutch patients because of communication problems, like in the following case? A patient who speaks reasonable Dutch demands from the general practitioner that he refers his wife, who does not speak Dutch, to a neurologist for her back problems. He is not satisfied with life

⁶ The male doctor could have disrespected the wish of the father, by overruling him and taking care of the girl. By Dutch law he would have been entitled to do so if the health condition of the girl was life threatening.

style advice and painkillers. After repeated requests by the husband, without having communicated directly to the wife, the GP does refer the patient, even though he is of the opinion that the neurologist cannot do more than he can do for the patient.

One student reported about a woman who was completely veiled who presented a complaint of a harmless spot on her cheek. She had to undress completely for an overall inspection of her skin. From a medical-technical point of view this is undoubtedly a correct approach, the student reported, but, he added that, according to him, the approach the doctor followed clearly harmed the doctor-patient relationship. Can what the doctor did be classified as an example of indirect discrimination? To answer this question we at least have to know how the patient experienced the medical examination. She may not have used the term discrimination in the description of her experience, but may have expressed a feeling of un-ease, resulting in the possibility of being less inclined to access medical care a second time when needed.

A last example of the opaqueness of discrimination I would like to give is the way refugee women are treated. I refer, in this case, to anthropological research done by Tankink (2009) among refugee women in the Netherlands who had experienced sexual violence in their country of origin in the context of the political conflict in that country.⁷ None of the 20 women Tankink spoke to during her research, who revealed that they were raped, had ever told their physician about their rape experiences, because their physicians had never asked them about it. Most of the women would have told the doctor if he or she had asked them, but it is too shameful to bring up their rape experiences themselves, so they keep silent. They consider a doctor, however, as one of the few persons to whom they could confide their secret, but only if they were invited to speak by the doctor. The fact that this had never happened to the women in Tankink's research, resulted in the fact that many of the women's complaints were never diagnosed and treated in a satisfactory way. Often, women were referred from one specialist to the other, without ever having been given the opportunity to tell their story with the assistance of a professional translator. Also in these cases, the women themselves may not have experienced the way they were treated as outright discrimination. In depth study of doctors' attitudes towards refugee women, however, may have brought such discriminatory attitudes to light.

7. Combating Discrimination in Health Care

After having narrowed my focus to discrimination within the doctor's office, let me broaden it again and include other levels of the health care system.

⁷ The research by Tankink was PhD research. The only recent publication in English about this research up to now is Tankink and Richters (2007).

In general, in order to combat discrimination in health care, health professionals and managers of health institutions should be sensitized to the phenomenon of discrimination in health care and learn to identify it. In addition, researchers should make more efforts to study it, in order to determine to what extent discrimination, whether direct or indirect, inequity in access to health care, whether horizontal inequity (unequal treatment and care for equal need) or vertical in-equity (equal treatment and care for different need), exists. A second goal of this study should be the contribution to awareness-raising concerning the problem among policy makers and health care professionals.

Partners for Health has produced a toolkit with detailed guidelines on what could and should be done in the combating discrimination in health care. The toolkit contains questions to be raised and answered, elements of discrimination to be identified, additional research questions, and general recommendations.⁸ Below, I give a very brief summary of the toolkit.

Four questions regarding discrimination and exclusion from (good quality) care

1. To which aspects of health care is the problem related? How does discrimination take place? As discrimination is to a large extent the result of specific interactions between migrants and health care employees (medical as well as non-medical), factors should be identified that influence these interactions. One of them, for instance, is the attitude of the health care employees towards migrants when they define their presentation of complaints as ‘theatrical’, consider psychosocial aspects of life as not open for discussion, or label the attitude of the migrant as ‘demanding’.⁹
2. In which phase of the health care trajectory does the problem occur? One of the possible sub-questions regarding the first phase is: is the migrant population adequately informed about health promoting behaviour and available health care facilities?
3. Where does the problem originate from? The origin could be governmental policy and public opinion towards immigration, (forced) migrant or minority populations which contribute to a negative attitude towards the newly arrived.
4. What are the consequences of discrimination? Possible consequences are: searching for alternative care, incorrect referrals, relative under-use of services or the deterioration of health status.

⁸ Partners for Health made this toolkit available on its website. It is not known whether, by whom and how frequent the toolkit has been used by visitors of this website.

⁹ The medical students often report about such attitudes to me.

Identification of discrimination

In attempts to identify discrimination questions can be asked in the following domains:

1. Context: when, where, who is involved?
2. Complication: what went wrong, what was not acceptable?
3. Explanation: how to explain that a certain event is experienced or labelled as discrimination?
4. Argumentation: why can an event considered to be discrimination?
5. Reaction: how has the person (victim) reacted to the event?

Identification of risk factors

1. Lack of professional reflexivity;
2. A mono-cultural, mono-ethnic, and/or mono-linguistic health care context;
3. Lack of continuity and consistency in the development of health care facilities resulting in stagnation in accumulation of intercultural expertise;
4. Domination of bureaucratic procedures, leading to an impersonal approach of patients;
5. Negative perception of citizenship of migrants in public opinion and among health care professionals.

Additional research questions

First of all, because of the ambiguity and opaqueness of discrimination, it may be advisable to ‘measure’ the intensity of the feeling of having been discriminated or the perception of discrimination, instead of discrimination per se. Research questions which could be added to the four questions already listed above are:

1. Is the observed event or phenomenon incidental or structural?
2. Does the phenomenon concern individual patients, specific ethnic or cultural groups, or all migrants, refugees, and asylum seekers?
3. Is the phenomenon restricted to specific or all health care institutions?
4. Is the phenomenon restricted to a specific town, region or nation, or does it occur all over the EU?

General recommendations

1. Research on the needs and health seeking behaviour of specific groups;
2. Epidemiological research on cases of discrimination;
3. Introduction of anti-discrimination codes and procedures in health care that take cultural sensitivity and language differences into account;
4. Establishment of a national bureau (or other accessible points offices) for the reporting of discrimination;
5. Campaigns led by governments and health care institutes to inform migrants about their rights in relation to health care.

Conclusion

Discrimination in health care is often an opaque phenomenon. On the side of the health care provider, if discrimination happens it is often subtle and unconscious. Research on discrimination within health care is very limited, particularly on the question of what happens in terms of discrimination within doctors' offices. We therefore do not know if and to what extent discrimination occurs, in which forms it occurs, and what the consequences of discrimination are in quantitative terms regarding inequity in access to health promotion and health care services. We have limited figures on this inequity, but those we do have show that we need more insight in underlying factors that contribute to this inequity. There is enough evidence that discrimination in doctors' offices is one of the key factors to consider in this context. It is to be expected that more attention to that factor can contribute to the promotion of migrants' right to health.

References

- Baldwin-Ravagan, L., J. du Grucy and L. London (1999): *An ambulance of the wrong colour: Health professionals, human rights and ethics in South Africa*. Capetown: University of Capetown Press.
- Bekker, H.J. and M. Lhajoui (2004): *Health and literacy in first- and second-generation Moroccan Berber women in the Netherlands: Ill literacy?* In: *International Journal for Equity in Health* 3: 8. Published online 2004 June 28.
- Equalities Review (2007): *Fairness and freedom: The final report of the equalities review*. Available at www.theequalitiesreview.org.uk
- Geiger, H.J. (2006): *Health disparities: What do we know? What do we need to know? What should be know?* In: A.J. Schulz & L. Mullings, eds. *Gender, race, class and health: Intersectional approaches*. San Francisco. Jossey-Bass: 261-289.

- Hobson, W.D. (2001): Racial discrimination in health care interview project: A special report. Public Health, Seattle & King County.
- Johansen, R.E.B. (2006): Care for infibulated woman giving birth in Norway: An anthropological analysis of health workers' management of a medically and culturally unfamiliar issue. In: *Medical Anthropology Quarterly* 20 (4): 516-544.
- Jonkers, M., A. Richters, J. Zwart, F. Öry and J. van Roosmalen (2009): Severe maternal morbidity among immigrant women: A study on patient perspectives in the Netherlands. Unpublished manuscript.
- Meeuwesen, L., J.A.M. Harmsen, R.M.D. Bernsen and M.A. Bruijnzeels (2006): Do Dutch doctors communicate differently with immigrant patients than with Dutch patients? In: *Social Science & Medicine* 63 (11): 2407-2417.
- Partners for Health (no date): A tool kit to identify and fight discrimination against migrants in health care. Available at www.salutepertutti.org
- Richters, A. (red.) (2003): Etnische pluriformiteit en kwaliteit van zorg op twee grootstedelijke poliklinieken gynaecologie/verloskunde: Verslag van een verkennend onderzoek. (Ethnic pluriformity and quality of care on two big city outpatient clinics for gynaecology and obstetrics: Report of an exploratory study). Heemstede: SMART.
- Richters, A. and K. van Vliet, red. (1999): Gezondheidsvoorlichting aan Marokkaanse vrouwen in Leiden: Verslag van drie deelonderzoeken (Health education for Moroccan women in Leiden: Report of three studies). Leiden: Stichting Vrouwengezondheidszorg.
- Scheppers, E., E. van Dongen, J. (Jos) Dekker, J. Geertzen and J. (Joost) Dekker (2006): "Potential barriers to the use of health services among ethnic minorities: a review". In: *Family Practice* 23 (3): 325-348.
- Schouten, B.C. and L. Ludwien Meeuwesen (2006): "Cultural differences in medical communication: A review of the literature". In: *Patient Education and Counseling* 64 (1): 21-34.
- Signaleringscommissie Kanker van KWF Kankerbestrijding (2006): Allochtonen en kanker: Sociaal-culturele en epidemiologische aspecten (Migrants and cancer: Socio-cultural and epidemiological aspects). Amsterdam.
- Stirbu, I., A.E. Kunst, V. Bos, E.F. van Beeck (2006): "Differences in avoidable mortality between migrants and the native Dutch in the Netherlands". In: *BMC Public Health* 6: 78. Open Access article.
- Stronks, K., A.C.J. Ravelli and S.A. Reijneveld (2001): "Immigrants in the Netherlands: Equal access for equal needs?" In: *Journal of Epidemiological Community Health* 55: 701-707.
- Tankink, M. (2009): Over zwijgen gesproken: Een medisch-antropologische studie Over zwijgen gesproken: Een medisch-antropologische studie onder vluchtelingenvrouwen in Nederland, afkomstig uit Afghanistan, Bosnië-Herzegovina en Zuid Soedan, naar het omgaan met ervaringen van aan oorlog gerelateerd seksueel geweld. Utrecht: Pharos (Speaking about

silence: A medical anthropological study among refugee women in the Netherlands, coming from Afghanistan, Bosnia-Herzegovina and South Sudan, of the coping with experiences of war related sexual violence).

Tankink, M. and A. Richters (2007): "Silence as a coping strategy: The case of refugee women in the Netherlands from South-Sudan who experienced sexual violence in the context of war". In: Boris Drozdek and John P. Wilson (Eds.): *Voices of trauma: Treating survivors across cultures*. Springer: 191-210.

Van Dongen, E. (2003): Research report of Partners for Health, Phase II: Combating discrimination in health care. Available at www.salutepertutti.org

Visser, O., A.M. van Pepper, F.G.O. Öry and F.E. van Leeuwen (2005): "Results of breast cancer screening in first generation migrants in Northwest Netherlands". In: *European Journal of Cancer Prevention* 14 (3): 251-255.

Wimmer-Puchinger, B., H. Wolf and A. Engleder (2006): "Migrantinnen im Gesundheitssystem: Inanspruchnahme, Zugangsbarrieren und Strategien zur Gesundheitsförderung". In: *Bundesgesundheitsblatt - Gesundheitsforschung - Gesundheitsschutz* 49 (9): 884-892.

Zwart J.J., J.M. Richters, F. Öry, J.I.P. de Vries, K.W.M. Bloemenkamp and J. van Roosmalen (2008): "Severe maternal morbidity during pregnancy, delivery and puerperium in the Netherlands: A nationwide population-based study of 371 000 pregnancies". In: *BJOG: An International Journal of Obstetrics and Gynaecology* 115 (7): 842-850.

Social Inequality, Health and Healthcare: Gender-specific Patterns in Germany

Birgit Babitsch

Social inequality of women has many faces. In addition to general social conditions, the specific features of social inequality of women are formed by gender relationships. Gender relationships influence the distribution of valuable resources such as education, income, and power between men and women, and they determine which opportunities are available to females and males. They also shape social structural changes affecting both sexes but having different consequences for women and men (e.g. long-term unemployment). Therefore, social inequality of women cannot be described, much less understood, without explicit consideration of gender inequality.

Similar patterns of social inequality of women can be found around the world, but the extent of inequality differs considerably. Women generally have fewer financial resources than men. Moreover, they frequently have lower education levels than men or drop out of school without a certificate, and those with school certificates benefit from them to a lesser extent than men of the same age group. Furthermore, women are still rarely represented in the top levels of management. A good approach to defining gender-specific differences that often result in disadvantages for women and for increasing the awareness of these issues in political and social discussions is presented in the report entitled "Women and Gender Equity", which was published by the WHO Commission on Social Determinants of Health. According to this approach, gender equity is explicitly integrated in the context of human rights (for details, see article by Östlin in this volume). This creates a different perspective from which the existence of gender inequality is treated as an unjust aspect of social reality that must be abolished, and which singularly seeks ways to eliminate this inequality. This method leads to important thought-provoking questions, such as: "*What is being done to ensure that women have equal access to education?*", "*What is being done to ensure that women have the same opportunities as men to participate in the labour market?*", and "*What is being done to reduce the gender pay gap between men and women with the same jobs?*".

The present article explores the structures and characteristics of social inequality of women, using typical life circumstances to concisely illustrate the combined effects of social and gender inequality on women. The correlations between social inequality and health and health care for women are also discussed.

Social Inequality and Gender Inequality: two Sides of the same Coin?

Social inequality manifests itself as unequal access to valuable resources in society, which are most often measured in terms of education level, professional position or prestige, and income. In this theoretical approach, the objective is to identify and define social groups with more or less access to these resources and to define their position according to a vertical social hierarchy (e.g. social class). Critics of this social stratification scheme have clearly demonstrated the need to consider other 'new dimensions of inequality' and 'horizontal inequality', especially when describing the social status of women (Babitsch 2005 and others). In this context, it is to be considered that gender relationships and the gender inequalities inherent to them structure the social inequality of women and initiate gender-specific processes of inclusion and exclusion. Several examples of gender-specific social exclusion have been worked out in women's/gender studies and shown that gender is e.g. inherent in occupations and the opportunities of getting higher positions (glass ceiling).

Consideration of the gender perspective in social inequality research was intensely discussed (Babitsch 2005), which revealed that androcentrism is present in the classical concepts of social inequality and identified significant deficiencies in the methods of determining social differences between men and woman. A prime example is the basic assumption of consistency between the professional biography and status of a person (i.e. a man). In other words, a person's education level is assumed to be consistent with his or her job position and income. In the majority of cases, these assumptions do not apply to women and in current society, they do not apply to a substantially growing percentage of the total population.

Therefore, women face specific forms of discrimination and social exclusion which persist not only because they are an integral part of the gender system, but also because they belong to the process of 'doing gender'.

Concrete examples found in education and the workforce:

- Despite the equalisation of education levels, considerable gender-specific differences in vocational choices still persist (segregation of the labour market).
- Despite the rising participation rate of women in the labour market,
 - women still have lower job positions even though (young) women now have higher education levels (i.e. the economic return from education is lower for women),
 - a higher percentage of women than men have precarious and part-time jobs,
 - women still bear a disproportionate burden of reproductive work.
- Women earn less money for the same work (income inequality).

- Women have a higher risk of long-term unemployment and poverty.

These facts clearly illustrate the combined effects of social and gender inequality. Three central issues will be discussed in greater detail in the examples presented below.

Example: Education

In terms of formal education levels in Germany, women have not only caught up with men but also, young women have overtaken young men (Federal Office of Statistics 2007a; Stürzer 2005). After the changes in the education system in the 1960s, the percentage of girls at higher education entrance qualification ('Abitur') increased considerably, from around 40% in 1960/61 to 54.5 % in 2004/2005. At the same time, the percentage of boys at higher education entrance qualification decreased from 60% to 46% (Stürzer 2005), whereas the percentage of boys in secondary general schools ('Hauptschule') increased. These development trends are also reflected in both types of school certificates. The percentage of boys who dropped out of school without any school-leaving certificate at all, or received a secondary general school certificate increased considerably.

By contrast, the long record of gender-specific differences in vocational training is still unbroken. The occupational preferences of young men and women reflect the gender stereotypes prevailing in society. In addition, career choices are co-determined by the structures of the vocational training and labour markets. Unlike young men, young women focus on a small number of occupations. Physician's assistant, office clerk, and clerk in the retail trade are their preferred vocational choices, whereas young men prefer motor vehicle mechatronic, systems mechanics, and industrial mechanics (Federal Office of Statistics 2007a). The gender-specific differences in higher education are not as great. Nearly half of all first-year students are women. In 2005, business studies was the most popular major selected by young men and women; among the women, German literature and related studies ranked second, followed by medicine. Among the young men, industrial engineering studies ranked second, followed by informatics (Federal Office of Statistics 2007b). Overall, it can be concluded that female students are dominant in social science and cultural studies, while a higher percentage of males are enrolled in science and engineering courses. Thus, more men than women choose more innovative and better paying professions (BMFJFJ 2008a).

Example: Professional Position and Occupational Status

The equalisation of academic and professional educational qualifications of men and women has only had a limited effect on the professional position of women. Women find themselves in lower-level and lower-paying jobs, while men still predominate in the upper levels of professional hierarchy. The gap between men and women persists in academic faculties and other sectors. Despite the equal proportion of women among first-year students, the percentage of women steadily decreases with academic qualification level, reaching a percentage of 13.6% females among university professors (Federal Office of Statistics 2007a). In the industry, the situation is similar. According to analyses of the microcensus performed by the Federal Office of Statistics in 2004, the proportion of female executives is only 33%, and the proportion of women at top executive levels is only 21% (Federal Office of Statistics 2005).

There are still significant differences between the sexes regarding their rate of participation in the labour market. However, the total participation of women in the labour market has increased: in 2004, the proportion of women in the workforce was 44.8%. In addition, an increasing number of mothers remain in the labour market. The proportion of working mothers (57%) was, however, much lower than that of working fathers (87%). This difference reflects the different role patterns of men and women. The data clearly show that the younger the children, the lower the rate of participation of women in the labour market (Federal Office of Statistics 2006). If women have a job, they often work part-time or are marginally employed. On the whole, the prevalence of these types of jobs in the labour market has increased. Eighty-five percent of the employees in these job positions are women who, according to their own statements, take this type of employment in order to be able to fulfil their family duties. As a rule, part-time labour not only equates to a lower income, but also to a career setback.

When considering all occupation-related aspects such as part-time work, the proportion of individuals in low-level job positions, and downward mobility (i.e. the proportion of individuals working in jobs below their professional qualifications), it becomes clear that women face disadvantages in all areas, which, in a nutshell, represent facets of gender-related inequality. Sufficient consideration of these aspects in characterisations of social inequality is, however, still lacking.

Example: Earned Income

Analyses of earned income also reveal a high persistence of the effects of gender inequality. According to Eurostat data, women's salaries in Europe were an average 15% lower than those of men in 2006, with differences ranging from 3% (Malta) to 25% (Estonia) (Figure 1) (BMFSFJ 2008b). Germany ranks third

to last, along with Slovakia. In these two countries, the earned income of women is 22% less than that of men working similar hours.

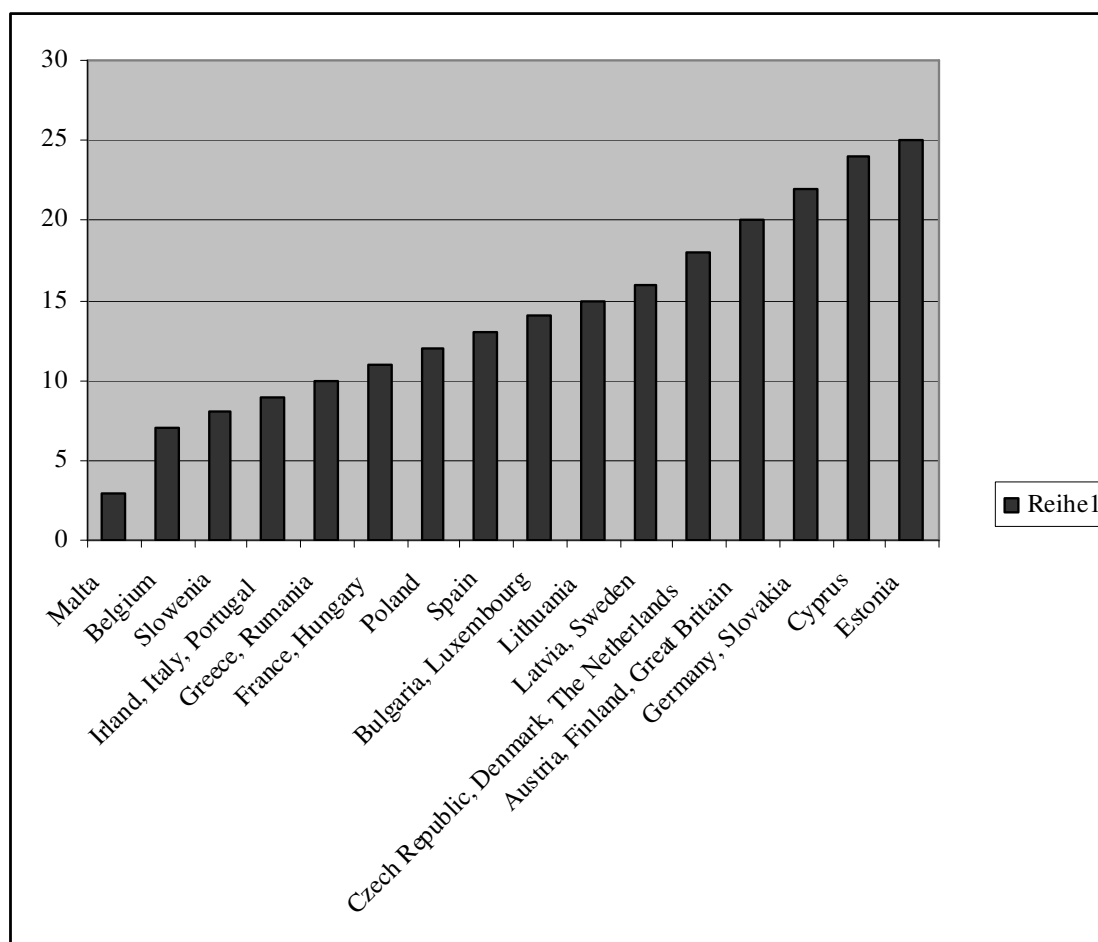


Figure 1: Gender Pay Gap (BMFSFJ 2008a)

The differences in gross salaries and wages increase significantly when net pay is taken into account: in Germany, the difference is 26 to 32 %. A major reason for the difference in net pay is that married women generally choose an unfavourable tax class due to family-related reasons, resulting in lower net pay. The gender pay gap for women in Germany rises considerably with increasing age. Younger women (up to 24 years of age) earn 7.8% less than men of the same age, whereas women aged 55 or older earn 26.7% less than their male counterparts (BMFSFJ 2008a). By the age of 25 to 34 years, women's income is already 17.8 % less than that of men of the same age. *"The unequal distribution of men and women in the work force and the unequal distribution of income between men and women results in an unequal distribution of wealth among men and women; women have only 70 % as much capital as the average man."* (Cornelißen et al. 2005: 220).

In the 1950s, the job performance of women was regarded as reduced performance, and that of men as normal performance; this was used as the main justification for unequal pay practices. As the statistics show, the gender pay gap has not changed in the meantime although the principle of 'equal pay for equal work' now applies in Germany (BMFSFJ 2008a). Different factors – both structural and cultural – and the gender relationships intertwined between them contribute to the persistence of unequal pay. The main reason is that women are still assigned the responsibility for reproductive tasks, which usually begin with the birth of the first child. The mothers solve the problem by reducing their work hours or by quitting their jobs. Further reasons are the gender segregation of the labour market and lower economic returns on the qualifications acquired by women. The concept of a woman/wife working to earn some extra money is still present in the minds of many people, including employers (BMFSFJ 2008a). This has far-reaching consequences for women, for example, in their attempts to end antiquated role concepts and patterns.

Social Inequality of Women: what exactly does that imply?

Social inequality of women has specific features. This does not mean that men do not experience similar problems, but the extent, frequency, and consequences of these problems differ between the sexes. Three examples of life circumstances resulting in social inequality of women are presented below. They illustrate the social circumstances of women and characterise the health implications related to them.

Poverty

Certain population groups are at a particularly high risk of poverty. Single parents, single seniors (particularly women), households with small children and/or several children, immigrants, unemployed persons, and persons with irregular employment are the most vulnerable groups.

Sixteen percent of women and 11% of men in Germany live below the poverty line (Lampert et al. 2005). The risk of poverty is significantly higher in Eastern Germany, namely, 21% for women and 17% for men. Compared to men, more women live in permanent poverty (7.5% vs. 10.9%) and receive social welfare during working age (3.7% vs. 2.5%) (Cornelißen et al. 2005). The risk of poverty differs according to age, sex, and place of residence. The risk is higher for men and women living in the 'New German States' (Eastern Germany) than for those living in the 'Old German States', and for younger adults compared to adults up to 64 years of age. Almost one-fifth of all German women over the age of 65 are at risk of poverty.

The risk of becoming poor is not necessarily connected to sex but is an expression of gender and, thus, the tasks that are differently assigned to men and women by society. In particular, the impact of motherhood and the responsibility for child-raising on the career is a significant risk factor for poverty among women (Cornelißen et al. 2005).

There is a clearly negative correlation between poverty and health: 27.2% of women and 21.2% of men in the at-risk-of-poverty group consider their state of health to be “fair” or “poor” compared to 18.4% of women and 11.3% of men in the highest income group (Lampert et al. 2005). Based on the data from the German Socio-Economic Panel Study, low-income is associated with an increased risk of mortality in terms of both general life expectancy and healthy life expectancy (Lampert et al. 2007). Comparison of the lowest income segment (<60) with the highest (<150) revealed a life expectancy difference of 10.8 years for men and 8.4 years for women. The difference is even higher for the healthy life expectancy, averaging 14.3 years for men and 10.2 years for women.

Unemployment

Unemployment is regarded as the primary cause of poverty. Germany had an unemployment rate of 10.1 % in 2007 (BMAS 2008). The average unemployment rate for men was 9.8% (8.1% in West Germany compared to 16.7% in East Germany); this was slightly lower than the rate for women (10.4% overall, 8.7 % for West Germany, and 16.8 % for East Germany). Of the total number of unemployed persons, the percentage of persons affected by long-term unemployment was 41.7%. Women were more often affected than men (43.5% versus 40.4%). In addition, women generally make lower unemployment and social security tax payments, resulting in a higher rate of poverty in the event of unemployment.

The assessment of the self-perceived health status of unemployed persons is significantly worse than those of employed persons. This is reflected in a higher rate of health complaints and diseases, as was shown by the data from the German Health Survey, a phone survey conducted in 2003; moreover, there is close correlation between the duration of unemployment and the degree of ill health or health impairment (Bammann & Helmert 2000; BMAS 2008). Long-term unemployed women have a 7.4 times higher risk of having a health impairment that affects their activities of daily living; the odds ratio for men is 7.3 (Figure 2).

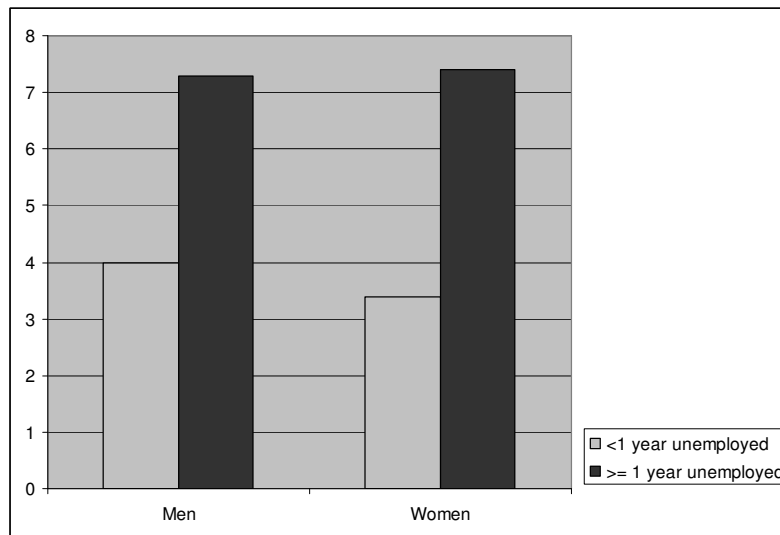


Figure 2: Long-term unemployment and health impairment (Odds ratio, ref. employed; BMAS 2008)

The percentage of unemployed persons who rated their health as ‘very good’ or ‘good’ also decreases as the duration of unemployment increases: one-third of long-term unemployed persons surveyed rated their health as ‘very good’ or ‘good’ compared to one-half of the working persons. The risk of disease is also an indicator of health inequality for unemployed persons. The disease-related odds ratios for long-term unemployed men and women combined were highest for chronic bronchitis (OR: 3.41), depression (OR: 3.36), and arthritis (OR: 2.14); those for long-term unemployed women were highest for depression (OR: 2.74), hypertension (OR: 2.16), and cardiac arrhythmias (OR: 2.14) (BMGS 2005).

Single parenthood

The recently published Third Report on Poverty and Wealth in Germany (BMAS 2008) confirms that the large majority of single parents are women (only 3% are men). Thirty-six percent of all single parents are vulnerable to poverty. Around 35% of recipients of social welfare are single parents. Due to the unequal gender distribution, the percentage of women (26.3%) was significantly higher than that of men (6.1%). These problematic life circumstances are reflected in the low subjective satisfaction ratings of single mothers (Figure 3).

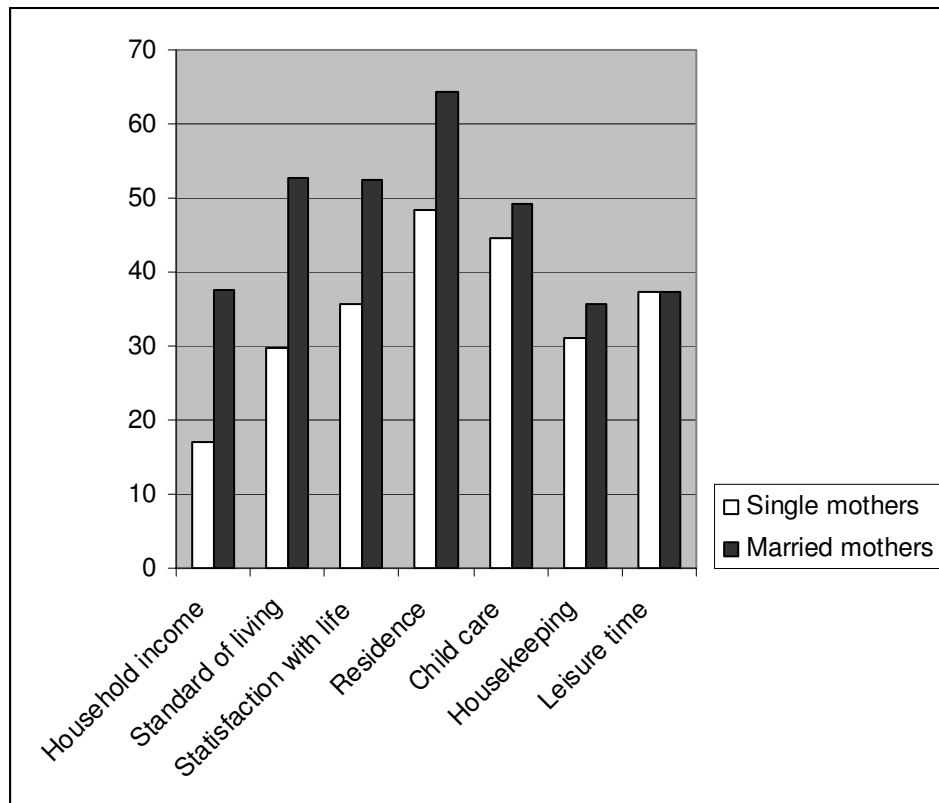


Figure 3: Satisfaction of single and married mothers ('very satisfied and satisfied'; Percentages; RKI 2008)

In all areas surveyed, a much lower proportion of single mothers were satisfied or very satisfied than married mothers. Differences in the categories 'household income', 'standard of living', and 'general self-satisfaction' were particularly large. Women predominantly bear the consequences of failed marriages and relationships, including the financial setbacks resulting from them (BMGS 2005).

As shown in Table 1, the lower subjective satisfaction ratings of single mothers are also reflected in an inferior health situation. Compared to mothers living with a spouse or partner, single mothers are less likely to rate their health as 'good' or 'very good', and they have a 2.4 times higher risk of having a health-related impairment that affects their activities of daily living. The incidence of diseases is higher in single mothers than in married mothers.

Life time prevalence	Single mothers (n=89)	Married mothers (n=728)
Chron. Bronchitis	9.0	3.9
Inflammation of the liver, Hepatitis	10.2	4.1
Pyelitis	23.6	14.2
Kidney Stones, renal colic	15.7	5.2
Migraine	36.0	26.3
Mental illnesses	24.7	10.9
Contact allergies	25.0	34.8
Other allergies	14.9	20.4
Diseases of the womb, ovaries, fallopian tubes	25.3	17.2

Table 1: Health situation of single and married mothers (RKI 2008)

Higher percentages of single mothers were affected by all diseases except 'other allergies'. In the case of chronic bronchitis, hepatitis, kidney stones, and psychological disorders, the differences were particularly great.

In summary, the two main issues highlighted by the data are: 1) health inequality affects both men and women, but in different ways; and 2) specific life circumstances, such as single parenthood, lead to the accumulation of inequalities which have a negative impact on the life course and on health. In order to sufficiently understand these findings, it is necessary to consider horizontal inequality structures and mechanisms fuelled by gender relationships and the inequality structures inherent to them. Although relevant influences such as material conditions, cultural and behavioural factors, psychosocial factors, life events, healthcare provision, early childhood experiences, and socio-environmental influences have been studied, a definitive explanation of gender-specific differences in health inequality is still lacking, although some explanatory models have meanwhile been proposed (Babitsch 2005).

Social Inequalities in Health Care

Measures to reduce healthcare costs as well as the two-class system of health insurance and the unequal access to health care services related to it have frequently been in the headlines in the past few months and are therefore topics of public discussion. Some studies indicate that persons insured under the statutory health insurance system have to wait longer for the same medical treatments than persons with private health insurance. The subject of the under-, over- and maldistribution of healthcare was raised in the 2001 report by the Advisory Council on the Assessment of Developments in the Health Care System (SVR 2000/2001), which concluded, among other things, that the quality and, in particular, the efficiency of healthcare must be improved. The presence of deficits was obvious, but a systematic analysis is lacking. The report did not adequately consider the existence of gender differences, making it impossible to adequately describe and quantify the under-, over- and maldistribution of healthcare for men or women. This also makes it hard to define potential obstacles to access on the one hand and differences in the quality of treatment on the other. We know from the women's/gender studies that there are several gender-specific differences in healthcare, which also have an impact on the quality of received treatment. Studies and health reports show that we can find an overdistribution of hormone replacement therapy and pharmacotherapy in women, but an under- and maldistribution of battered women in the health care system. Furthermore it has to be dealt with different perceptions of symptoms or health reports by female and male patients in the health care system may result from androcentrism in medicine and gender-role stereotyping by health care professionals. E.g. female patients are more often at risk of being treated according to male norms; symptoms of myocardial infarction in women are more often not adequately diagnosed because they are labelled as 'atypical', which results in treatment delays and/or inadequate treatment.

In contrast to the United States and Great Britain, the issue of barriers to medical care was only recently broached and researched in Germany. One reason for this is presumably the structure of the German public healthcare system and the extensive availability of health insurance coverage, both in terms of the number of persons covered by health insurance and the health insurance services provided by law. However, recent healthcare reforms in Germany led to cuts in the services covered free of additional charge and to a rise in the number of people without health insurance. The exact number of persons without health insurance is unknown, but one can assume that it has increased in recent years and that it now includes different groups (such as self-employed persons). Differences in the use of healthcare services according to sex/gender, social status and ethnicity for reasons not related to free choice but to structural influences have also been identified. The extent to which these differences indicate or equate to barriers to access is difficult to determine.

Along with the healthcare reforms, insurees in Germany are now required to pay surcharges for a growing number of healthcare services, and the amount of the additional charges has increased. Surcharges are regarded as a main instrument for healthcare cost containment (Gerlinger 2007). As of 2004, low-income persons were no longer completely exempt from charges for healthcare services. Now, the rule is that the fees borne by the patient must not exceed 2 % of the insuree's gross income. The consequences of these surcharges, particularly for low-income individuals in Germany, cannot be quantified. It is not clear how these insurance surcharges affect men and women in terms of their financial situation, the use of health-related services and, last but not least, morbidity and mortality rates. International studies show that insurance surcharges have a negative effect on disadvantaged social groups, resulting in a decrease in the utilisation of available medical services (Gerlinger 2007).

Since women have fewer financial resources than men, one can assume that women are more disadvantaged by these surcharges than men. The financial disadvantage of women results from their lower wages and salaries, long periods of unemployment due to reproductive tasks and, as a result, lower benefit payments from the state (unemployment benefits, pensions). Single women and single mothers are particularly affected (the percentage of single mothers living in poverty is extremely high). The specific effects of additional charges for medical service on women have not yet been studied and therefore cannot be estimated with certainty.

In conclusion, it must be remembered that currently, no reliable definition of the status quo is available, that the available descriptions of the effects of the German healthcare reforms are insufficient, and that it is not possible to identify the consequences of these reforms. Therefore, targeted research projects to assess the effects of the health care reforms with due consideration of women-specific aspects and of the correlations between social inequality and healthcare are required.

Conclusions

These discussions elucidate the impact of gender on social and health conditions and illuminate the correlations between social inequality and health. As a horizontal dimension, gender forms the structures in society and the lives of individuals and, thus, replicates the gender relationships prevailing in society. In particular, the descriptions of the social conditions of men and women in Germany demonstrate the persistence of differences between the sexes, even though equalisation can be observed in some areas.

Systematic inclusion of gender as a category in research on social inequality and health will certainly make this research much more complex. However, the effort is worthwhile. Attention to gender not only provides a more precise

description of health-related gender inequalities, but also elucidates the processes underlying these problems. Explication of health inequality with due consideration of gender-specific differences should be given high priority in future research. This would provide a basis for the development of gender-appropriate measures which could be used to achieve a selective change in burden and to stimulate resources. This research should consider not only the quantitative differences still existing in social life circumstances of men and women, but also and most importantly, their qualitative impact on social and health inequality. Thus, it is crucial to investigate whether equal education and vocational training levels and similar household incomes have the same implications for women as they do for men. The accumulation of social disadvantages, as can be found in some particularly vulnerable groups, should also be given special attention.

References

- Babitsch, B. (2005): Soziale Ungleichheit, Geschlecht, und Gesundheit. Bern: Verlag Hans Huber.
- Bammann, K. and Helmert U. (2000): Arbeitslosigkeit, soziale Ungleichheit und Gesundheit. In: Helmert, U., Bammann, K., Voges, W. and Müller, R. (Hrsg.): Müssen Arme früher sterben? Soziale Ungleichheit und Gesundheit in Deutschland. Weinheim, Munich: Juventa Verlag: 159-185.
- BMAS – Federal Ministry of Labour and Social Affairs (2008): Lebenslagen in Deutschland. 3. Armuts- und Reichtumsbericht. Bonn.
- BMFSFJ – Federal Ministry for Family, Senior Citizens, Women and Youth (2008a): Mädchen und Jungen in Deutschland. Lebenssituationen – Unterschiede – Gemeinsamkeiten. Berlin.
- BMFSFJ – Federal Ministry for Family, Senior Citizens, Women and Youth (2008b): Entgeltungleichheit zwischen Frauen und Männern. Einstellungen, Erfahrungen und Forderungen der Bevölkerung zum ‚gender pay gap. Berlin.
- BMGS - Federal Ministry of Health and Social Affairs (2005): Lebenslagen in Deutschland. 2. Armuts- und Reichtumsbericht. Bonn.
- Cornelißen, W., Dressel, C. and Lohel, V. (2005): Erwerbseinkommen von Frauen und Männern. In: Cornelißen, W. (Hrsg.): Gender-Datenreport. 1. Datenreport zur Gleichstellung von Frauen und Männern in der Bundesrepublik Deutschland. Bundesministeriums für Familie, Senioren, Frauen und Jugend. Munich: 159-223.
- Gerlinger, T. (2007): Soziale Ungleichheit von Gesundheitschancen: Anmerkungen zum Beitrag der Gesundheitspolitik. Diskussionspapiere des Instituts für Medizinische Soziologie (2007 – 2). Frankfurt am Main.

Lampert, T., Saß, A., Häfeling, M. and Ziese, T. (2005): Armut, soziale Ungleichheit und Gesundheit. Expertise des Robert Koch-Instituts zum 2. Armuts- und Reichtumsbericht der Bundesregierung. Berlin: Robert Koch Institut.

Lampert, T., Knoll, E. and Dunkelberg, A. (2007): Soziale Ungleichheit der Lebenserwartung in Deutschland. APuZ: 11-18.

Federal Office of Statistics (eds.) (2005):. Leben und Arbeiten in Deutschland – Mikrozensus 2005. Tabellenanhang zur Pressebroschüre. Wiesbaden.

Federal Office of Statistics (eds.) (2006): Armut und Lebensbedingungen. Ergebnisse aus LEBEN IN EUROPA für Deutschland 2005. Wiesbaden.

Federal Office of Statistics (eds.) (2007a): Datenreport 2006. Wiesbaden.

Federal Office of Statistics (eds.) (2007b): Statistisches Jahrbuch 2006 für die Bundesrepublik Deutschland. Wiesbaden.

RKI – Robert Koch Institute (2008): Health in Germany. Berlin.

SVR – Advisory Council on the Assessment of Developments in the Health Care System (2000/2001): Über-, Unter- und Fehlversorgung. www.svr-gesundheit.de.

Stürzer, M. (2005): Bildung, Ausbildung und Weiterbildung. In: Cornelißen, W. (Hrsg.) Gender-Datenreport. 1. Datenreport zur Gleichstellung von Frauen und Männern in der Bundesrepublik Deutschland. Bundesministeriums für Familie, Senioren, Frauen und Jugend. Munich: 21-98.

Domestic Violence and Health Care

Sabine Bohne

Introduction

Violence against women and especially intimate partner violence is a widespread global phenomenon and has serious social, health and economic consequences for the women who experience it. It impoverishes not only individual women suffering from the various consequences and pain, but also communities, societies and nations at many levels. As the prevalence and incidence of intimate partner violence is high and the health care consequences extensive, health care should be sensitised to gender issues and prepared to tackle the needs of women affected by gender violence – particularly intimate partner violence.

Since the 1990s international and supranational organisations have defined violence against women as a form of human rights violation. The United Nations General Assembly summarizes and highlights the ongoing discussion of the women's movement:

“Violence against women is a violation of women's human rights and prevents women from enjoying their human rights and fundamental freedoms, such as the rights to life and security of the person, to the highest attainable standard of physical and mental health, to education, work and housing and to participation in public life” (UN General Assembly 2006: 47).

“Such violence perpetuates the subordination of women and the unequal distribution of power between women and men. It has consequences for women's health and well-being, carries a heavy human and economic cost” (UN 2006: 47/48).¹

In section 1 the focus will be on international key instruments on human rights to explore and underline the dimension of human rights violations by intimate partner violence. There should be a growing awareness of all key professionals dealing with appropriate responses to the victims of intimate personal violence on the highlighted dimension of human rights.

Several international and national prevalence studies document the high rate of intimate partner violence and explore the extent of physical, psychological and sexual violence against women. Intimate partner violence has also been

¹ Analysing the costs of violence against women is useful for understanding the severity of the problem as it shows its economic impact on businesses, the State, community groups and individuals. It emphasizes the pervasiveness of such violence and confirms that it is a public concern, not a private issue. Such analysis can provide important information for specific budgetary allocations for programmes to prevent and redress violence against women and demonstrates that much more should be invested in early intervention and prevention strategies, rather than allowing such violence to continue unabated (UN General Assembly 2006: 50). For an overview on cost studies see Hagemann-White et al. (2006).

recognized as a serious public health issue. The health consequences for women have been well documented in several studies and shown to range from short- and middle- to long term effects (see section 2).

The health care sector has a unique role in a multi-sectoral response to intimate violence as all women visit health care providers for medical treatment even when the symptoms and health consequences are not visibly or obviously the result of a violent episode. In recent years major efforts have been made to integrate the health care sector in multi-professional intervention approaches in cases of intimate partner violence. Several studies have explored the barriers health care providers must overcome in order to identify women affected by intimate partner violence as well as the female patient psychological barriers to disclose abuse. This will be addressed in section 3. Some recommendations and challenges which the health care sector must meet to be able to provide appropriate responses to intimate partner violence will be summarized in section 4 and principle attitudes in intervention addressed. Within the scope of this chapter the pathway for implementation of the recommendations can not be addressed. But there are well documented approaches and guidelines for improving the health care response although most of the approaches have yet to be rigorously evaluated.

1. Violence against Women: a Form of Human Rights Violations

Categorizing violence against women as a matter of human rights because recognizing such violence as a violation of human rights is important for a number of reasons. It clarifies the binding obligations on member states of the United Nations and of human rights conventions specifically to prevent, eradicate and prosecute perpetrators of such violence. These obligations arise from the duty of government bodies to take steps to respect, protect, promote and fulfil human rights. Moreover, addressing violence against women as a human rights issue empowers women, positioning them not as passive recipients of discretionary benefits but as active legal subjects. Understanding violence against women as a human rights concern does not preclude other approaches to preventing and eliminating violence, such as education, health, development and criminal justice efforts.

“Rather, addressing violence against women as a human rights issue encourages an indivisible, holistic and multi-sectoral response that adds a human rights dimension to work in all sectors. It calls for strengthening and accelerating initiatives in all areas to prevent and eliminate violence against women, including in the criminal justice, health, development, humanitarian, peace-building and security sectors” (UN General Assembly 2006: 18).

During the early 1990s, efforts by the women’s movement to place women’s rights firmly on the agenda of international rights and to gain recognition of

violence against women as a human rights issue gained momentum. The World Conference on Human Rights in Vienna (1993) accepted that the rights of women and girls are “*an inalienable, integral and indivisible part of universal human rights*” (United Nations 1993a: 18). Gender-based violence and all forms of sexual harassment and exploitation, including those resulting from cultural prejudice and international trafficking, are incompatible with the dignity and worth of the human person, and must be eliminated. The United Nations General Assembly, in December 1993, adopted the Declaration on the Elimination of Violence against Women. It is the first international human rights instrument to deal exclusively with violence against women, a groundbreaking document that became the basis for many other parallel processes.

The Declaration defines violence against women as “*any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.*” (General Assembly Resolution 48/104 of 20 December 1993).²

It broadens the definition of violence by including both the physical and psychological harm done towards women, and it includes acts in both private and public life.

Although this declaration is a policy statement without binding force, it carries significant international legitimacy as an expression of the collective body of member states of the UN.

Prior to this, the Committee on the Elimination of Discrimination against Women (CEDAW), established in 1982 to monitor implementation of the Convention on the Elimination of All Forms of Discrimination against Women (General Assembly Resolution 34/180), contributed significantly to the recognition of violence against women as a human rights issue. In its General recommendation No. 19 (1992), CEDAW asserted unequivocally that violence against women constitutes a form of gender-based discrimination and that discrimination is a major cause of such violence:

“Gender-based violence, which impairs or nullifies the enjoyment by women of human rights and fundamental freedoms under general international law or under human rights conventions, is discrimination within the meaning of article 1 of the Convention” (CEDAW General recommendation No. 19, para 7).³

Under the new Optional Protocol to CEDAW, which has been in force since 2000, ratifying states recognize the authority of the Committee to receive and consider complaints from individuals or groups within that state’s jurisdiction. The Optional Protocol authorises the Committee to receive and examine

² [http://www.unhchr.ch/huridocda/huridoca.nsf/\(Symbol\)/A.RES.48.104.En](http://www.unhchr.ch/huridocda/huridoca.nsf/(Symbol)/A.RES.48.104.En)

³ <http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm>

communications from individuals claiming to be the victim of a breach of one of the provisions of the Convention by a party state.

An additional outcome of the Vienna conference was the appointment of a Special Rapporteur on violence against women by the Commission on Human Rights in 1994, entrusting her with the task of analyzing and documenting the phenomenon, and holding governments accountable for human rights violations against women.

Council of Europe

In 1993 the European Ministerial Conference on Equality between Women and Men adopted a declaration stating:

"Violence against women constitutes an infringement of the right to life, security, liberty and dignity of the victim and, consequently, a hindrance to the functioning of a democratic society, based on the rule of law".⁴

In Recommendation 1450 (2000) the Parliamentary Assembly of the Council of Europe "*condemns violence against women as being a general violation of their rights as human beings – the right to life, safety, dignity and physical and psychological well-being*". This Recommendation clearly states the widespread existence of oppression of women as manifested in domestic violence, rape and sexual mutilation. It also recognizes the important role played by NGOs and "*invites member states to fully support such NGO's in their national and international activities*" (Parliamentary Assembly 2000).⁵

In 2002 the Recommendation Rec(2002)5⁶ of the Committee of Ministers to Member States on the Protection of Women against Violence was adopted. This comprehensive recommendation recognises among other issues that member states of the Council of Europe "*have an obligation to exercise due diligence to prevent, investigate and punish acts of violence, whether those acts are perpetrated by the state or private persons, and provide protection to victims*" (Rec (2002) 5 article II). Member states should "*improve interactions between the scientific community, the NGOs in the field, political decision-makers and legislative, health, educational, social and police bodies in order to design co-ordinated actions against violence*" (Rec (2002) 5 article VII). The recommendation was the first international instrument to propose a global strategy to prevent violence and to protect the victims covering all forms of gender-based violence. It also calls on governments to inform the Council of Europe on the follow-up at the national level. Moreover, in 2006 the Council of

⁴ www.humanrights.coe.int/equality/Eng/EqualityCommittee/Conferences/ministerialconferences.htm

⁵ <http://assembly.coe.int/Mainf.asp?link=/Documents/AdoptedText/ta00/EREC1450.htm>

⁶ [http://www.coe.int/t/e/human_rights/equality/05._violence_against_women/003_Rec\(2002\)05.asp](http://www.coe.int/t/e/human_rights/equality/05._violence_against_women/003_Rec(2002)05.asp)

Europe launched the campaign ‘Stop violence against women, including domestic violence’.⁷

These developments at the international and European level highlights the policy decision to support co-ordinated action and multi-sectoral approaches including grass roots NGOs to combat violence against women, to show zero tolerance to violence against women and to implement appropriate measures on national and regional levels for intervention and prevention.

2. Prevalence and Consequences of Violence against Women

Defining Violence

In the previous section, several definitions of gender-based violence have been highlighted. With the focus placed on the health care sector, the definition by the World Health Organization (WHO) is useful because it reflects the challenges for the health care system to provide appropriate responses, recognizes a wide range of outcomes beyond injury or death and highlights the need to tackle the challenge of the immense burden violence poses to individuals, families, communities and the health care system. According to the WHO definition, violence is “*the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group of community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation*” (WHO 2002: 5).

The inclusion of the word ‘power’ expands the conventional understanding of violence to include those acts that result from a power relationship and includes threats and intimidation. The definition should be understood to include neglect and all types of physical, sexual and psychological violence, as well as suicide and other self-abusive acts (WHO 2002: 5).

The pervasiveness of different forms of violence against women within intimate relationships, commonly referred to as domestic violence or spousal abuse, is now well established. There is a growing body of research on intimate partner violence, which has expanded to capture the experience of women in intimate relationships beyond formal marriage.

For a better understanding of the complex phenomenon of intimate partner violence, it is important to recognize that intimate partner violence or domestic violence is more likely to show a pattern of abusive behaviour against the woman than to be a single event. It consists of a variety of abusive acts that occur in multiple episodes over the course of the relationship. All parts of this pattern interact with each other and can have profound physical and emotional

⁷ <http://www.coe.int/t/dg2/equality/DOMESTICVIOLENCECAMPAIGN/>

effects on women. Women suffering from intimate partner violence respond to the entire pattern of abuse rather than simply to one episode or one tactic (FVPPF 1998). Forms of intimate partner violence include physical, sexual, psychological and economic violence. Physical violence includes behaviours such as pushing, shoving, slapping, hitting, kicking, biting, choking, burning, the use of weapons, or other acts that are likely to result in injury or death.

The definition of sexual violence varies in many prevalence studies as it is difficult to define exactly where sexual violence by intimate partners begins and where pressure is perceived as an “unwelcome” sexual advance, but not a violation (Schrötte, Martinez et al. 2006: 17). Existing guidelines for field practice describe that acts of sexual violence involve non-consenting sexual encounters in which women either have been pressured, coerced or forced into sexualized contact. Sexual violence includes behaviours such as forcible penetration, vaginally, anally or orally by the offender. Women may be coerced or forced to perform a kind of sex they do not want (e.g., sex with third parties, physically painful sex, sexual activity they find offensive, verbal degradation during sex, viewing sexually violent material) or at a time they do not want it (e.g., when exhausted, when ill, in front of children, after a physical assault, when asleep) (FVPPF 1998).

Psychological or emotional violence against women has received less attention in research on intimate partner violence than physical and sexual violence. There is no common understanding of which acts or combination of acts, as well as frequency of acts constitutes psychological or emotional violence. The Commission Against Gender Violence of the National Health System’s Interterritorial Council of Spain uses a helpful comprehensive definition of psychological violence as follows:

“Deliberate and longstanding conduct that puts the woman’s psychological and emotional integrity and her personal dignity at jeopardy, with the purpose of imposing those behavioural rules the man considers his partner should abide by. It materialises in threats, verbal abuse, humiliations or debasing treatment, exigency of obedience, social isolation, attribution of blame, freedom deprivation, economic control, emotional blackmail, rejection or abandonment.” (Commission Against Gender Violence of the National Health System’s Interterritorial Council. Spain 2008: 18)

Psychological violence can be thought of as an ongoing process in which one individual systematically diminishes and destroys the inner self of another and is often used by an offender as a means of establishing control over the victim (Hermann 1992).

Scope and Extent of Intimate Partner Violence

Population-based surveys that interview women about their experiences with violence are considered the most reliable method for gathering information on violence against women in a general population. Population-based surveys are likely to give a more accurate picture of the extent of violence against women than data from administrative records because they include the experiences of women regardless of whether they have reported the violence to authorities or not. Such studies have been conducted in 71 countries around the world (UN General Assembly 2006).⁸

A review of 50 population-based studies in 36 countries before 1999 showed that the lifetime prevalence of physical violence by intimate partners ranged between 10% and over 50 % (Heise et al. 1999). At its most severe, intimate partner violence leads to death. Research studies on femicide from Australia, Canada, Israel, South Africa and the United States of America show that 40% to 70% of female murder victims were killed by their boyfriends or husbands. Murder was the second leading cause of death for girls aged 15 to 18 in a study in the United State, and 78% of homicide victims in the study were killed by an acquaintance or an intimate partner (Coyne-Beasley et al. 2003, UN General Assembly 2006: 38).

The WHO conducted a multi-country-study on Women's Health and Domestic Violence in mostly non-European Countries, including but not restricted to low- and middle-income countries. Over 24.000 women aged 15- to 49-years in 15 sites in 10 countries (Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Serbia and Montenegro, Thailand and the United Republic of Tanzania) were interviewed using a common methodology. The results show that between one-third and three-quarters of women (35% to 76%) had been physically or sexually assaulted by someone since the age of 15 in 13 of the 15 sites studied. In almost all the settings the majority of this violence was perpetrated by a current or previous partner, rather than by other persons (Garcia-Moreno et al. 2005a).⁹

Violence can also pose a serious risk during pregnancy. The prevalence of intimate partner violence during pregnancy is estimated to be 5,3% during pregnancy and 8,7% around the time of pregnancy (Saltzman et al. 2003). A prevalence rate of 11,1% was found in a population-based survey of over 6000 women from South Carolina (Cokkides et. al 1999). Several studies across

⁸ For an overview see: UN General Assembly (2006); Martinez et al. (2006); Garcia-Moreno et al. (2005a)

⁹ According the study, overall, 15 to 71% of women who ever had a partner had been physically or sexually assaulted by an intimate partner. About a half of these women reported that the violence was currently ongoing (occurred in the past 12 months preceding the interview). In the majority of settings a greater proportion of women had experienced "severe" physical violence than those suffering "moderate" physical violence. More than one-fifth (21% to 66%) of women reporting physical violence in the study had never told anyone of their partner's violence before the study interview (Garcia-Moreno/Heise et al. 2005b: 1282).

different developing countries indicate that violence during pregnancy ranges from 4% to 32%, and that the prevalence of moderate to severe physical violence during pregnancy is about 13% (UN General Assembly 2006).

European Prevalence Studies

Since the 1990s, many European countries have conducted national prevalence studies on the extent of physical, sexual and psychological violence against women.¹⁰ Some of the surveys concentrated on violence by intimate partners; other surveys have also included other victim-perpetrator-relationships and violence outside of the homes. They showed that women experience violence predominantly by current or former partners and less often by known or unknown persons in other contexts (Martinez, Schröttle et al. 2006). A few prevalence studies have also obtained information about the health impact of different forms of interpersonal violence on victims, indicating that violence against women greatly affects all aspects of women's health, from immediate physical harm to the longer-term impairment of victims' mental, physical and social health.

“The lifetime prevalence of physical and/or sexual violence by current and/or former partners ranges in the European studies from 4% to over 30%; the lifetime prevalence of physical violence alone ranges from 6% to over 30%, and the lifetime prevalence of sexual violence by intimate partners from 4% to over 20%, depending on methodology and also on the broad or narrow definitions of violence. Psychological violence by intimate partners has been published in some studies as a separate category; the lifetime-rate is between 19% and 42%” (Martinez, Schröttle et al. 2006:13).

Because the methodology of the numerous European studies performed to date are not comparable with each other, the CAHRV¹¹ prevalence researcher group carried out a systematic and comparable reanalysis of data from five European countries (conducted in Finland, Sweden, Germany, Lithuania, France). It allows more accurate data comparisons between countries on the basis of harmonization of definitions of violence, of age-groups and calculation bases for prevalence rates.

The following results of the extent of violence in several countries relate to women in the central age group of 20-59.¹²

¹⁰ See overview on studies and methodology in: Martinez et al. (2006)

¹¹ Coordination Action on Human Rights Violations (CAHRV) see: www.cahrv.uni-osnabrueck.de

¹² They stem from the CAHRV-data reanalyses conducted by several prevalence researchers in 2006 (Schröttle et al 2006: 10ff.

Physical violence by intimate partners

The lifetime prevalence rates for physical violence by current and/or former partners documented in table 1 range from almost 21% to 33% for women who have ever had a partner. The detailed data re-analysis in the CAHRV expert groups finds lower rates of physical partner violence in Sweden and the highest rates in Lithuania (Schröttle, Martinez et al. 2006: 12). Between 9% and 23% of women in the central age groups has experienced at least one act of physical violence by current partner. Here again prevalence rates in Sweden are lowest and prevalence rates in Lithuania highest whereas Finnish and German rates fall in between.

The prevalence rates for violence by former partners are very similar and extremely high (32% to 42%) related to the prevalence rates by current partners (13% to 24%).

	Finland	Germany	Lithuania	Sweden
Physical violence by current and/or former partner (based on women who have ever had a partner)	27,5%	27,9%	32,7%	20,5%
Physical violence by current partner (based on women who currently have a partner)	17,0%	13,2%	23,4%	8,6%
Physical violence by former partner (based on women who have previously had a partner)	42,1%	39,5%	41,9%	31,8%

Table 1: Physical violence by intimate partners – lifetime-prevalence. Age-group: 20-59 (Schröttle, Martinez et al. 2006 : 12).

Sexual Violence by Intimate Partners

It is very difficult to define exactly where sexual violence by intimate partners begins and where pressure is perceived as an (unwelcome) sexual advance, but not a violation. In some studies a rather broad definition of unwanted sexual acts is used, other studies define it by forced acts that refer to legal definitions of rape and attempted rape. Some studies use very exact and clinical phrases to identify sexual violence in the questionnaires, others remain rather vague (Schröttle, Martinez et al. 2006: 17). In all studies there is a relative consensus on the contents and the categorisation of acts of sexual violence but the detailed description of the actions, the structuring of the questionnaires, the time frame, and above all the grouping together of events in the subdivision of private and public spheres differs. Thus the comparability of sexual violence between countries is limited. However, the CAHRV expert groups came to the conclusion that cautious comparisons between countries are possible because all five surveys that were included obtained information on forced sexual acts, and

did so in a similar way. All but the Finnish study differentiate between forced sexual acts and attempts to force acts (see table 2).

	Finland	Germany	Lithuania	Sweden
Sexual violence by current and/or former partner (based on women who have ever had a partner)	11,5%	6,5%	7,5%	6,2%
Sexual violence by current partner (based on women who currently have a partner)	5,0%	1,0%	2,9%	1,4%
Sexual violence by former partner (based on women who have previously had a partner before)	17,6%	12,1%	12,4%	11,1%

Table 2: Sexual violence by intimate partners – lifetime-prevalence. Age-group: 20-59, (Schröttle, Martinez et al. 2006: 18).

According to the CAHRV expert group the differences may to some extent be a consequence of methodology and wording, and might reflect differences in reporting or in the sensitivity of the topic (for which empirical evidence is lacking at present). It seems that in the Finnish study rates of sexual violence by partners are relatively high compared to the rates in the German, Lithuanian and Swedish studies. Furthermore, the Finnish and Swedish surveys were administered in the same way. Thus there may in fact be higher rates of sexual violence against women by current and former partners in Finland. It seems that they are extremely high with regard to sexual violence by former partners that was experienced by almost one in six women (18%) who had ever separated from a partner in Finland and by 11% to 12% of the women in the other countries (Schröttle, Martinez et al. 2006: 18f).

Psychological violence, threat and control by partners

It is still very difficult to define exactly what psychological violence in intimate partner relationships is, where it begins and when it is just one aspect of interpersonal conflict. In most prevalence studies several dimensions of dominance, humiliating behaviour, threat and control in order to measure psychological violence are used; sometimes indicators are developed in order to assess lower or higher levels of psychological violence (Schröttle, Martinez et al. 2006: 22). In the structured data reanalyses only questions on psychological violence were included that were similar in the surveys (see table 3).

Table 3 shows relatively high overall rates of psychological violence in the Lithuanian study, lower rates in the Finnish and German study and again lowest rates in the Swedish study. Between 12% of women in the Swedish and 29% of women in the Lithuanian study have reported at least one of these behaviours for

the current partner. This was the case for 14% of women in the German and almost 17% of women in the French study.

	France	Finland	Germany	Lithuania	Sweden
a) extreme jealousy	(4,4%)	8,2%	8,1%	24,4%	5,7%
b) restricting the woman from seeing friends or other relatives	3,2%	5,7%	8,1%	15,2%	0,5%
c) humiliating behaviour	(24,5%)	6,7%	(2,6%)	17,1%	5,9%
d) economic control	(1,2%)	3,8%	5,2%	(12,2%)	2,2%
e) threaten to harm the children	(1,1%)	0,2%	(0,6%)	8%	0,0%
f) threaten to commit suicide	(1,0%)	2,8%	1,3%	4,9%	1,0%
At least one of these ...	(24,3%)	16,5%	14,3%	28,6%	11,6%

Table 3: Psychological violence by current intimate partner – lifetime-prevalence. Age-group: 20-59, (Schröttle, Martinez et al. 2006: 24).

As the French data refers to annual rates only whereas the other surveys have not set time periods; in these questions refer to the ‘current’ partner, comparing the French data with the other surveys is limited. The figures that are not fully comparable are in parentheses ().

The overview on prevalence studies above document the high level of physical, sexual and psychological violence against women in intimate partnership that has serious consequences for the women’s well being. Future research should pay attention and monitor the development in order to learn more about political and societal framework conditions to lower the rates of intimate violence (Schröttle, Martinez et al. 2006).

Health Consequences of Intimate Partner Violence

The health consequences of intimate partner violence range from short- and middle term to long-term consequences and are far ‘broader’ than most health care providers are aware of. Beyond ‘visible’ injuries often seen in emergency departments, intimate partner violence can lead to serious psychosomatic and mental health problems that are not easily recognized as consequences of violence experienced.

It is well documented that women with a current or past experience of intimate partner violence use primary care and specialist outpatient services more frequently, are issued more prescription medication and admitted to hospital more often than non-abused women (Campbell et al. 2002).

Studies show that women who have experienced physical or sexual abuse in childhood and/or in adulthood experience ill health more frequently than other women with regard to physical health status, physical functioning, psychological

well-being and the adoption of further risk behaviours (Campbell et al. 2002, Plichta 2004, RKI 2008).

The consequences of interpersonal violence for women's health range from nonfatal outcomes such as physical injuries, gastrointestinal disorders, chronic health problems and consequences for reproductive health to fatal outcomes such as suicide and homicide.¹³ Physical, psychological and sexual violence also have consequences for women's mental health, such as depression, low self-esteem and posttraumatic stress disorder, as well as behavioural outcomes such as alcohol and drug abuse, sexual risk taking and self-injurious behaviour. It has become increasingly clear that injuries represent only the tip of the iceberg of negative health effects (Plichta 2004).

Physical and (psycho)somatic Consequences

Injuries sustained by abused vary from minor to life threatening. Studies reveal that minor injuries (scratches, bruises, welt) are the most common, while lacerations, knife wounds, broken bones, head injuries, sore muscles, broken teeth, internal injuries and bullet wounds occur with increasing frequency of violence (Tjaden & Thoennes 2000). Women affected by physical violence by intimate partner are more likely to be injured in the head, neck, face, thorax, adomen and breast than other women who are injured under other circumstances (Muellemann et al. 1996).

Population-based studies consistently report an increased risk for disability among victims of interpersonal violence (Plichta 2004). There are often long-term functional impairments caused by these injuries. Permanent handicaps such as hardness of hearing caused by injuries to the ear drum or visual impairment can arise (Muellemann et al. 1996, Fanslow et al. 1998, Hellbernd 2006).

Women who are victims of violence suffer from chronic tensions, fear and insecurities, which can result in psychosomatic symptoms and chronic illnesses and syndromes. In a review by Campbell et al. (2002) the analysed studies show a significant connection between experiencing violence and headaches, migrane, shoulder and neck pains and chronic back pain (Hellbernd 2006).

Women suffering from intimate partner violence also have significantly more than average self reported gastrointestinal symptoms, i.e. loss of appetite, eating disorders and diagnosed functional gastrointestinal symptoms (i.e. chronic irritable bowel syndrome) associated with chronic stress (Campbell et al. 2002). These disorders may begin during an acutely violent and thus stressful relationship, be related to child sexual abuse or both. The subsequent functional damage to the bowel can last far longer than the violent relationship.

¹³ For an overview see: Campbell 2002; Hellbernd 2006, WHO 2002, Plichta 2004; RKI 2008

Furthermore, the injuries, fear and stress associated with intimate partner violence can result in chronic health problems such as chronic pain (i.e. headaches, back pain) or recurring central nervous system symptoms (Campbell et al. 2002). A greater prevalence of chronic pain among women suffering interpersonal violence is documented in several large studies (Pflichta 2004). Greater pain levels are also found in abused women in patient populations with specific disorders such as fibromyalgia, gastroinsintestinal orders and facial pain. Chronic pain syndromes are more common in women who have experienced domestic violence and child abuse (Kendall-Tacket et al 1993).

Mental Health Outcomes

International studies document several psychological symptoms that are associated with a history of interpersonal violence in childhood and in adult life. Psychological outcomes especially associated with violence against women are depression, stress symptoms, panic attacks, post traumatic stress disorder (PTSD), eating disorders and suicidal thoughts and behaviours (Campbell et al. 2002; Hagemann-White & Bohne 2003; Hellbernd 2006; RKI 2008).

A review of mental health problems among women with a history of interpersonal violence in the United States (Golding 1999) reported that victims had a three to five times greater likelihood of depression, suicidal thoughts and behaviours, posttraumatic stress disorder (PTSD) and substance abuse than non-victims. Frequency and greater severity of physical violence including life threatening experiences have been shown to relate to the development of PTSD. Multiple experiences of victimization throughout childhood and adulthood have been found to be associated with greater PTSD (Dutton et al. 2006). The degree of depression is significantly related to the frequency and severity of the abuse. According to Golding (1999), the risk of depression and post-traumatic stress disorder is associated with intimate partner violence even higher than that resulting from childhood sexual assault. Depression has also been associated with other life stressors that often accompany domestic violence such as child abuse, daily stressors, forced sex with an intimate partner, negative life events etc. (Campbell et al. 2002).

Research on trauma has greatly increased over the past two decades, one result being that there is no simple picture or definition of PTSD, its cause or its treatment. Unlike most other psychiatric disorders, the criteria for PTSD include an anchor event or mental construct of a fearful event. The importance of this criterion is to place emphasis on an environmental trigger for the disorder.

According to Jordan et al. (2004), patients may describe fear and terror, flashbacks during which prior episodes of violence are relived, marked expressions of denial and avoidance, constricted affect, loss of memory for aspects of the traumatic incident, sleeping difficulties and nightmares, chronic

anxiety and hypervigilance, and marked physiological reactivity. “Extreme traumatic stressors” which are included in the criteria defining PTSD are characteristic of the experience of women victimized by intimate partner violence. Stressors inflicted by a known person are particularly likely to cause acute psychological distress (Jordan et al. 2004). The construct of posttraumatic stress encourages a focus on the cause of the stress (the outside coercion of a violent partner) rather than on an attributed ‘weakness’ of the abused woman. This approach emphasises that many of the psychological experiences of the affected women are normal human responses to a traumatic event, a message that can be very re-assuring for victims (Jordan et al. 2004).

According to Jordan et al. (2004) it is important for clinicians to identify those factors related to a client and her experience that will impact the likelihood of her suffering post trauma and other types of abuse-related reactions.

Intimate partner violence is also a significant risk factor for suicidal behaviour among women (Abott et al. 1995; Bergmann & Brismar 1991; Stark & Flitcraft 1996). Golding (1999) found a mean rate of 23,7% of battered women had attempted suicide, compared to 0,1% to 4,3% in the general adult female population. Across studies included in the review, the highest attempted suicide rates occurred among psychiatric patients.

Health behaviours

Abused women are more likely to have risky health behaviours than non-abused women. Several studies have found that women affected by interpersonal violence are more likely to consume alcohol and drugs, have a high tobacco consumption or have a significant higher use of pain medications than other women (Campbell 1992; Cokkinides & Coker 1998; Müller & Schröttle 2004; Pflichta 2004).

The question arises whether women try to blunt their reactions to trauma by dulling their senses with alcohol and drugs or whether women who use alcohol and drugs are more likely to live in ways that put them at greater risk of being abused by men. In the United States, a study conducted over the course of two two-years periods found that women who used illicit drugs, but not those who used alcohol, were at increased risk of being abused over the next two years of follow-up. As expected, any past or recent history of abuse was associated with increased rates of alcohol and drug use, even after controlling for prior use and other factors. These findings suggest that increased alcohol use is more an after-the-fact coping response to victimization, whereas drug use increases risk of being victimized at the same time that victimization increases the likelihood of using drugs (Heise et al. 1999: 22).

Reproductive and Maternal Health Consequences

Gynaecological problems are the most consistent, longest lasting and largest physical health difference between abused and non-abused women. Differential symptoms and conditions include sexually transmitted diseases, vaginal bleeding or infection, fibroids, genital infections, chronic pelvic pain and urinary-tract infection (Campbell et al. 2002). In one of the best-sampled US population-based studies of self-reported data, the odds of having a gynaecological problem were three times greater than average for victims of interpersonal violence. The combination of physical and sexual violence that characterises the experience of most abused women puts these women at an even higher risk for health problems than women only physically assaulted (Campbell et al. 2002).

Violence can also pose a serious risk during pregnancy. In Plichta's (2004) review of the research literature clear association emerged between violence around the time of a pregnancy and harmful maternal health behaviour. The main health effect specific to abuse during pregnancy is the threat to health and risk of death of the mother, fetus, or both from trauma. Physical abuse in pregnancy is associated with health problems during pregnancy such as sexually transmitted diseases, urinary tract infections, substance abuse, depression and other mental health problems¹⁴.

There is also more likely to be a delay in obtaining maternal health care (Plichta 2004; Hamberger et al. 2004). An average delay of 6,5 weeks is reported in one study with another study reporting women who are abused being twice as likely not to receive care until the third trimester (Mc Faarlane & Parker et al. 1996)

Pregnancy outcomes are negatively associated with violence exposure. Pre-term labour is found to be significantly related to violence, as is low birth weight, spontaneous abortion, hospitalization because of injuries and vaginal infections (Hamberger et al. 2004, Plichta 2004).

Health Impact Summary

Intimate partner violence has long-term negative outcomes even after the abuse has ended. The physical and emotional effects of intimate partner violence and threatened abuse may improve once the victim is no longer in the dangerous relationship. In a study of abused women, most perceived their physical and emotional health as deteriorating from the initial stages of the relationship, worsening during the time of abuse, and improving once the relationship ended

¹⁴ For an overview on existing studies see: Hamberger & Phelan 2004: 41f

(Jordan et al. 2004). These effects can manifest themselves in poor health status, poor quality of life and a comparatively greater use of health services.

As the studies above show, violence in intimate partnership is a significant direct and indirect risk factor for various physical health problems frequently seen in the health care settings. Intimate partner violence is one of the most common causes of injury in women (Campbell et al. 2002; WHO 2002; Garcia-Moreno et al. 2005a).

Women who have been targeted for intimate partner violence can be identified in a health-care setting where they seek treatment, care and support. However, health care providers need to be aware that women often do not disclose abuse, even when it is the underlying cause of their health-care visit.

3. Barriers for Appropriate Health Care

Health care provider barriers

Health care providers play an important role in impeding or facilitating appropriate assessment, diagnosis and treatment. An important component of the assessment and diagnostic process involves interviewing techniques and strategies as well as clinical observation. A number of factors can support health care providers' efforts to gather information as well as patients' efforts to provide information and receive the help they want and need (Hamberger et al. 2004).

However, studies show that health care providers have a number of barriers that obstruct a conscious effort to explore for interpersonal violence; the most typically identified barrier is lack of education and knowledge (Hamberger et al. 2004).¹⁵ It appears the most basic educational and knowledge deficits include lack of overall knowledge about domestic violence, such as a working definition of what domestic violence is, the dynamic of violence and the prevalence of victims in typical specialised health care settings. For untrained health care providers domestic violence is 'not on the radar screen' (Hamberger et al 2004: 166) and they may assume that their patients do not have such problems. Related to this knowledge deficit is a lack of understanding and skill to screen for intimate partner violence in the health care setting. Health professionals might have some knowledge about intimate partner violence but less understanding of how to ask women in a way that put victims at ease and facilitate valid responses. They also might not know how to respond appropriately when a woman disclose violence. Moreover, there is often a lack of information about specialised support services for female victims of violence in the community to which a provider could refer (Hamberger et al. 2004; Rönnberg et al. 2000).

¹⁵ for an overview of studies see Rönnberg et al. (2000) and Hamberger et al. (2004)

Another frequently mentioned barrier to routine screening in a medical setting is the fear of health professionals that women will be offended if asked about domestic abuse, the fear of overstepping boundaries and intruding into private family matters (Hamberger et al. 2004). But several studies show that most of the women in fact approve of being asked about domestic violence in health care settings (Gloor et al. 2004; Hamberger et al. 1998; Hellbernd et al. 2004; Westmarland et al. 2004). Studies suggest that certain forms of questioning in an empathic way may facilitate the comfort of the woman and help to disclose intimate partner violence.

A major barrier to screening and responding appropriately to intimate partner violence victims is time pressure. One result of a study conducted by Minsky et al. (2005) is that many health care providers discussed feeling overworked and overwhelmed by their current staffing responsibilities. They viewed adding intimate partner violence screening and intervention as a major impediment to performing their other duties in a professional and positive manner. Health care professionals also feared they might open ‘Pandora’s box’ upon identifying victims of intimate partner violence. Included in this box are strong emotional responses of the patient, time spent in crisis management, loss of control over the rest of schedule, fear of reprisal by the abusive partner, fear of litigation and inability to control the outcome for the woman etc (Hamberger et al. 2004; Rönnerberg et al. 2000). Health care providers are accustomed to following protocols and treatment guidelines and are trained to assess, diagnose and prescribe treatment. Intimate partner violence does not lend itself so neatly to such a model. The problem of time pressures could be also considered as a health system barrier (Hamberger et al. 2004).

Furthermore, provider attitudes and accountability can be a barrier for screening and appropriate response on disclosure. Several studies found that health care professionals hold attitudes and beliefs/myths about intimate partner violence that blame the victim. Frustration has also been identified in response to the female victim’s lack of ‘willpower’ to change her circumstances, once she has been identified as a victim, and with patients returning to abusive partners several times (Hamberger et al. 2004).

Another barrier is lacking inner-institutional support such as standard descriptions and protocols on dealing with victims of intimate partner.¹⁶ There is also a considerable debate about whether health care professionals who identify victims of intimate partner violence should be obliged to report cases to the criminal justice system (mandatory reporting).¹⁷ Many health care providers believe that this is a breach of confidentiality and can result in lower disclosure and increased risk for women (UN General Assembly 2006: 63).

¹⁶ For institutional barriers see the article by Hellbernd & Brzank in this book.

¹⁷ In many European countries with a national health care system financed by the state, doctors are obliged to report cases of domestic violence. Whereas in countries with an insurance paid system, this is not the case.

As experiences with intervention in medical facilities show, individual and institutional barriers can be overcome. The reason that violence is rarely made an issue in the health care setting is largely based on the fact that health care providers are not trained to face violence phenomena. In most of the curricula for health professionals training, intimate partner violence is not an issue (Surprenant 2002; Hellbernd et al. 2004).

Psychological Barriers to Disclose Violence

Female patients who struggle with intimate partner violence rarely volunteer or discuss such information with their health care providers. Although health care providers themselves create many barriers to screening and identification, female patients also create barriers to their own identification as a victim of interpersonal violence. This can be a logical survival mechanism designed to avoid further harm. Major barriers which female patients experience include lack of trust, fear of retribution and fear of loss of control over decision-making, concern that the health care provider might 'take over'.

According to Hellbernd (2006), a principal reason women are reluctant to volunteer information about violent experiences are feelings of shame and guilt, and a sense that they are responsible for the violence. Most women hope that they can stop a partner's abusive behaviour by doing everything he wishes. Most women fear that health care providers might take action without their consent, i.e. that the police or child protection services will be informed or the perpetrator approached. Another serious reason for women not to disclose abuse is the fear of an escalation of the abuse and threats when the abuse is disclosed and thus becomes 'public knowledge'. As the mental health consequences show, long term abuse can damage women's self-confidence and self-esteem to such an extent that looking for and acceptance of help and support in and of itself becomes difficult or – seemingly – next to impossible (Dutton 2002).

Results of the German prevalence study show that a significant number of the women interviewed had not previously ever told anyone about the violence. In the case of physical violence, 63% of the women had previously confided in a third person. In the case of sexual violence, only 53% had done so (Müller & Schröttele 2004).

However, studies verify that in the course of health treatment, female patients want their exposure to violence and its effect on their health conditions taken into account in the treatment setting (Hamberger et al. 2004). If abused women seek professional help, health care providers are the first contact person they would trust, followed by the police and specialised support services (Müller & Schröttele 2004).

4. Improving Health Care Responses

What Women Value most

The review of several studies by Hamberger et al. (2004) shows that abused women have fairly clear ideas about what constitutes helpful and effective health care interventions. Specifically, women suffering intimate partner violence value respect of their autonomy and decision-making abilities. They most value emotional support and validation of their experiences and want careful examinations of the violence history and consequential injuries (Hamberger et al. 2004: 235). Furthermore, women suffering intimate partner violence are concerned about the safety of children in the home and the medical record of child abuse.

Principles of Intervention in Cases of Intimate Partner Violence

The first principle of care for intervention in cases of intimate partner violence is patterned after the Hippocratic oath, admonishing physicians ‘to help – at least to do no harm’¹⁸. Physicians should be trained to attain a basic level of competence to identify victims of intimate partner, to conduct preliminary risk assessments and refer women to specialised services for further support. *“Inappropriate care or careless approaches to treatments should never result in injury or loss of life to any of the parties involved”* (Jordan et al. 2004:102). Furthermore, appropriate responses to women suffering from the consequences of intimate partner violence should not be a model of pathologising their reactions but a model of empowerment. The reactions to life-threatening trauma should be seen as reasonable in their context rather than as symptoms of illness or disorder. In practice this principle ensures an environment which accepts the victim and avoids blaming her. Providing safety for women and children must have priority and should be the foundation on which all treatment decisions are based (Jordan et al. 2004).

A debate in recent years has emerged over the benefits and risks of having health care provider routinely screen women for intimate partner violence. In resource-poor settings, routine screening can harm women if health care providers are not prepared to respond appropriately. This is the case if privacy and confidentiality cannot be assured or if a referral to specialised supporting system is lacking (Morrison et al. 2007). A number of experts recommend selective screening – asking only women with certain conditions that may raise the suspicion of intimate violence, so-called ‘red flags’:

¹⁸ www.geocities.com/everwild7/noharm.html

- Chronic, vague complaints that have no obvious physical cause,
- Injuries that do not match the explanation of how they occurred,
- A male partner who is overly attentive, controlling, or unwilling to leave the woman's side,
- Physical injury during pregnancy,
- Late entry into prenatal care,
- A history of attempted suicide or suicidal thoughts,
- Delays between injuries and seeking treatment,
- Urinary tract infection,
- Chronic irritable bowel syndrome,
- Chronic pelvic pain (Heise et al. 1999: 24).

But women have a very different view. In an evaluation research review on good practice (Hanmer, Gloor et al. 2006), a CAHRV group summarized the evaluation results of studies that explored the standpoint of women:

“By a considerable majority, patients are positive about initiatives that routinely ask about victimisation experiences” (Hanmer, Gloor et al 2006: 49).

Some research exists on screening projects demonstrating the effectiveness for early identification, support and referral (Hellbernd et al. 2004; Regan 2004; Romito et al. 2004; Westmarland et al. 2004).

Many programs have tried to strengthen the health service response to intimate partner violence in the past decades. The central lesson is that improving health service responses requires a system-wide approach (Heise et al 1999, WHO 2002). Examples include strengthening policies, protocols and norms, upgrading the infrastructure of clinics to ensure privacy and adequate supplies. It is recommended that all health professionals and health care administration management be trained and thus enabled to respond appropriately to intimate partner violence. It must be ensured that only trained staff screen women for violence histories and that a referral network exists or, failing that, that a cohesive network be established. Health care professionals should be competent to provide emotional, non-judgemental support, assess a woman's level of danger, provide crisis intervention, document the cases and make referrals to specialised women's support services.

Following recommendations from a WHO study aim at strengthening the health care sector response to violence against women:

1. Develop a comprehensive health sector response to the effects of violence against women by:

- identifying roles for health professionals in advocating for prevention of violence and in providing services for women
- coordinating and working with other health professionals and with other actors that care for abused women (for example, by creating formal referral processes and protocols)
- integrating appropriate not-stigmatising, non-blaming, respectful, secure, and confidential responses to violence against women in: all aspects of care (such as emergency services, reproductive health services, mental health services, HIV related services)
- sensitising and training of health professionals.

2. Use reproductive health services as entry points for identifying and supporting women in abusive relationships, and for delivering referral or support services:

- Establish protocols and referral systems to enable trained reproductive health providers to recognise and respond appropriately to violence, ensuring confidentiality, and making women's safety a priority.
- Add an anti-violence component to antenatal services, parenting classes, and other services that involve men (Garcia-Moreno et al. 2005b).

The WHO also published a handbook on interpersonal violence prevention programmes which aims to present a framework and methodology for the identification, classification and documentation of such programmes (WHO 2004). The handbook includes an overview of the public health approach to understand and prevent violence. The public health approach is science-based and promotes a multidisciplinary response system in which multiple professions and policy areas contribute to violence prevention, including educators, health care workers, the police, NGOs and government ministries responsible for social policy – the focus and not exclusively on public health professionals (WHO 2004: 10).

5. Conclusion

During the past several years much effort has been made to raise awareness on violence against women as a form of human right violation and on the unique role of the health care sector in a multi-sectoral approach to combat violence against women. Right now there is growing effort to strengthen policies and system-wide approaches to integrate the health care sector in existing multi-agency strategies for intervention. Guidelines and protocols have been developed in many countries and recommendations formulated by the WHO and national and international organisations. In some countries guidelines, protocols and training units on the topic are well established and systematically implemented. In other countries, there has been no effort to strengthen

healthcare intervention in cases of intimate partner violence. In many European countries, removing barriers to appropriate health care responses is very challenging as the health care sector is not a hierarchical system where decisions, if made by stake-holders, can be nationally implemented top-down. Therefore it is necessary that there be a clear policy decision at the national level (reinforced through binding guidelines and protocols), as well as at the relevant management levels decisive for the implementation of appropriate measures and programmes. For example, in the clinical context a clear decision on the part of management and administration is needed if measures intended to improve health care responses and in order to care adequately for victims of violence are to be implemented in reality. Investment in appropriate programmes and measures for intervention and prevention in cases of intimate partner violence can reduce the immense burden for society, but moreover may reduce the pain and suffering of individuals when the needs of victims are tackled appropriately. Much more effort should be also made in conducting research on the effectiveness of measures, whether recently developed guidelines and protocols are in fact being used in the field and to what effect. Models of promising and good practice should be rigorously evaluated and – where validated – be replicated. Science-based health care and health care setting violence intervention research should highlight the question what is really helpful for women who suffer from intimate partner violence.

References

- Abott, J.; Johnson, R.; Koziol-McLain, J.; Lowenstein, S.R. (1995): Domestic violence against women. Incidence and prevalence in an emergency department population. In: *Jama* 273 (22): 1763-7.
- Bergman, B; Brismar, B. (1991): Suicide attempts by battered wives. In: *Acta Psychiatr Scand* 83 (5): 380-4.
- Campbell, J. (1992): Prevention of Wife Battering: Insights from Cultural Analysis. In: *Response to the Victimization of Women and Children* 14 (3): 18-24.
- Campbell, J.; Jones, A.S.; Dienemann, J.; Kub, J.; Schollenberger, J et al. (2002): Intimate partner violence and physical health consequences. In: *Arch Intern Med* 162 (10): 1157-63.
- Cokkinides, V.E.; Coker, A.L.; Sanderson, M.; Addy, C.; Bethea, L. (1999): Physical violence during pregnancy: maternal complications and birth outcomes. In: *Obstet Gynecol* 93 (5 Pt 1): 661-6.
- Commission Against Gender Violence of the National Health System's Interterritorial Council (2008): Common protocol for a healthcare response to gender violence. Ministry of health and consumers affairs. Spain

www.msc.es/organizacion/sns/planCalidadSNS/pdf/equidad/commonProtocol.pdf

Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)
www.un.org/womenwatch/daw/cedaw/

Council of Europe (2002): Recommendation Rec (2002)5 of the Committee of Ministers to member States on the protection of women against violence adopted on 30 April 2002
www.coe.int/t/e/human_rights/equality/05._violence_against_women/

Council of Europe Parliamentary Assembly Recommendation 1450 (2000): Violence against women in Europe.
<http://assembly.coe.int/Mainf.asp?link=/Documents/AdoptedText/ta00/EREC1450.htm>

Coney-Beasley, T.; Moracco, K.E.; Casteel, M.J. (2003): Adolescent femicide: a population-based study. In: Archives of Pediatric and Adolescent Medicine 157 (4): 355-360.

Dutton, M.A. (2002): Empowering and healing the battered woman. A model for assessment & intervention. New York : Springer Publishing Company.

Dutton, M.A.; Green, B.L.; Stacey, I.K.; Darren, M.R.; Zeffiro, T.A.; Krause, E.D. (2006): Intimate partner violence, PTSD, and adverse health outcomes. In: Journal of interpersonal violence 21 (7) Sage publications: 958-968.
www.jiv.sagepub.com/cgi/content/abstract/21/7/955

Family Violence Prevention Fund FVPF (1998): Improving the Health Care Response to Domestic Violence: A Resource Manual for Health Care Providers. San Francisco .
www.endabuse.org

Fanslow, J., Norton, R.N. and Spinola, C.G. (1998): Indicators of assault-related injuries among women presenting to the ED emergency department. In: Ann Emerg Med. 32: 1-8.

García-Moreno, C.; Jansen, H.; Ellsberg, M.; Heise, L. and Watts, C. (2005a): WHO Multi-country Study on Women's Health and Domestic Violence against Women.
www.who.int/gender/violence/who_multicountry_study/en/

Garcia-Moreno, C.; Heise, L.; Jansen, H.; Ellsberg, M. and Watts, C. (2005b): Public Health: violence against women. In: Science 310 (5752): 1282 – 1283.
DOI: 10.1126/science.1121400

Gloor, D. and Meier, H. (2004): Frauen, Gesundheit und Gewalt im sozialen Nahraum. Repräsentativbefragung bei Patientinnen der Maternité Inselhof Triemli, Klinik für Geburtshilfe und Gynäkologie. Hrsg. von dem Büro für die Gleichstellung von Frau und Mann der Stadt Zürich und der Klinik Maternité Inselhof Triemli. HuberZürich.

Golding, J.M. (1999): Intimate partner violence as a risk factor for mental disorders: a meta-analysis. In: Journal of Family Violence 14 (1): 1-17.

Hagemann-White, C. and Bohne, S. (2003): Versorgungsbedarf und Anforderungen an Professionelle im Gesundheitswesen im Problembereich Gewalt gegen Frauen. Expertise für die Enquêtekommission. Zukunft einer frauengerechten Gesundheitsversorgung in Nordrhein-Westfalen. Osnabrück.

- Hagemann-White, C.; Katenbrink, J. and Rabe, H. (2006): Combating violence against women. Stocktaking study on the measures and actions taken in Council of Europe member States. Directorate General of Human Rights, Strasbourg.
www.coe.int/equality
- Hamberger, L.K. and Phelan, M. B. (2004): Domestic violence screening and intervention in medical and mental healthcare settings. New York: Springer publishing company.
- Hanmer, J.; Gloor, D. et al. (2006): Agencies and evaluation of good practice: domestic violence, rape and sexual assault. www.uni-osnabrueck.de - publications
- Heise, L.; Ellsberg, M. and Goettemoeller, M. (1999): Ending Violence Against Women. Baltimore. Centre for Health and Gender Equity – CHANGE. John Hopkins University: School of Public Health.
- Hellbernd, H.; Brzank, P.; Wieners, K. and Maschewsky-Schneider, U. (2004): Häusliche Gewalt gegen Frauen: gesundheitliche Versorgung. In: Das S.I.G.N.A.L.-Interventionsprogramm. Handbuch für die Praxis, Wissenschaftlicher Bericht. Gefördert mit Mitteln des Bundesministeriums für Familie, Senioren, Frauen und Jugend. Berlin.
www.bmfsfj.de/Kategorien/Forschungsnetz/forschungsberichte,did=18204.html
- Hellbernd, H. (2006): Häusliche Gewalt gegen Frauen: gesundheitliche Versorgung. In: Das S.I.G.N.A.L.-Interventionsprogramm. Curriculum. Gefördert mit Mitteln des Bundesministeriums für Familie, Senioren, Frauen und Jugend. BMFSFJ. Berlin.
- Herman, J.L. (1992): Trauma and Recovery: The Aftermath of Violence – From Domestic Abuse to Political Terror. New York.
- Jordan, C. E.; Nietzel, M.T.; Walker, R. and Logan, T.K. (2004): Intimate Partner Violence: A Clinical Training Guide for Mental Health Professionals. New York
- Kendall-Tackett, K. A.; Williams, L. M. and Finkelhor, D. (1993): Impact of sexual abuse on children: A review and synthesis of recent empirical studies. In: Psychol. Bull., Jg. 113: 164-180.
- Martinez, M.; Schröttle, M.; Condon, S. et al. (2006): State of European research on the prevalence of interpersonal violence and its impact on health and human rights. In: CAHRV – Report 2006. Co-ordination Action on Human Rights Violations funded through the European Commission, 6th Framework Programme, Project No. 506348.
<http://www.cahrvi.uni-osnabrueck.de> - publication
- McFarlane, J.; Parker, B. and Soeken, K. (1996): Abuse during pregnancy: associations with maternal health and infant birth weight. In: Nurs Res 45 (1): 37-42.
- Minsky-Kelly, D.; Hamberger, L.K.; Pape, D. and Wolff, M. (2005): We've had training, now what?: Qualitative Analysis of barriers to domestic violence screening and referral in a health care setting. In: Journal of Interpersonal Violence, Sage publications (20): 1288.
- Morrison, A.; Ellsberg, M. and Bott, S. (2007): Addressing Gender-Based Violence: A critical review of Interventions. Published by Oxford University Press on behalf of the

International Bank for Reconstruction and Development (THE WORLD BANK Research Observer Advance Access).

- Muelleman, R.L.; Lenaghan, P.A. and Pakieser, R.A. (1996): Battered women: injury locations and types. In: *Ann Emerg Med* 28 (5): 486-492.
- Muelleman, R.L.; Lenaghan, P.A. and Pakieser, R.A. (1998): Nonbattering presentations to the ED of women in physically abusive relationships. In: *Am J Emerg Med* 16 (2): 128-131.
- Müller, U. and Schröttle, M. (2004): Lebenssituation, Sicherheit und Gesundheit von Frauen in Deutschland. Eine repräsentative Untersuchung zu Gewalt gegen Frauen in Deutschland. Im Auftrag des Bundesministerium für Familie, Senioren, Frauen und Jugend.
Download der Kurz- und Langfassungen dieser und der folgenden Dokumentationen unter: www.bmfsfj.de Stichwort→Forschungsnetz→Forschungsberichte)
- Pflichta, S.B. (2004): Intimate partner violence and physical health consequences. Policy and practice implications. In: *Journal of interpersonal violence*, Sage Publications 19 (11): 1296-1323.
- Surprenant, Z. (2002): The Abuse Assessment Response Course by Physicians for a Violence-free Society (PVS). Physicians for a Violence-free Society (PVS).
- Regan, L. (2004): Final Report on the Portsmouth Domestic Violence Early Intervention Project (EIP) Evaluation. London Metropolitan University.
- Robert Koch Institut RKI (Hg.) (2008): Gesundheitliche Folgen von Gewalt unter besonderer Berücksichtigung von häuslicher Gewalt gegen Frauen. Editor: Hornberg, C.; Schröttle, M.; Bohne, S.: RKI Gesundheitsberichterstattung des Bundes, Heft 42.
- Rönnerberg, A. K. and Hammarström, A. (2000): Barriers within the health care system to dealing with sexualized violence: a literature review. In: *Scand. J. Public Health* 28: 222-229.
- Romito, P.; De Marchi, M.; Molzan T.; Ciociano Bottaretto R. and Tavi, M. (2004): Identifying violence among women patients attending family practices: The role of research in community change. In: *Journal of Community and Applied Social Psychology* 14: 1-16.
- Saltzman, L.E.; Johnson, C.H.; Gilbert, B.C. and Goodwin, M.M. (2003): Physical abuse around the time of pregnancy: An examination of prevalence and risk factors in 16 states. *Matern Child Health J.* 7: 31-43.
- Schröttle, M.; Martinez, M.; Condon, S. et al. (2006): Comparative reanalysis of prevalence of violence against women and health impact data in Europe – obstacles and possible solutions. Testing a comparative approach on selected studies. In: CAHRV – Report 2007. Co-ordination Action on Human Rights Violations funded through the European Commission, 6th Framework Programme, Project No. 506348. www.cahrv.uni-osnabrueck.de

- Stark, E.; Flitcraft, A. (1996): *Women at Risk: Domestic Violence and Women's Health*. Thousand Oaks
- Tjaden, P. and Thoennes, N. (2000): Prevalence and consequences of male-to-female and female-to-male intimate partner violence as measured by the National Violence Against Women Survey. In: *Violence Against Women*, 6. Jg. (2): 142-161.
- UN General Assembly (2006): 61st session: In-depth study on all forms of violence against women. Report of the Secretary-General. A/61/122/Add.1.
- United Nations Declaration on the Elimination of Violence against Women, General Assembly Resolution, December 1993.
[www.unhcr.ch/huridocda/huridoca.nsf/\(Symbol\)/A.RES.48.104.En](http://www.unhcr.ch/huridocda/huridoca.nsf/(Symbol)/A.RES.48.104.En)
- Westmarland, N.; Hester, M. and Reid, P. (2004): *Routine Enquiry about Domestic Violence in General Practices: a Pilot Project*. Bristol: School for Policy Studies, University of Bristol.
- WHO (2004): *Handbook for the documentation of interpersonal violence prevention programmes*. Geneva
- WHO (2002): *World report on violence and health*, D.L. Krug, E.; Mercy, J.A.; Zwi, A.B.; Lozano, R.; Editor. World Health Organization: Geneva.

Domestic Violence against Women: Health Care Needs and the S.I.G.N.A.L.-Intervention Programme

Hildegard Hellbernd & Petra Brzank

Introduction

When describing the German approach to domestic violence (DV) and health care, we have to emphasize the S.I.G.N.A.L.-project and its contribution to the discussion and the subsequent development of different types of interventions. Similar to other countries, the German discussion about gender based violence against women started in 1970 and the serious health consequences caused by DV were described by workers and researchers of women's shelters at the end of 1970. Inspired by project models in the USA, like RADAR-project, which were introduced at the 4th World Conference on Women in Beijing in 1995, S.I.G.N.A.L. started in 1999 at the Charité University Medicine in Berlin. It was established by German nurses, who faced victims of DV and their severe injuries in their daily work. 'S.I.G.N.A.L. – against violence against women' was the first health care intervention programme concerned with reducing violence against women and enhancing medical care for abused women. Before S.I.G.N.A.L. commenced, there was no similar intervention of a combined approach in addressing the issue of DV within the health care sector and attempting to intervene. The programme is based on different elements: The acronym S.I.G.N.A.L. gives detailed action recommendations to health care professionals when they encounter a victim of DV. With DV focused training they learn how to treat victims without blaming them. Information about further support and advocacy for the affected women reduces the burden on health care professionals. During the pilot phase, the first German documentation form was developed in order to give evidence about the injuries, women had suffered.

The project implementation process was evaluated by the Institute of Public Health Science at the Technical University Berlin from 2000 to 2003, and was funded by the German Ministry of Family, Senior Citizens, Women and Youth (BMFSFJ). Besides monitoring the model project, another main focus of the evaluation team was in estimating and describing the problem. For the first time in Germany, data was collected and analysed to describe the prevalence and health impact of DV and to assess the health care needs of women affected by DV (Wieners and Hellbernd 2000; Hellbernd and Wieners 2002). An initial female patient-survey was undertaken in a hospital accident and emergency department (A&E Dept) (Brzank, Hellbernd et al. 2004).

This article details the epidemiology of DV in Germany, such as, prevalence, health consequences and the health care situation of victimised women, the potential role of health care providers for intervention and prevention, and the expectations of women towards health care professionals. Basic elements,

international standards and behavioural recommendations are described according to the S.I.G.N.A.L.-acronym. Furthermore, the main aspects of the implementation process will be explained. Concluding with the importance of DV and the related health aspects within the health care sector.

Definition

According to the World Health Organization (WHO) violence is defined by

“The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation.” (WHO 1996)

DV describes violence between adults in the family such as between parents or intimate partners. Nowadays, DV is used synonymously with Intimate Partner Violence (IPV). The lack of gender in the terms DV or IPV has been criticized by feminist researchers: *The figures demonstrate the gender differences, and in most cases, men are the violent perpetrator against their wives or intimate female partner and their children* (Schweikert 2000; Kommoß 2002).¹

DV or IPV specify a complex system of abuse which covers a pattern of physical, emotional/psychical and sexual violence in order to achieve power and control within a relationship. Ongoing DV forces victims to live in continual fear of the next unpredictable outburst of violence.

DV/IPV can affect any woman regardless of social, economic, religious or cultural affiliation.

Prevalence

Concerning the prevalence of DV/IPV in Germany, we can draw on the results of two investigations.

1) The national representative study on violence against women was conducted on behalf of BMFSFJ. The study was based on a representative community random sample in which more than 10,000 women were asked anonymously about their experience with violence. According to the results of this cross-sectional study:

¹ cf. Crime statistics eg.:

Berlin www.berlin.de/imperia/md/content/seninn/abteilungiii/kriminalitaetsstatistiken2007/pks.pdf,

Hessen www.familienatlas.de/global/show_document.asp?id=aaaaaaaaaepfx,

Brandenburg www.internetwache.brandenburg.de/fm/85/Lagebild-hausliche_gewalt%202004.pdf

- every fourth woman, 25%, suffered physical and/or sexual violence as IPV
- every seventh woman, 13%, reported sexual violence irrespective of the victim-perpetrator relationship
- more than one third of the victims reported injuries caused by violence during their life-time after the age of sixteen. (Müller & Schröttle 2004)

These German figures for DV or IPV correspond to the results for European prevalence studies on this subject (Schröttle, Martinez et al. 2006).

2) The S.I.G.N.A.L.-female patient survey: During the S.I.G.N.A.L.-evaluation, in the early summer of 2002 a quantitative, cross-sectional survey was undertaken in Germany with female A&E Dept. patients (aged 18 - 60) to document lifetime prevalence of DV in women, sequelae and the expectations of support and intervention. The data-analysis was based on 806 women; the response rate was 70.3%. 36.6% of women reported at least one episode of domestic violence after the age of 16. 4.6% were victims of DV within the past year. 1.5% of women presented to the emergency department for treatment of injuries caused by violence during the seven weeks of investigation.

Figure 1 shows the prevalence of the different kinds of violence the interviewed women experienced from their intimate partners or family members. Physical (26.6%) and psychological violence (30.8%) were more often reported than sexual violence (12.7%). The complex abuse system of DV becomes apparent by the high overlap of the different violence forms. Few women reported one single form of violence (32 women only physical, 3 women only sexual, and 61 women only psychological violence) whereas the majority of interviewed women reported two or more forms of violence.

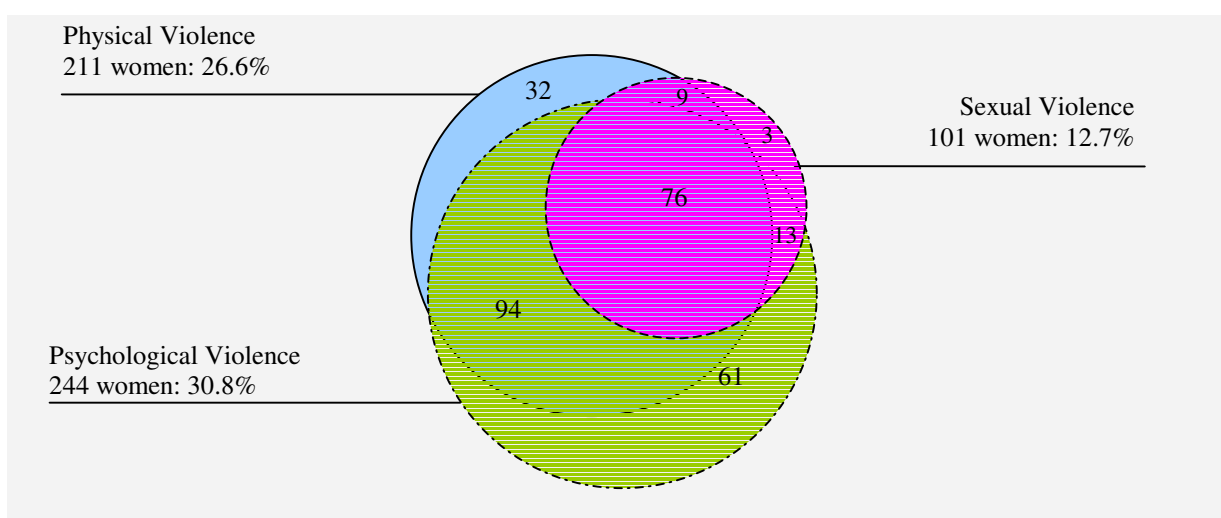


Figure 1: Overlap of lifetime prevalence of physical, sexual and psychological violence as DV after the age of 16 (n=793²)

² Only women who answered the questions to all three violence forms have been included.

Health Consequences

Violence has a serious impact on health, health behaviour and health prospects. The WHO considers violence as a significant risk factor in morbidity and mortality in women. Short, middle and long term health consequences have been shown. (Krug, Dahlberg et al. 2002)

The effects on health, health behaviour and health prospects are profound. A variety of international studies, principally from the US, demonstrate the correlation between violence victimisation and multifaceted health consequences (cf. Hellbernd, Brzank et al. 2004) (see figure 2):

- **Acute non-fatal:** Most obvious and visible are injuries as a direct consequence of physical violence, like incision wounds, cuts, lacerations and burns, bruises, haematoma, strangulation marks, gunshot wounds, stab wounds, fractures, injuries of the eardrum and the jaw and dental injuries. Violence can cause permanent disabilities such as impairments of sight, hearing and mobility.
- **Fatal injuries:** Women die from their fatal injuries, are murdered or commit suicide.
- **Somatic and psychosomatic complaints:** Psychosomatic reactions including chronic pain syndromes, gastrointestinal disorders, breathing difficulty, and eating disorders are rarely attributed to the impact of DV because of their multifactor causes. Additionally, violence can cause chronic-strain anxiety and uneasiness which are manifested in psychosomatic complaints as a reaction to stress. Violence can also interfere with reproductive health by increasing the risk of complications during pregnancy, injury to the foetus, premature birth, lower birth weight or mis-carriage.
- **Psychological consequences are often more serious:** Exposure of women to violence also results in a number of documented mental health sequelae such as depression, panic attacks and other anxiety disorders, nervousness, sleep disorders, lack of concentration, disorders of sexual sensitivity, fear of intimacy, low self-respect and self-esteem, suicidal behaviour and suicide, self-harm, and post-traumatic stress disorder (PTSD). Additionally, permanent personality disorders, borderline disorders, and multiple personality disorders (dissociative identity disorder) have been identified as possible consequences of violence.
- **Unhealthy coping strategies:** Victims of DV often resort to hazardous health strategies in order to deal with the effects of DV e.g. consumption of intoxicating or perception-distorting substances which act as a temporary escape and help women repress or alleviate their traumatic experiences. These substances include amongst others sedatives, tobacco, alcohol, other medication or drugs.

- **Health care:** International studies have also shown that victimised women seek higher levels of health care, surgery, in-patient and psychological treatment than non-abused women. Violence is seldom taken into account as a cause of injuries/health problems and may result in inappropriate care (under/over treatment). Early detection of violence related disorders as well as appropriate treatment therefore may therefore reduce health care costs.

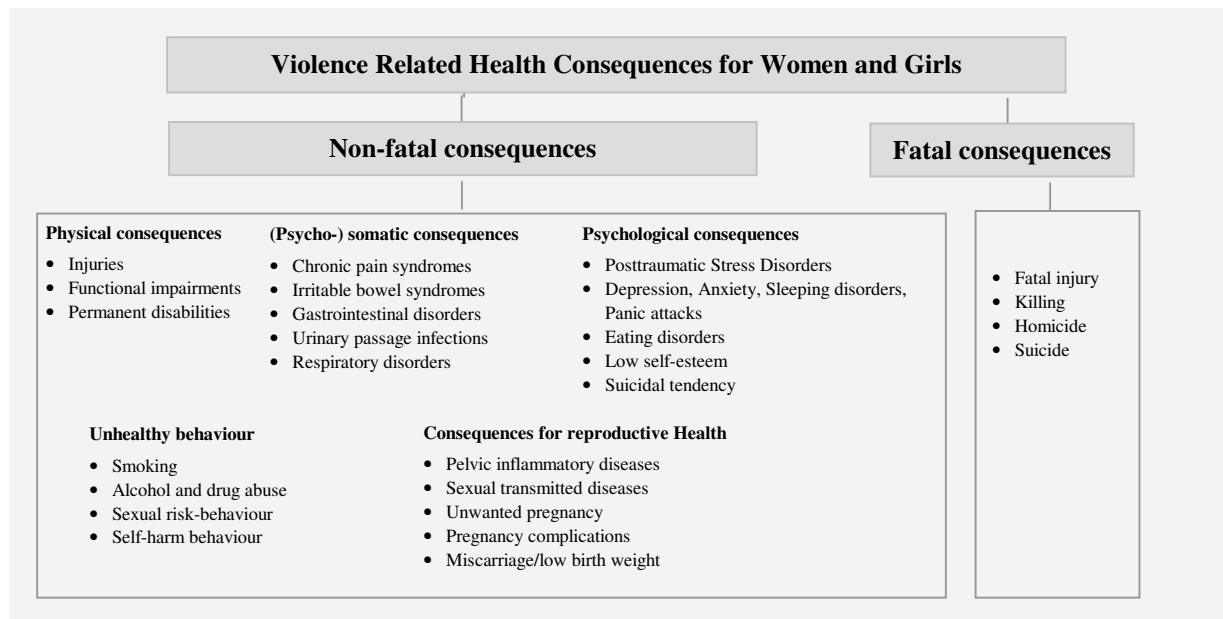


Figure 2: Violence related Health Consequences for Women and Girls (CHANGE 1999) (cf. Hellbernd, Brzank et al. 2004)

According to the German representative survey (Müller and Schröttle 2004), 64% of victims of physical or sexual intimate partner violence reported physical injuries as a direct consequence of these violent acts. The majority of these women reported haematomas/bruises (89%) followed by general body pain (26%), open wounds (20%), abdominal pain and distortion/strains (18%), head- (18%) and vaginal-injuries (10%), concussion (10%), body fractures (5%), miscarriage (4%) and internal injuries (3%).

In the S.I.G.N.A.L.-survey (Brzank, Hellbernd et al. 2004), 57% of the victims of at least one episode of domestic violence in their lifetime reported health consequences, 32% stated that they suffered physical as well as psychological consequences, 3% reported exclusively physical impacts in nature and 22% exclusively psychological impacts (see figure 3).

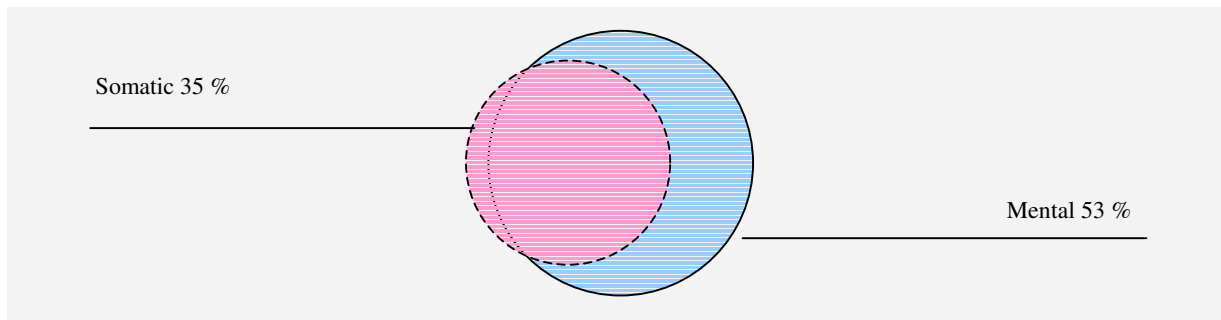


Figure 3: Health consequences caused by physical and/or sexual IPV (n=229)

Ranked by prevalence, the dominant injuries were haematoma/bruises (44%), fractures/ruptures (10%) and stab/gunshot wounds/burns (10%). 60% of all injuries were located in head region, 17% of which were injuries of the mouth, jawbone or teeth. By a comparison of the interviewed patients, all victim groups reported attending the A&E Dept. more often because of injuries than non-victims.

Women who experienced violence during the last twelve months had a significantly higher level of attendance at hospital A&E Dept. because of oral and maxillofacial injuries.

Victimised women recognized somatic complaints and pain syndromes to be causally connected with violence: The health disorders most frequently stated were gastro-intestinal disorders (23%), headaches/ migraines (18%) and cardiovascular complaints (14%). In comparison with the women who had not suffered violence the victimized women sought more often medical treatment in the emergency ward because of unspecific abdominal pain.

With respect to psychological consequences, anxiety/panic attacks prevailed (33%) co-morbid with depression (15%). Auto-aggressive behaviour and suicide attempts were indicated by 5% of participants during their lifetime.

Half of the women who reported health consequences had received medical care, in their lifetime, for their violence related injuries or complaints: 22% received care in the A&E Dept., 35% in private practice and 10% received clinical inpatient treatment.

Health Care Situation

Violence is a significant risk factor for the health of women. In the face of multiple and complex health disorders, an appropriate consideration of violence as a cause of injuries or disorder is required in the treatment context.

The German representative study about violence against women showed that one in five women, (20%), experiencing physical or sexual violence was treated by a doctor. However, 14% of women severely injured through physical

violence and 27% of women injured through sexual assault reported they hadn't sought medical assistance, although their injuries merited it. Especially in cases of sexual violence, it appears women find recourse to medical help difficult. Only 12% of these women had consulted a doctor (Müller/Schröttle 2004).

When women seek medical care there is a high risk that the cause of the injury or complaint will not be identified. Violence as a background or context for a medical complaint or injury is often underestimated. According to a Berlin survey, only one out of ten cases of DV were detected by GPs (Mark 2000).

The neglect of violence as a cause or context of illnesses or injuries can result in inappropriate health care response. Intimate partner violence is often unrecognized, health care characterised by missed diagnosis, medicalisation, denial and inadequate care. Inappropriate treatment can result in a complaint worsening into a chronic condition or into a long-lasting disability and impairment.

A lack of consideration of the causes behind medical complaints can lead to a greater demand being placed on health care providers. Affected women go to health care facilities more frequently, have a higher surgery rate, need more in-patient care, and increasingly utilise mental health care facilities (cf. Krug, Dahlberg et al. 2002). Studies from psychosomatic clinics show that women traumatised by violence exhibit long histories of inappropriate treatments with unsuccessful therapies (Verbundprojekt 2001).

Health care providers' key role in the intervention against violence

A timely intervention can prevent not only inappropriate treatment but can prevent further violence. Health care professionals are often the only people outside a woman's social isolation who witness the results of physical violence on the woman's body.

In the German representative study, doctors were identified as the preferred contact person for women looking for institutional help outside family and friends; in second place the surveyed women identified women's advisory organisations and shelters; in third place came the police (Müller/Schröttle 2004).

The S.I.G.N.A.L.-survey of 806 female patients on a Berlin based A&E Dept. showed that for 67% of respondents, a doctor would be considered an important contact person in cases of abuse. However, only 7.5%, of the women have ever been asked by their doctor about possible experiences of violence (Hellbernd/Brzank et al. 2004).

Health care professionals play an important intermediary role by referring women to further resources within the health system. They can take on a key position in the support of abused women and in the prevention of domestic

violence. To best use this chance of intervention, it is important for the health care staff to be equipped with the necessary skills.

A prerequisite is the recognition of injuries and disorders caused by violence and sensitivity to these problems and issues. Talking with a patient early on about violence and pointing out support services can be a decisive step in reducing violence.

Patient expectations

International studies have shown that many women talk openly about the abuse and mistreatment when they are approached in a direct, sympathetic and non-condemning manner (Rodriguez, Quiroga et al. 1996; Hamberger, Ambuel et al. 1998). Surveys in Germany confirm these findings. For example, a hypothetical question about a future incident of domestic violence was given to all respondents in the S.I.G.N.A.L.-enquiry. Their preferred criteria for a contact person was “showing understanding” which was indicated by more than half of respondents (51%), one third would prefer a female, and one in ten would prefer the contact person to be a medical doctor. Nevertheless, female patients affected by violence often prefer to contact female staff: Of the women who had suffered acute violence, 45.5%, preferred a female health care provider; among interviewed women exposed to sexual violence, 36%, wanted a female health care provider (Hellbernd, Brzank et al. 2004).

Further insight into the expectations of women affected by violence towards health care is given by a German representative survey. In a qualitative interview, seven group-discussions were held with a total of 77 women participating (Glammeier, Müller et al. 2004). With regards to medical care, women affected by violence approached the health care staff with the following requests:

- Acknowledgement of violence as a trigger of health problems,
- No downplaying of psychological reactions to violence situations,
- No medication without considering the causes of the symptoms,
- A sensitive approach towards their living situation and towards the problem of domestic violence in the case of obvious symptoms and psychosomatic disorders,
- No tranquilisation with psychotropic drugs,
- Concern for their living situation, which makes it easier for them to disclose the violence situation, i.e. sensitivity towards their situation.

Within the health care system, it is of major importance that victims of violence are dealt with by staff, who respond sensitively and competently to the

realities of their situation, and who are able to refer the women to specific support facilities.

During the S.I.G.N.A.L.-patient survey, female patients were asked about their opinion regarding routine screening for violence in medical history case notes, as already recommended in Anglo-American countries where such questions are routinely included. The answers were clear: Nearly 80% of the surveyed women desired the routine inclusion of violence-related questions; 39% considered the questions important, 39% considered the questions uncomfortable, however, still important. The study shows no significant difference in response between women who have been affected by violence and those who have not (Hellbernd/Brzank et al 2004).

Health care personnel are important contact people for women affected by violence, but barriers on both sides, which hinder the ease with which violence can be talked often, remain. If a patient manages to conquer feelings of shame and fear, and speak about painful memories, there is always the risk that she will not be taken seriously, or understood, or receive any advice pertinent to the realities of her life.

Whether an intervention takes place, depends to a large degree on whether the abused woman finds competent health care professionals. The Berlin S.I.G.N.A.L.-intervention programme aimed to improve this situation and included the conditions of need oriented health care for female victims of intimate partner violence.

Intervention in domestic violence

The concept of the S.I.G.N.A.L.-programme, with regards to the intervention model and measures taken against domestic violence, was developed and field tested in Anglo-American countries. The S.I.G.N.A.L.-programme is based on the following intervention steps:

- identify violence and actively asking for violence
- documentation of injuries and health problems for use in legal proceedings
- danger and safety assessment
- dissemination of information and referral to counselling and shelter facilities

These intervention steps come together to form the S.I.G.N.A.L.-guidelines. These have been developed as an orientation for establishing relevant contact with victims of sexual and domestic violence. Each letter of the acronym stands for a guideline recommendation.

S.I.G.N.A.L.–guidelines

The **S.I.G.N.A.L.**-guidelines for the hospital staff are as follows:

Speak to the patient and indicate your willingness to help.
--

S	Women open up if they sense that someone is genuinely listening to them and will take their issues seriously.
----------	---

An active response to violence is important as few women, out of embarrassment or fear, tend not to speak out about violence being the cause of the illness or injury. From studies we know that doctors and nurses are valued as contact people, and that female patients respond positively to the idea of being questioned openly about possible violence (Hellbernd/Brzank et al. 2004, Müller/ Schröttle 2004).

Indicators of violence ‘Red Flags’

There are indicators in certain cases and with certain symptoms which point to the possible presence of violence. These indicators are adopted as alarm signals or ‘Red Flags’.

Situational evidence: For example, a refusal by the accompanying partner to leave the patient’s side; a tendency to answer for the patient and appear too overprotective; the explanation of how the injury occurred doesn’t correspond to the actual injury; the explanation is contradictory and/or full of omissions. From time to time, the female patient will attempt to downplay or conceal the injury. Medical staff should also be alert to conspicuously long time lapses between the consultation and the origin of the injury.

The type of injury and complaint: For example, typical signs of self defence injuries, multiple injuries distributed over the entire body, injuries at different stages of healing, further common injuries include: ear drum injuries, physical violence during pregnancy, fractured nasal bones, broken arms, ribs, jaws and teeth. Research indicates that the head and face are most affected by violence.

Violence can also be behind unspecific complaints such as a variety of psychosomatic and mental illnesses, above all anxiety, panic attacks, stomach and abdominal complaints and unexplained pains.

Further, aspects of health behaviour should be observed, for example, a disregard for chronic illnesses such as high blood pressure, diabetes, asthma or HIV infection, or late and irregular recourse to preventative medical check ups.

Some basic conditions should be met before attempting to speak with a patient about violence. To talk to health professionals and to disclose violence a patient has to feel secure, accepted and respected.

An atmosphere which encourages trust consists of:

- A private room
- A demonstration that the patient is taken seriously
- A clear position regarding domestic violence
- Treating the patient with respect and respecting the decisions they take
- A thought for the danger the patient faces.
- Consideration of their security

It is important to target specific groups at higher risk of being victims of violence, such as disabled women, when considering questions about violence. German studies show a high incidence of violence among women with migration background. In these cases, attention should be given to the knowledge of the language and the need of a neutral interpreter.

**Interview the patient using simple and unbiased questions.
Listen without judgement.**

I Women often fear not being taken seriously and can feel ashamed about their situation. They may have difficulty speaking out about the violence.

Speaking about domestic violence is not easy, not for the medical staff, or for the victim of abuse. Staff as well as patients find unframed questions about violence too abrupt. It is recommendable to explain why such questions are being asked. It is also important to convey that violence is taken very seriously by health professionals. Examples could run along the following lines:

- It has been our experience that injuries often are caused by another person, therefore we now ask all patients if....
- We know that many women are the victims of violence therefore we ask all female patients whether they have been physically, mentally or sexually injured.

Seldom, will a woman affected by violence answer 'yes', when asked about domestic violence. Most women do not identify themselves in this category. It is more appropriate to ask directed questions, such as, whether the patient was beaten, whether she is safe at home, or whether someone had injured her. The term 'injured' makes it possible for the patient to speak about emotional and/or physical abuse. Examples of questions are:

- Could it be that you were beaten, kicked, pushed, bitten? Was this by your partner?
- How did you manage to fall down the stairs? Did someone push you? Did someone frighten you?
- Your complaint can be the result of stress. Do you feel safe and secure at home?

Victims of violence are often so caught up in a dynamic of mistreatment that they take on the perspective of the perpetrator, and consider themselves guilty and responsible for the violence. It is important to convey to women, used to humiliation and abasement, that nobody has the right to treat another person with violence and intimidation. The importance of signalling a condemnation of violence shouldn't be underestimated – it can be a therapeutic message.

A patient's right not to speak about this topic should be respected. She must bear the consequences of her decision. For example she might know, that a separation from her partner doesn't mean the end of violence. Health care professionals do not always find it easy to accept when a woman decides to stay in a violent relationship.

Gauge new and old injuries with a detailed examination.

G Injuries at different stages of healing may be an indication of domestic violence

The documentation of traces of violence can be crucial for victims of domestic violence. Generally women have no 'proof' that abuse is taking place behind closed doors. It is the experience of women's counselling services and women's shelters that women often have no legal documentation detailing their injuries; therefore they have no objective evidence, only descriptions in their own words, of the violence they suffered, when they want to go to court.

A woman's health records can play an important part in bringing perpetrators to justice. They can also be an influencing factor in housing and immigration decisions.

A thorough examination of the injuries and complaints is required as it is not uncommon for injuries to be concealed under clothing. Along with obvious injuries, 'minor' injuries should also be taken into consideration, for example, bruises, contusions, excoriations, which are at different stages of healing and go frequently unmentioned by the women themselves. Small injuries are frequently overlooked as they do not require medical attention. Medical-legal consultants point out that minor injuries and marks, which are by their very nature easy to miss, indicate a form of abuse.

Any examination heightens the risk of re-traumatisation. It is important to involve and communicate with the patient during the examination to minimise the risk that they experience feelings of loss-of-control, or being made to feel like an object.

N Note and document all medical findings and information in such a way that they could be used as evidence in court.

A clear and completely medical documentation is important for a successful prosecution. Departments of forensic or legal medicine are competent and offer cooperation in many cities for documenting injuries. The forensic medicine offers advice what a medical record should include (Graß 2004). Namely:

- Details about the medical examiner
- Details of the patient
- Details given by the patient regarding the background to the medical complaint
- Detailed medical evidence of the physical injury, the psychological situation and the neurological findings
- Details about the objects and any clothing that was archived when applicable
- Details of further measures taken such as pronouncements of being unable to work, referral to another doctor, clarification of protection possibilities, referral to a women's shelter or a woman's consultancy.

A body map on which the injuries can be indicated is also recommended for inclusion within the documentation. Statements should also be taken pertaining to the size of the injuries in centimetres and millimetres.

Photographic documentation is particularly convincing, for this the agreement of the patient is vital. With this it is pertinent to include both detailed pictures of the injuries, with measurements and size, along with photographs of the injured party. A digital camera will serve for this purpose.

A description of the events in the words of the patient should be written down, to avoid third party interpretation of events or a subjective evaluation of the patient or the abuse.

All diagnosed complaints and illnesses should be noted along with the documentation of the injuries. Also documentation pertaining to psychological states such as panic attacks, psychological agitation, and traumatisation can all be helpful before a judge and should be included within any documentation.

Legally admissible documentation detailing the health consequences to someone who suffers violence can be decisive, whether the aggressor can be held responsible for their action or not; sound documentation can strengthen a woman's resolve and underpin criminal proceedings against the aggressor or result in a restraining order.

Assess the patient's safety needs.

- A** Every intervention must offer patients an assessment of their needs for addressing the violence and maximising their safety.

The danger of violence escalating is at its greatest when a woman has made her abuse public and/or separates from the violent partner. Therefore it makes sense to clarify:

- Is the patient able to / or want to return to home; does she feel safe there?
- Does the patient prefer to go to a woman's shelter, or to friends or relatives? Is it necessary to ask the police to provide personal protection?
- Is there a possibility of accommodation for a night at the hospital? Within the S.I.G.N.A.L-programme is the possibility to accommodate abused women in the short term.

Children are always affected by domestic violence, as clearly shown in the Baden-Württemberg investigation in "Support needs of children and young people affected by domestic violence", conducted in 2007, by Seith and Kavemann. There is a high level of co-occurrence between intimate partner violence and child abuse. An analysis of different studies in the US of America concluded that in cases of child abuse, 45% to 59%, showed the mother also suffered violence (cf. Hellbernd/Brzank et al. 2004).

The question that arises is to what extent are children directly or indirectly affected by domestic violence? If the patient doesn't want to return home, consideration must be given as to whether the children will be unattended and should be collected.

The objective of all support and information is to help the patient find a way out of the abuse. It is not to persuade the patient to leave her violent partner or to mediate within the relationship. A woman in an abusive relationship is often best able to judge whether separation would mark the end of violence or whether this would result in an increased risk of violence.

A comprehensive danger assessment is generally not possible in typical medical practise; this falls more within the remit of women's shelters or the police. Thought should be given to how the woman's security can be ensured and the best way to communicate to her that she will be taken care of. Existing

questionnaires concerning the danger assessment contain some helpful pointers about security.

List of Contacts and Individual Safety Plan.

L Offer the patient emergency phone numbers and details of appropriate support services. Develop with the patient a personal safety plan that the patient can make use of when they feel that the time is right.

Many women are unaware or only partially informed, of existing resources. Of the 806 female patients questioned, in the A&E Dept of the Charité hospital Benjamin Franklin only a quarter knew of any assistance. 26% of those surveyed had heard there were corresponding centres of information. 48% of those surveyed knew nothing about any corresponding support facilities (Hellbernd/Brzank et al. 2004). Based on this, the importance of providing the patients with telephone numbers and address of assistance and support facilities is paramount.

Abused patients frequently need clarification about:

- Centres of information for abused women, women's shelters
- Psychological therapy
- The possibility of legal representation

The provision of this information and contact support can be a decisive factor for a woman. 'Emergency cards' listing addresses for assistance have proven successful. They can be used at a later date and so displayed in a way that the woman can take one inconspicuously.

The objective of the S.I.G.N.A.L.-intervention programme is to help the individual patient, to strengthen her situation, provide encouragement for her to challenge the dynamic of abuse, and break free of her social isolation.

The following practises are less apt for dealing with abuse: Patients should not be bullied into filing a report with the police. If the victim is unconvinced about a report, it often follows that the preliminary investigations are abandoned and the aggressor feels confirmed in his behaviour. No recommendation of partner therapy should be given as long as the aggressor takes no responsibility for the violence. There are special information centres and programmes for violent partners.

The implementation of the S.I.G.N.A.L.-Intervention programme

The objective of the S.I.G.N.A.L.-project within the Berlin based clinic was to make use of existent chances for prevention of violence within the health sector

and provide targeted support and care for abused women. However, a set of instructions for the clinic's staff is not enough to improve the level of care for victims of abuse. Along with the sensitisation and competence of medical and care staff, the formulation of internal and external cooperation structures and structural measures to anchor the intervention programme over the long term are needed.

Different measures and materials have been developed in order to implement the programme into the working practise of medical care:

- Specific courses and further trainings for nurses and medical staff
- The development of a documentation form to facilitate the provision of legally admissible documentation of the patients' medical complaints and injuries
- Development and provision of specific information material for victims of abuse
- Development of a cooperation structure between different departments within the hospital as a guarantee of the adequate support and care for abuse victims as in-patients
- Forging contact links with external support and assistance facilities
- Advocacy to end the taboos associated with violence and bring this theme out into the open

Basic to the successful implementation of the S.I.G.N.A.L.-programme was bringing together a multi-disciplinary 'project management group' comprising of internal clinic employees and external participants. Employees from external women's support organisations brought contextual knowledge of the violence problem and raised the importance of considering the perspective of the abused women. The project management group took responsibility for the implementation process: The execution and content of concept development, the structure and organisation of the project, the internal and external public relations work, the development of trainings and informing staff, the creation of a network and cooperation structures, and the financing. During the implementation it was necessary to establish a coordination post within the clinic. To that end a working group of committed care personnel, the so called 'On-site Group', was created in the A&E Dept in order to anchor the project on the emergency ward. The group varied the questions according to what arose from hands-on work with intervention and the sessions with victims of abuse.

The project was planned to be implemented in the emergency ward of the clinic and at a later date expanded into other departments and stations.

Evaluation and Scientific Monitoring

The results of the concomitant research show that A&E Departments are important places of refuge for women who have suffered violence. A feasible and target-group oriented concept for training was developed in the course of the S.I.G.N.A.L.-project, successfully reaching various staff members in the hospital. While nurses took part in a two-day training, it was difficult to provide training to doctors. For this group training was provided within the context of institutional trainings in a much shorter time frame.

The evaluation of the training programme demonstrated that hospital staff viewed this process as a positive experience. The trainings were successful in sensitizing the hospital staff to the problem of domestic violence. Standards for appropriate health care for patients who suffered intimate partner violence were conveyed to staff members as were guidelines for acting competently. Training participants considered the training and curriculum as essential in providing information about the problem of violence against women, intervention and support strategies for these problems, and resources regarding local counselling programmes and shelters were found to be particularly helpful for their everyday work.

The evaluation of the S.I.G.N.A.L.-project shows that the implementation of an intervention programme is a long term undertaking and best achieved through staggered introduction. The project was adopted and adapted by care staff significantly quicker than by the doctors. The care field forms a mainstay of the project not only because of their closeness to the patients but also carers undertook more comprehensive trainings two-day training instead of a one-hour seminar). For an adequate support of the patients' interests a cooperation and network between medical care and social support facilities is required. To this end, the development of a local network of advisory and shelter projects is recommendable. The manner in which better care for victims of abuse can be achieved within a hospital context and which aspects are of especial pertinence are set out in detail in the S.I.G.N.A.L. manual (Hellbernd/Brzank et al. 2004) and in the materials about the implementation of intervention programmes (Brzank 2005).

S.I.G.N.A.L. association

'S.I.G.N.A.L. – intervention in health care against violence against women', a non profit organisation, was founded in 2002 in order to spread intervention programmes and advocate for the improvement of health care services for women affected by violence.

The organisation is an interdisciplinary cooperation project with staff and facilities drawn from health care, women's shelter and counsel centres and

public health research. It offers further training and lectures for employees in the health care field, offers advice and counselling for health care professionals and program managers on implementation of intervention programmes and creates supporting material. Further activities are public relations work, seminars at medical university and nursing schools and train-the-trainer seminars as well as networking to improve the links between institutions involved in health care and women's support and counselling centres.

German strategies to combat domestic violence against women in the health care setting

Since 2000 requirements for better health care of victimised women provoked a lot of discussion and domestic violence or intimate partner violence was increasingly recognized as an important health related topic (Verbundprojekt 2001, Hellbernd & Wieners 2002, Hagemann-White & Bohne 2003). Committed physicians understood their working field to be important for intervention. Domestic violence then was discussed at annual meetings of the German medical association and several resolutions passed e.g. to integrate DV into the professional training of physicians and to develop quality standards. More and more articles on DV and treatment/behaviour recommendations were published in the journals of the medical associations (Hellbernd 2004). Departments of Legal medicine had also an important contribution (e.g. University Clinic Hamburg, Köln and Düsseldorf).

Survey results like the German representative Study on violence against Women (Müller & Schrötle 2004) and the S.I.G.N.A.L.-Female Patients survey (Hellbernd, Brzank et al. 2004) showed the seriousness of the problem and confirmed the role of health care professionals as an important support for women with a history of DV.

The German Ministry for Family, Senior Citizens, Women and Youth formulated the first national action plan (1999 – 2004) financed the Federal Coordination Women's Health (BKF) from 2002 and 2005 to collaborate together with health and advocacy experts strategies for a better health care approach for victimized women. As an echo, several German federal states formed action plans and alliances against DV (Nancy Gage-Lindner 2002), regional action coordination were formed by different profession groups with the aim to involve the health care sector (GiGnet 2008).

Nowadays in nearly each German States medical guidelines, recommendation and documentation forms for DV are available (Blättner et al. 2008, lögd 2005, Hellbernd 2006).

But although intimate partner violence has been integrated in several professional health care trainings and many initiatives for a better health care have started, there is still a lack of structural anchoring and evaluation.

Following the strategy of S.I.G.N.A.L., the new model project 'Medizinische Intervention gegen Gewalt' (MIGG) (medical intervention against violence) will prove support and health care for victimised patients within general practice in 5 different German regions. A practical programme within ambulant medical treatment ought to be developed based on the intervention possibilities against intimate partner violence and sexual violence and to ensure a better networking between GPs and advocacy, shelters and support centres. Embedded in the 2nd German action plan to combat Violence against Women the project is funded by the BMFSFJ till the end of 2010 (www.MIGG-Frauen.de).

References

- Blättner, B.; Frerick, B. et al. (2008): Gesundheitliche Folgen häuslicher Gewalt: Ärzte sollten genau hinsehen. In: Deutsches Ärzteblatt 105/1-2: A 23-26.
- Brzank, P. (2005): Häusliche Gewalt gegen Frauen: gesundheitliche Versorgung. Das S.I.G.N.A.L.-Interventionsprogramm. Materialien zur Implementierung von Interventionsprogrammen. Berlin, Gefördert vom Bundesministerium für Familie, Senioren, Frauen und Jugend.
- Brzank, P.; Hellbernd, H. and Maschewsky-Schneider, U. (2004): Domestic Violence Against Women: Negative Health Consequences and Need for Care-Results of an Inquiry among First-Aid-Patients. In: Gesundheitswesen 66 (3): 164-9.
- Campbell, J., A. S. Jones et al. (2002): Intimate partner violence and physical health consequences. In: Arch Intern Med 162 (10): 1157-63.
- GiG-net – Forschungsnetz Gewalt im Geschlechterverhältnis (Hrsg.) (2008): Gewalt im Geschlechterverhältnis. Erkenntnisse und Konsequenzen für Politik, Wissenschaft und Soziale Praxis. Verlag Barbara Budrich, Opladen.
- Glammeier, S.; Müller, U. and Schröttle, M. (2004): Unterstützungs- und Hilfebedarf aus der Sicht gewaltbetroffener Frauen. In: Müller, U., Schröttle, M.: Lebenssituation, Sicherheit und Gesundheit von Frauen in Deutschland. Eine repräsentative Untersuchung zu Gewalt gegen Frauen in Deutschland. Im Auftrag des Bundesministeriums für Familie, Senioren, Frauen und Jugend. Berlin: 618-731.
- Graß, H. (2004): Rechtsmedizinische Kompetenz im Netzwerk gegen häusliche Gewalt. Optimierung der ambulanten Versorgung gewaltbetroffener Frauen. Implementierungsworkshop der BKF, Hamburg 21./22.11.2003. S. Bohne. BKF – Bundeskoordination Frauengesundheit. Bremen.

- Hagemann-White, C. and Bohne, S. (2003): Versorgungsbedarfe und Anforderungen an Professionelle im Gesundheitswesen im Problembereich Gewalt gegen Frauen und Mädchen, Gutachten für die Enquetekommission ‚Zukunft einer frauengerechten Gesundheitsversorgung in NRW‘, www.landtag.nrw.de
- Hamberger, L.K.; Ambuel, B. et al. (1998) : Physical interaction with battered women : the women’s perspective. In: Arch Fam Med 7 (6): 575-82.
- Hellbernd, H. and Wieners, K. (2002): Gewalt gegen Frauen im häuslichen Bereich – Gesundheitliche Folgen, Versorgungssituation und Versorgungsrealität." In: Jahrbuch Kritische Medizin 36 (Versorgungsbedarfe und Versorgungsrealitäten): 135-148.
- Hellbernd, H.; Brzank, P.; Wieners, K. and Maschewsky-Schneider, U. (2004): Häusliche Gewalt gegen Frauen: gesundheitliche Versorgung. Das S.I.G.N.A.L.-Interventionsprogramm. Handbuch für die Praxis, Wissenschaftlicher Bericht. Gefördert mit Mitteln des Bundesministeriums für Familie, Senioren, Frauen und Jugend. Berlin.
- Hellbernd, H. (2006): Häusliche Gewalt gegen Frauen: gesundheitliche Versorgung. Das S.I.G.N.A.L.-Interventionsprogramm. Curriculum. Gefördert mit Mitteln des Bundesministeriums für Familie, Senioren, Frauen und Jugend. Berlin.
- Kavemann, B. and Seith, C. (2006): „Es ist ganz wichtig, die Kinder da nicht alleine zu lassen“, Unterstützungsangebote für Kinder als Zeugen und Opfer häuslicher Gewalt. Eine Evaluationsstudie, Arbeitspapier der Landesstiftung Baden-Württemberg, Soziale Verantwortung & Kultur Nr. 3.
- Kommoß, K. (2002): Opfer- und Tatverdächtigenstruktur häuslicher Gewalt aus der ‚Sicht‘ der Berliner Polizei 2001. Berliner Forum Gewaltprävention: Häusliche Gewalt. Landeskommision Berlin gegen Gewalt. Berlin. 1/2002.
- Mark, H. (2000): "Häusliche Gewalt gegen Frauen aus der Sicht niedergelassener Ärztinnen und Ärzte: Ergebnisse einer Befragung in den Berliner Bezirken Hohenschönhausen und Lichtenberg." In: Zeitschrift für Gesundheitswissenschaften 8 (4): 332-46.
- Müller, U. and Schröttle, M. (2004): Lebenssituation, Sicherheit und Gesundheit von Frauen in Deutschland. Eine repräsentative Untersuchung zu Gewalt gegen Frauen in Deutschland. Im Auftrag des Bundesministeriums für Familie, Senioren, Frauen und Jugend. Berlin.
- Müller, U. and Schröttle, M. (2004): Health, Well-Being and Personal Safety of Women in Germany. A Representative Study of Violence against Women in Germany. Federal Ministry for Family Affairs, Senior Citizens, Women and Youth. Berlin. www.bmfsfj.de/bmfsfj/generator/RedaktionBMFSFJ/Abteilung4/Pdf-Anlagen/kurzfassung-gewalt-frauen-englisch.property=pdf,bereich=bmfsfj,sprache=de,rwb=true.pdf
- Rodriguez, M. A.; Quiroga, S. S. et al. (1996): Breaking the silence. Battered women’s perspectives on medical care. In: Arch Fam Med 5 (3): 153-8.

- Schröttle, M.; Martinez, M. et al. Co-ordination on Action on Human Rights Violations (CAHRV) (2006): Comparative reanalysis of prevalence of violence against women and health impact data in Europe – obstacles and possible solutions. Testing a comparative approach on selected studies. Osnabrück.
- Schweikert, B. (2000): Gewalt ist kein Schicksal. Ausgangsbedingungen, Praxis und Möglichkeiten einer rechtlichen Intervention bei häuslicher Gewalt gegen Frauen unter besonderer Berücksichtigung von polizei- und zivilrechtlichen Befugnissen. Baden-Baden.
- Verbundprojekt (ed.). (2001): Bericht zur gesundheitlichen Lage von Frauen in Deutschland. Schriftenreihe des BMFSFJ. Stuttgart.
- WHO (2002): World report on violence and health. Genf.
- WHO (1996): Global Consultation on Violence and Health. Violence: a public health priority (document WHO/EHA/SPI.POA.2), Geneva, World Health Organization.
- Wieners, K. and Hellbernd, H. (2000): Violence can make you ill - the connections between violence and health. Women's health network: State of Affairs, Concepts, Approaches, Organizations in the Health Movement. Country Report Germany. EWHNET - European Women's Health Network.

Equity in Reproductive Health in Central and Eastern Europe: The Hungarian Experience

Zsuzsa Gyórfy, Krisztina László, Szilvia Ádám & Mária Kopp

Introduction

The Definition of Equity and Inequality in Reproductive Health

The world's population increases by 77 million every year, yet male and female fertility has been declining over the past decades in developed countries. The decline in fertility may originate in biological factors and behavioural/attitude changes, and in many instances also in economic and social factors.

Both social factors and work environment play an important role in the development of reproductive disorders and subsequent decline in fertility. Today's women, at least in Western societies, have the right to control their own body. Female researchers from England highlight that this right can only be exercised in an appropriate social and economical environment (Earle 2007). It is also obvious that some women have limited or no right at all to control their own reproductive processes, i.e., they may have limited or no access to health care, family planning, prenatal care or infertility treatment.

Some studies show that poverty and social exclusion continue to be the most significant factors that determine women's reproductive health. Among the poorest women, the number of miscarriages and pre-term births has doubled. The proportion of stillbirth and intrauterine deaths is higher among underprivileged women. Children born to women with low social status have lower birth weight and are more likely to be premature babies or have a birth defect. Similarly, premature birth and low birth weight are more prevalent among mothers with lower level of education (Mackenbach 2006). Several social factors have been linked to reproductive health such as: isolation, minority status, unemployment, lack of pre-natal care, smoking, and malnutrition. The role of certain biological factors in reproductive health should not be dis-regarded. For example, becoming pregnant too early or too late or the high prevalence of pre-term birth within the family may contribute to the development of reproductive disorders.

Besides biological and socio-economic factors, the work environment also plays an important role in the existence of inequalities in reproductive health. Occupational and social factors are often associated. In particular, poverty, inequality in living conditions or existential insecurity may have an impact on women's reproductive health. Some of the occupational risk factors associated with adverse reproductive health include night shifts, rotating/split shifts, and emotionally or physically demanding work.

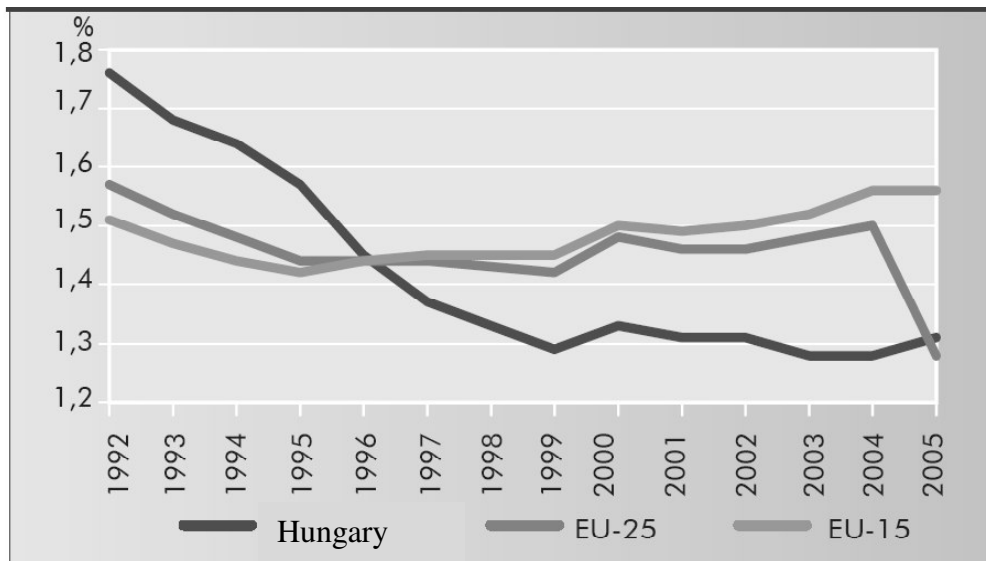
Physically demanding work was found to increase the risk of abortion, preterm labour and low birth weight. The first study in this area was conducted in the 1980s among 50 000 Canadian women (McDonald 1988). The study found a strong relationship between spontaneous abortions and physically demanding work tasks such as having to lift heavy weights, having to do the work in an up-right position during the eight work hours, shift work and the long working week (≥ 46 hours). A reduced fertility rate was observed in women who performed very intensive work with high energy losses. Similar results were obtained by other studies as well: shift work was associated with a lower number of pregnancies and more infertility problems (Ahlborg 1996; Bisanti 1996).

In the following section, we discuss health inequalities in reproductive disorders specific to Hungary. After presenting trends in fertility rates and the health inequalities in abortion rates and in complications during pregnancy, we discuss two special problems characteristic to Hungary: that of the effect of the family support system on fertility rates and that of the inequalities regarding the discrepancy between the number of planned and actually delivered children. The results have presented from Hungarostudy 2002: nation-wide representative study.

National Statistics and Surveys: Changes in Fertility Rates in Hungary

For the last four decades, the number of live births in Hungary has been lower than that required to maintain the number of the population. Although this phenomenon has been commonly observed across Europe, it started much earlier in Hungary. It is noteworthy that the low fertility rate does not seem to be a temporary phenomenon but rather a fundamental demographic trend, which is not expected to improve in the near future, either in Hungary, or in other European countries.

One of the indices of the population's reproductive status is the total fertility rate (TFR). This is defined as the average number of children that a woman would give birth to over her lifetime if (1) she was to experience the exact current age-specific fertility rates through her lifetime, and if (2) she was to survive until the end of her reproductive life; it is calculated by summing the single-year age-specific rates at a given time. The TFR has been particularly low in the ex-socialist countries of Central and Eastern Europe when compared to other countries. For example, in 2006 the TFR was 1.31 in Hungary, 1.14 in the Czech Republic, and 1.29 in Poland. Similar TFRs were observed in Spain (1.26) and in Italy (1.20), but higher ones were in the US (2.03), France (1.90), Norway (1.78), and Sweden (1.57) (Figure 1).



Source: Central Statistical Office 2006

Figure 1. International comparison of TFR

Since the fundamental political changes from 1989, fertility has been characterized by a significant downward trend. While the TFR decreased from 2.02 to 1.78, i.e., by 0.24 percentage points between 1960 and 1989 (over a period of 29 years), it decreased by 0.46 percentage points in the last eight years, reaching 1.35. Provided that the fertility rate remains constant, this translates into 135 births for 100 women, that is 70-75 births less than those required to reproduce the parental generation. In other words, the size of the offspring generation is 35% smaller than that of the parent generation.

Taken all these tendencies into consideration, studies exploring the attitudes toward and the willingness to engage in pregnancy are of particular importance in Hungary. Several studies have shown that the family and the children as an institution has a more central role in Hungarian society, as compared to the neighbouring countries (Cseh-Szombathy 1991, 1994, 2001; Pongrácz Tné 1994, 2000; S. Molnár 2000, Somlai 2000; Tóth 1994, 1998; Utassy Á. 2000). Of note are studies conducted at the beginning of the 90s among young married couples about their plans to have children. The results indicated that 100 families planned on average a total of 214 children. This figure was higher than that reported by young couples ten years earlier. It was particularly noteworthy that 25% of the couples wanted to have three or more children, which was significantly higher compared to that reported in previous research. Most of the couples (62%) wished to have two children. Couples reported that they did not want to not have children. In another study, women aged between 18 and 41 were asked about the number of children they wanted to have (Kamarás 2004). The results showed that the average number of children they wished to give life to was 2.10, which was similar to the 2.14 reported by newly-weds. These data are noteworthy because in the 90s fertility decreased significantly, hence the

difference between the number of planned and delivered children increased. This suggests that young couples may have changed their reproductive behaviour by postponing pregnancies.

The changes in fertility observed since 1990 can not be attributed only to the decrease in birth rates. Birth postponement, defined as an increase in the age at which women give birth to their first child, is also likely to play a role. In 2006 Hungarian women delivering their first child were, on average, 27.3 years old, whereas the average age of those delivering their second child was 29.5 years. This represents an increase of four and three years respectively compared to the mid 90s. The trend is similar in the case of countries from EU-15, but with the age being generally 1.5 years higher. The proportion of women above the age of 30 who deliver their first baby has also increased considerably. Birth postponement has also been associated with an increase in the average age at marriage, with significant changes in the sexual behaviour of adolescents, i.e. an earlier onset of sexual activity compared to their parents' (Central Statistical Office 2004; UN 1999).

Besides birth postponement, more and more single women in Hungary are becoming mothers. Their proportion in the total births is estimated to be over 30% (Central Statistical Office 2006). This is in line with the European trend, which shows a high proportion of children being born to single women. For example, the proportion of the proportion of extramarital children in Norway, Denmark, France, Finland, United Kingdom, Latvia, Sweden, and Iceland has been between 30-50%.

Induced abortion rates and pregnancy complications

As discussed above, between 1990 and 2006 the TFR has declined by 30% in Hungary. Similarly, during the same period the number of induced abortions has also decreased by approximately 40% (Kamarás 2004). However, despite this decrease, Hungarian abortion rates are still considerably higher than those registered in Western European countries (27 abortions for 1000 women with childbearing potential) (Pongráczné, Central Statistical Office 2006). In contrast with the improvement observed in the general female population of reproductive age, the proportion of single women who had had an induced abortion has increased considerably. In 2006, approximately 30% more single women had an induced abortion compared to age-matched, married or divorced women (Central Statistical Office 2006). Furthermore, the decrease in the number of abortions among women is not specific for all age groups. Among young women, no decrease in abortion rates can be observed; on the contrary, the number of abortions has increased among women aged 20 or less (Central Statistical Office 2006). The increasing prevalence of abortions in this younger group of women with no children may lead to serious consequences related to

the high risk of the surgical procedure itself at this age and to the potential negative impact on further pregnancies (such as premature delivery, secondary infertility).

The social risk factors for abortion thus convey important information: in Hungary educational attainment is the most important predictor both with respect to the practice of contraception and the prevalence of abortions. Both the number of delivered children and the rate of induced abortions per 100 live births is higher amongst those with low education than among the better educated groups. Among those with basic or lower education 83 abortions per 100 live births were registered in Hungary in 2006, whereas this figure was 44 among those with a college or a university degree (Central Statistical Office 2006).

When considering the distribution of these data both according to age and education, educational attainment differentiates only among women aged 20-29 years. In this age group abortion is two to three times more frequent among those with low compared to those with higher education. The gap between educational groups decreases considerably among women aged 30-34 years, and it almost entirely disappears among those aged over 35 years (Central Statistical Office 2006).

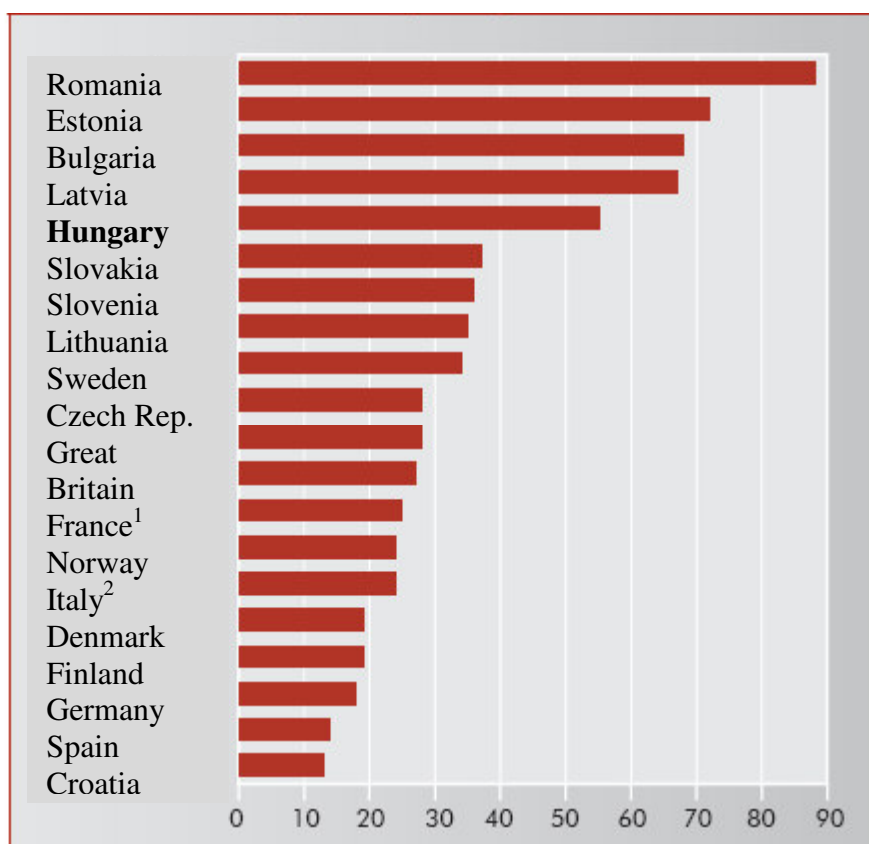
Differences according to employment status are also noteworthy: in 2006 there were 42 registered abortions for 100 live births among employed women, while among those not working this figure was 189, more than four times higher. The abortions/100 live births ratio was seven above average among unemployed women compared to below average among dependent women.

There is a changing trend in the area distribution of abortions: induced abortions have always been higher in the capital than in other regions of the country. However, during the last years we have been witnessing a change in this trend; since the 1990s the abortion rates are not any longer the highest in Budapest.

In a world-wide perspective Europe has a special position as regards its abortion-related picture: in Western Europe abortion rates are among the lowest, whereas in Eastern Europe they are the highest rates in the whole world. Thus differences between regions with respect to abortion are among the greatest in the world. They are considerably higher than the differences observed for natality. While the ratio between the country with the highest and the lowest natality rate is less than 2.5, the ratio for abortion rates is between 10-20, depending on the indicator chosen. The situation is the least favourable in Romania and Russia, where more than 200 procured abortions per 100 live births occur each year. This figure is about the half in other countries of Central and Eastern Europe, the Czech Republic having the most favourable situation. However, this rate is still more than 1.5 times higher than in Sweden (29 abortions/100 live births), the country with the highest abortion rate in Western

Europe and almost five times higher than in the Netherlands where this rate is the lowest in Europe (11 abortions/100 live births). There were 56 abortions/100 live births in Hungary in 2006, the country being thus in the first half of the European abortion list (Figure 3).

These differences between countries in abortion rates cannot be fully attributed to differences in national regulations. Procuring abortion is legal in all of the mentioned states. Furthermore, the availability of modern contraceptive methods in Central and Eastern Europe is comparable to those of Western European countries. Thus the recorded high abortion rates are very interesting (Figure 2).



¹ Data relate to 2000.

² Data relate to 2002.

Source: Central Statistical Office 2006

Figure 2 . Induced abortions in Europe

The Impact of Family Support System and of Women's Employment Rates for Fertility

The importance of women's financial situation and insecurity on their willingness to have children is also supported by the results from the Dialog

project which involved 14 European countries (Spéder 2005). This study revealed that the fear of the future is the most important cause for not having further children in Hungary. The second most important impediment was the high costs of child rearing.

The above problems are specific to other societies in Central and Eastern Europe as well. Nevertheless, we can observe important differences within the region. A recent comparative study between Hungary and Bulgaria showed that both post-communist countries are very similar with regard to the low fertility rates and to the widening social inequalities after 1990 (Klinger 2001). However, the two countries differed in certain motivations related to reproduction. Whilst in Hungary cohabiting women who were not employed were more likely to be willing to become pregnant than working ones, the reverse was true in Bulgaria: working women were more likely to have children. Hungarian women were more likely to postpone the birth of their first child if they were employed. Differences between the two countries were observed with respect to willingness to have the second child as well. Hungarian parents' housing conditions were very important in the decision to have a second child. If the Bulgarian parents' mood was positive they were willing to have the second child independently of their housing situation.

In light of these results, it is worth analysing the state-provided family support system, the policies that may increase motivation for having another child and the changes in women's employment rates in Hungary. Compared to other European countries, the family support system provided by the Hungarian state is considerable, representing 2% of the GDP. When analysing the relationship between the state support during parental leave and fertility, it can be observed that if the amount of family support changes relative to the GDP, it is followed by a 20-25% change in fertility. A decrease of 1% in the family support decreases the value of fertility indicators by 0.2-0.25%.

The duration of parental leave in Hungary is notably long, as it is three years for one child. Hungarian women are thus outside of the labour market for considerably longer periods than in other European countries. Thus Hungary differs in many aspects from other countries as regards women's employment during different periods of their life. While 25 years ago the natality was high in the countries where women were encouraged to have parental leave for a long period, this pattern has changed today. Natality is higher in countries where women return to work fairly soon after delivery; that is where women's employment rates are high and the conditions for women's employment are good. In these countries, childcare institutions are generally of high quality and the role of the state in this respect is more pronounced. Table 1 illustrates these associations.

	High employment rates for women	Low employment rates for women
Countries with high natality	Island Sweden Finland Norway The Netherlands Denmark England France Portugal Cyprus	Luxemburg Belgium Ireland Slovakia Romania Turkey
Countries with low natality	Germany Austria Slovenia Estonia Lithuania Latvia	Italy Spain Greece Malta Poland Czech Republic Hungary Croatia Bulgaria

Source: Population and social conditions. Labour Market. Employment. Eurostat. 2004

Table 1. European countries according to women's employment rates and natality

The above associations are supported by data from OECD as well: from all the countries of the European Union, the strongest association between having small children and the work status of women is observed in Hungary (OECD 2007). Findings from the family database of the OECD indicates that while in Hungary the employment rates of women are just slightly below those from the OECD average, those of mothers are the lowest in Hungary. The employment rates of women with children aged 0-2 years is the lowest, while the employment rates of women with children aged 3-5 years is the second lowest in the OECD (after Slovakia). The difference between employment rates of women with children aged 0-2 years and women with older children is the highest in Hungary. The employment rates of mothers is not only low but – both in absolute terms and compared to women without children – decreased considerably during the last years.

Country	No children	One child aged below 12 years	Three or more children aged below 12 years
Austria	83.4	77.8	57.4
Czech Republic	85.7	61.4	22.0
Denmark	77.1	80.3	67.2
Greece	56.5	54.2	39.6
Hungary	78.2	59.4	12.6
EU25	75.1	64.8	41.2

Source: Eurostat 2004.

Table 2. Employment rates in women aged 20-49 years by country and age of their children

Spousal/partner support plays an important role in harmonising the division of domestic labour and thus the productive and reproductive aspects of life. This may also influence the decision whether to have a child. According to data from EUROSTAT Hungarian women spent the highest number of hours on gainful work among working European women in 2006. Additionally, they perform 80% of all household work, even if they have a better-paid job and with higher prestige than their spouse (Bukodi 2005).

The type of couple	Gainful work		Household duties	
	Wife	Husband	Wife	Husband
The husband has better work than his wife	43.0	57.0	81.5	18.5
The wife has better work than her husband	48.2	51.8	79.5	20.5
The wife and the husband have equally good work	43.2	56.8	78.9	21.1

Source: Bukodi, 2005

Table 3. Proportion of time spent with gainful work and household duties on an average day among working couples in 2000

Hungarian mothers with one child spend on average four years away from work. In case of two children, they are away for 5.5 years. When resuming employment, their salary may be approximately 10% lower than their previous one, as their knowledge is considered to be devaluated. However, often they cannot even resume gainful employment, as their previous jobs may have disappeared or changed during their absence.

Results from the Hungarostudy 2002 nation-wide Representative Study

Method

The Hungarostudy 2002 is a national, cross-sectional survey which is representative of the Hungarian population over 18 years of age according to sex, age, and the 150 sub-regions in the country. The sampling was carried out using the National Population Register, which was updated using the 2001 National Census. A clustered, stratified sampling procedure was developed by experts at the National Population Register. All communities with a population of more than 10,000 were included in the sample as well as a randomly selected sample of smaller villages. In a second step, single persons were selected from this database in an age and gender distribution that was comparable to that existing in the specific county or settlement size from which they were drawn. The final sample thus reflected the gender, age, and settlement size characteristics of each given county. Two random samples of 13,000 persons were generated. The first sample was used for the study and the second sample allowed for replacements of individuals in the first sample who refused to participate.

In 2002, 12,643 persons were interviewed in their homes (Rózsa et al. 2003, Skrabski et al. 2004). The sample represented 0.16 % of the population above age 18. The refusal rate was 17.7 %. There were differences in refusals based upon residence where refusals tended to be higher in large cities than in small villages, and based on gender where refusals were 4% higher in men than in women. For each refusal, another person was selected of the same age and sex from the same community. This replacement procedure did not result in any significant selection bias. The final sample corresponded well to the population descriptors of the Central Statistical Office. We compared the distributions of selected important variables in the final dataset and in the original. The sampling error in each case was within statistically acceptable limits, with the highest estimated stratification error being 2.2 % in men aged 18-39. This error is within the limits of the permitted statistical deviation (Rózsa et al. 2003).

The interviewers in this study were district nurses and each interview was conducted over approximately one hour (Skrabski et al. 2004). Because of their education in health, district nurses were selected as the most competent persons for interviewing our subjects. These nurses were intensively trained for their duties over a two-week period, including personal supervision and three test interviews before they began data collection.

At the statistical analyses, first of all descriptive statistics we used to determine the prevalence of induced abortion among the Hungarian women. Unadjusted logistic models were performed to examine the association between induced abortion and the potential risk variables. A threshold of $p < 0.05$ was

established in order to consider an association significant. Statistical analyses were conducted using SPSS 10.0 for Windows.

The study approved by the Ethics Committee of the Semmelweis University in Budapest.

Psychosocial risk factors of induced abortion

According to our study 22 % of the sample had one ore more abortions, which means that each forth or fifth woman has experienced abortion. The role of risk and protective factors for induced abortion is illustrated by the odds ratios below:

Risk factors	Unadjusted OR	95 % confidence intervals	p
Sucide attempts	2.859	2.198-3.724	0.000
Foster child under state care	2.808	1.838-4.290	0.000
Abusive partner	2.423	2.223-2.902	0.000
Fear of being abused	2.081	1.543-2.808	0.000
Sucidal thoughts	1.988	2.195-3.724	0.000
Smoking	1.883	1.675-2.118	0.000
„Being a woman is a disadvantage”	1.800	1.425-2.275	0.000
Sucide attempts in family	1.800	1.545-2.097	0.000
Abuse experienced within the last 12 months	1.769	1.240-2.524	0.001
Abusive parents	1.668	1.38-1.989	0.000
High alcohol consumption	1.667	1.298-2.141	0.000
Completed suicide in family	1.538	1.289-1.836	0.000
Disadvantage resulting from social status	1.473	1.287-1.686	0.000
„My income is so low that I can hardly buy the necessary basic goods”	1.402	1.195-1.643	0.000
Divorced parents	1.340	1.132-1.587	0.000
Marital stress	1.319	1.145-1.520	0.001
Lasting absenteeism from home before age one	1.304	0,957-1.776	0.057

Parents not supportive	1.216	0,982-1.502	0.000
Health damaging physical conditions at work	1.127	1.030-1.389	0.011
Lack of partner support	1.127	0,980-1.296	0.000
At least mild depressive symptoms	1.159	0,987-1.361	0.077

Source: Hungarostudy 2002

Table 4. Odds ratios and 95% confidence intervals for the associations between abortion and specific factors

Table 4 presents the results of un-adjusted regression analyses conducted to investigate the association between characteristics of risk factors and induced abortion. Women reporting physical abuse had significantly higher risk for induced abortion compared to those without abuse. Compared with women without induced abortion, women had early traumatization and had lower social support.

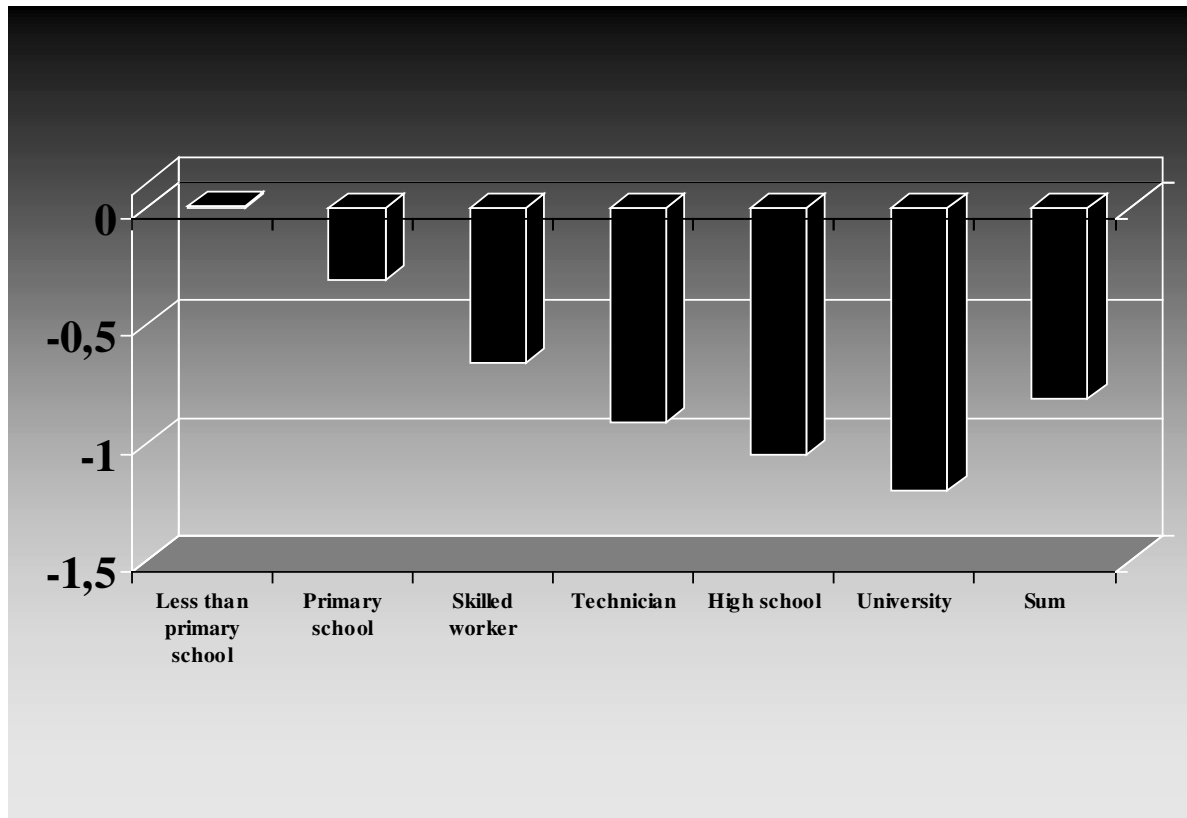
As seen above, the background factors of abortion group around four main distinct factors: (1) the role of physical abuse, (2) attachment disorders and prevailing early traumatization, (3) lack of social support, and (4) low financial status. It is also noteworthy that the rate of suicide attempts and suicidal thoughts are higher among women who had abortions, their Beck Depression scores are significantly higher, and the prevalence of self-destructive behaviours e. g. smoking, alcohol consumption are significantly related to abortions. On the other hand, religious faith, regular sport activities, high parental and partner support seem to be protective factors.

Differences between the planned and actual number of children

As discussed already, the average number of children the Hungarians of reproductive age would give birth to is below that they would like to have. In the following section, we analyse a number of factors that may contribute to the low natality in the Hungarian population.

One such factor is the level of education. While in Germany, for example, the willingness to have children decreases linearly with increasing education, the relationship in Hungary resembles to an inverse J-shaped curve. The number of delivered children is the highest among women with low education, decreases considerably for those with middle education and then increases somewhat in the highly educated group. We analysed the relation between educational attainment and the number of wished and delivered children in our Hungarostudy 2002 survey. The actual number of children was almost the same to that of desired ones in the group with low education. This was considerably different for women with high school or university degree. It is very noteworthy

that the number of children the highly educated women wished to have was considerably above average. However, the average number of children actually delivered by these women was the lowest (Figure 3).



Source: Hungarostudy

2002

Figure 3: The number of the planned and the actual number of children among women younger than 42 years of age, according to education

According to our follow-up study, not having children or not counting on help from own children in difficult life circumstances represents a 4-fold risk for premature mortality in middle aged men (Kopp & Skrabski 2006).

Further results from our study emphasized the importance of social support. The number of children given birth to was most strongly related to the extent young people felt they can rely on support from partners or spouses. Interestingly, among those living in a partnership, the support from the partner was an even more important predictor of having children than among married couples. Other sources of social support were also found to be important with regard to willingness to have children. For women, the support from neighbours was also an important factor. The fact that anxiety levels were increasing with the number of the children is indicative of increasing loads and insecurity on parents with children. This may also explain why men having children smoked more than those without children. The increased anxiety of couples with

children should be a responsibility of the society; having children is currently regarded as a hobby and as a personal undertaking of parents. They receive very little compensation for undertaking the responsibility and insecurities of rearing the next generation. The severity of this is shown by the fact that the number of hours spent with work is positively and significantly associated with the number of children, both among men and among women.

Results from our analyses from the Hungarostudy 2002 survey showed that women with young children had lower quality of life compared to women of same age and education who did not have children. On the other hand, the quality of life and the health of men having children was better and they perceived themselves more competent than their counterparts without children. These results suggest that women with children are exposed to high psychological and social strain in today's Hungary. At the same time, several studies have confirmed that the Hungarian society remains family and child-centered (Pongráczné 1994; Pongráczné – S. Molnár 2000). This means that while the number of women who wish to have children is very high, only a fraction of them eventually delivers one. This phenomenon shows a strong correlation with the level of education, i.e., women with university degrees give birth to a lower number of children.

Key Steps to Strengthen Women's Equity with Regard to Reproductive Health

While employment rates among women without children are high in comparison to Europe, the employment of women with small children is extremely low in Hungary. Hence, employment practices and the traditional nature of the society may significantly influence women's reproductive behaviour in Hungary.

Several studies have shown that a significant proportion of women favour part-time work in certain stages of their lives. The prevalence of part-time work is very low in Hungary in comparison to other European Union countries. In particular, approximately 6% of employed women and ca. 3% of employed men work part-time in Hungary, whereas on average ca. 30% of women and ca. 7% of men worked part-time in the European Union in 2004 (COM 2005). Furthermore, of the population aged between 15 and 64 years, only 1,529,000 worked in part-time employment in Hungary, and ca. 67% of them were women (Central Statistical Office 2005).

Another important factor which could influence reproductive behaviour is flexible work time. Among countries of the European Union, Hungary has the lowest number of workers with flexible working hours (ca 12%). This compares unfavourably to Sweden, for example, where the proportion of workers with flexible working time is around 58%. One of the objectives of flexible working time is to enable employees to start and finish their work according to their and

their families' needs; thus they can take their children to kindergarten or school and they can make themselves available to their employers very early or very late in the day. Furthermore, it is also important to note that the prevalence of remote work is the lowest in Hungary among all other European Union member states. Experience shows that part-time work and flexible working time play a significant role in harmonising the work and family domains among people with small children. On the other hand, if employers take into consideration their employees' family responsibilities, they become more loyal and more efficient. In 2002, the European Union passed a declaration that obligated work places and executives to protect employees' mental health. Supporting the harmonisation of work and family roles would serve as an important step towards the full realisation of the spirit of this declaration.

Summary

The present chapter aimed to give a short overview of the reproductive health inequalities specific to Hungary. We observed that the decrease in fertility rates appeared earlier compared to countries from Western Europe. Similarly to international data, the average maternal age at child birth and the number of children being born by single mothers shows an increasing tendency. The data presented also show that the Hungarian society is basically child-centred, thus the strong discrepancy between the number of planned and actually delivered children is even more striking. Social inequalities between educational and occupational groups are important determinants of the number of delivered children. The abortion rates specific to Hungary are among the highest in a European comparison. The data from the Hungarostudy 2002 survey furthermore show that there are important inequalities in abortion rates between educational and occupational groups and between the geographical regions of Hungary.

References

- Ahlborg, G. Jr, Axelsson G. and Bodin L. (1996): Shift work, nitrous oxide exposure, and spontaneous abortion among Swedish midwives. In: *International Journal of Epidemiology*, 25: 783-790.
- Bisanti, L. et al. (1996): Shift work and subfecundity: a European multicenter study. European Study Group on Infertility and Subfecundity. In: *Journal of Occupational and Environmental Medicine*, 38 (4): 352-358.
- Bukodi E. (2005): Női munkavállalás és munkaidő-felhasználás, .(Women's employment and productivity in Hungary.) In: Nagy Ildikó – Pongrácz Tiborné – Tóth István György (2005) szerk.: *Szerepváltozások. Jelentés a nők és a férfiak helyzetéről 2005*, Budapest, TÁRKI–Ifjúsági, Családügyi, Szociális és Esélyegyenlőségi Minisztérium: 15–43.

- (COM (2005) 44): Európai Közösségek Bizottsága – A Bizottság jelentése a Tanácsnak, az Európai Parlamentnek, az Európai Gazdasági és Szociális Bizottságnak és a Régiók Bizottságának 2005. évi jelentés a nemek közötti egyenlőségről 2005. Brüsszel, 14.2.
- Cseh-Szombathy L. (1991): A családi értékek változása és ennek hatása a családi funkciók alakulására. (The worth of family and it's impact on the function of family) In: Társas kapcsolatok. Szerk.: Utasi Ágnes. Gondolat Kiadó, Budapest.
- Cseh-Szombathy L. (1994): Értékváltozások a magyar családban. (The changes of the values in the hungarian families) INFO–Társadalomtudomány, 30.
- Cseh-Szombathy L. (2001): A népesedési folyamatok alakulása Magyarországon. (The increase of the population in Hungary) In: Népesedés és népesedéspolitika. Szerk.: Cseh-Szombathy L., Tóth P. P. Századvég Kiadó, Budapest.
- Earle, S., Letherby, G. (2007): Conceiving Time? Women who do or do not conceive. In: Sociology of Health & Illness, 29 (2): 233-250.
- Eurostat. (2004): Population and social conditions. Labour Market. Employment. http://epp.eurostat.ec.europa.eu/portal/page?_pageid=1073,46587259&_dad=portal&_schema=PORTAL&p_product_code=KS-CD-04-001.
- Gábos András (2003): A családtámogatási rendszer termékenységi hatásai – kutatási eredmények magyar adatokon. (The impact of the family support system for the increasing of the population –survey results on the hungarian data) In: Gál Róbert Iván (szerk.): Apák és fiúk és unokák. Osiris, Budapest: 66-83. old.
- Gábos András, Róbert Iván Gál and Gábor Kézdi (2005): Fertility effects of the pension system and other intergenerational transfers. Paper prepared for the 5th International Workshop of the Project on Intergenerational Equity (PIE). Tokyo, March: 10-12.
- Kamarás F. (2003): Fertility preferences versus actual behavior in Hungary, European Population Conference Warsaw, 26-30 August 2003, Population of Central and Eastern Europe. Challenges and Opportunities, (ed. Irena E. Kotowska and Janina Józwiak) Warsaw: 165-187.
- Kamarás F. (2004): :Kívánt és nem kívánt terhességek, gyerekek. (The planned and the unplanned pregnancies and children.)
- Ünnepi kötet a 70 éves Vavró István tiszteletére. (Klinger A. (2001): A késői gyerekvállalás problémái. (The problem of the late childbearing) In:Szerepváltozások, Szerk.: Nagy I., Pongrácz Tné, Tóth I. TÁRKI, SZCSM.
- Kopp, Mária and Skrabski Árpád (2006): Gyermekvállalás és életminőség, (The childbearing and quality of life) In: Kopp, M. and Kovács, M. (szerk) (2006) A Magyar népesség életminősége az ezredfordulón, Semmelweis Kiadó, Budapest, 253-262. old.

- Köllő János: Foglalkoztatáspolitikai eszközök az érettségivel nem rendelkezők munkaerőpiaci helyzetének javítására és az oktatási reformok előmozdítására. oktatas.mholnap.digitalnatives.hu/wiki/K%C3%B6ll%C5%91_
- KSH (2006): Nők és férfiak Magyarországon. (Central Statistical Office 2006: Women and men in Hungary) Szociális és Munkaügyi Minisztérium, 2007.
- KSH (1996): Európai Termékenységi és Családvizsgálat Magyarországon. (European fertility and family study in Hungary.) Demográfia, 1995. 4. szám: 309-339.
- Mackenbach, JP., Health Inequalities: Europe in Profile. An independent expert report commissioned by the UK Presidency of the EU, February 2006: 53.
- OECD (2007): Family Database, www.oecd.org./dataoecd/46/13.
- Pongrácz Tné (1994): Változások a magyar családban. (The changes of the hungarian family) INFO–Társadalomtudomány, 30.
- Pongrácz Tné and S. Molnár E. (2000): Kísérlet a „tradícióörző” és az attól elszakadó, „modernizálódó” családi értékek empirikus vizsgálatára. In: Emberi Viszonyok: Cseh-Szombathy László tiszteletére. Szerk.: Spéder Zsolt, Tóth Pál Péter. Századvég Kiadó, Budapest.
- Rózsa, S., Réthelyi, J., Stauder, A., Susánszky, É., Mészáros, E., Skrabski, Á. and Kopp, M. (2003): The health status of the Hungarian population according to the Hungarostudy 2002: The methods and the characteristics of the representative sample. *Psychiatria Hungarica* 18: 83-94. (in Hungarian)
- S. Molnár E. (2001): A közvélemény gyermekszám-preferenciái. (The public preferences of the number of children) *Demográfia*, 44: 3–4, 259–279.
- Skrabski, Á., Kopp, M. and Kawachi, I. (2004): Social Capital and Collective Efficacy in Hungary: Cross-sectional Associations with Middle-Aged Female and Male Mortality Rates. *Journal of Epidemiology & Community Health*, 58: 340-345.
- Spéder, Zs. (2005): Diversity of Family Structure in Europe Selected characteristics of partnerships, childhood, parenting, and economic well-being across Europe around the millennium. Day of European Demography held as a part of the 2. conference of IUSSP at the end of July 2005 in Tours, France.
- Tóth O. (1994): A házassággal, válással és az együttéléssel kapcsolatos attitűdök. (The attitudes of marriage, divorce and cohabitation) *INFO–Társadalomtudomány*, 30.
- Tóth O. (1998): Házasság és gyermek, vélekedés és viselkedés. (The marriage and the child: attitudes and behaviour.) *Századvég*, 11: 80–93.
- UN (2005): World Population Monitoring 2003.
- UN (1999): Fertility and Family Surveys in Countries of the ECE Region. Standard Country Report, Hungary. United Nations, New York, Genf.

Utasi Á. (2000): Tradicionális család individuális értékpreferenciákkal. (The traditional family with individual values/worth.) In: Emberi Viszonyok: Cseh-Szombathy László tiszteletére. Szerk.: Spéder Zsolt, Tóth Pál Péter. Századvég Kiadó, Budapest.

Chosen Women's Health Needs in Central-Eastern Europe: the Situation after the Process of Transformation-the example of Poland

Beata Tobiasz-Adamczyk

Introduction

Women living in Central-Eastern Europe do not constitute a homogenous population. Their lives are based on differing cultural and social contexts, and are also influenced by history, religion, social and behavioral norms, value systems, and life expectations. These cultural and social circumstances create diverse family systems, including different traditional female roles within the family. For example, until the second half of the 20th century, men dominated almost all walks of life. As a result, women were restricted to traditional duties within the family, such as child care and housekeeping (Titkow 1999).

This article will present issues especially important for women's health, relevant to their current demographic, social, cultural, and economic conditions, all of which significantly weigh on their quality of life. They also serve as health status indicators for general and specific morbidity, health system usage, cause-specific mortality, and the participation of women in health promotion interventions. Central-Eastern European transformation processes also led to many changes in the functioning of the healthcare system. Despite previous expectations, reforms introduced during this time did not lead to an increase in the quality of healthcare.

The new Polish Constitution (1997) overhauled several areas of everyday life, including healthcare. Since then, many attempts have been made to streamline public healthcare, yet none of these have led to any lasting increase in effectiveness. Legal guarantees concerning healthcare are outlined in the Constitution of the Republic of Poland. According to article 68, everyone has a right to health protection. In this regard, the Constitution outlines the responsibilities of public authorities in ensuring equal access to healthcare, financed by public resources, for all citizens, irrespective of their economic status; ensuring the healthcare of children, pregnant women, the disabled, and those in advanced age; combating health-related epidemics and preventing the detrimental health effects caused by environmental damage; and supporting healthy developmental processes, especially in children and adolescents (Korzeniewska & Nowakowska 2000).

The overhaul of Poland's healthcare system, amongst other changes, included a 1997 law concerning universal health insurance, leading to the creation of regional 'Health Funds' which began to function as of January 1, 1999. Following legislation passed in April 2003, these funds were then replaced by a single National Health Fund, the functioning of which is regulated

based on an August 2004 law concerning healthcare services financed by public resources (CSO, Social Surveys Division. Supervisor: Baran 2007).

Healthcare expenses, as related to healthcare services defined in the national health account, include expenses incurred by national and regional institutions, the National Health Fund, the private sector, and the foreign sector. In 2005, 68.7% of overall healthcare financing was provided by national and regional institutions (including the National Health Fund) and 31.3% was provided by the private sector. As for healthcare services in particular, 82.2% were financed by the public sector and 17.8% by the private sector. With respect to hospital-related expenses, 98.1% were financed by public sources and 1.9% by private sources. These percentages rise to 67.3% and 32.7%, respectively, for outpatient care and 15.5% and 84.5%, respectively, for dental care (CSO, Social Surveys Division. Supervisor: Baran 2007).

The main source of public healthcare funding is the National Health Fund. In total, its contribution to publicly funded healthcare amounted to 79% of the national health account.

In 2006, healthcare expenses financed by the National Health Fund amounted to 1.7% of the national budget, compared to 1.9% in 2005. For regional government budgets, this fraction amounted to 2.6%, compared to 2.5% in 2005. Government expenditures mostly included paying health insurance premiums and ensuring the healthcare of individuals not covered by health insurance (19.8%), sanitary inspections (18.3%), public health programs (15.7%), hospitals (11.1%), specialized healthcare (10.0%), and medical specialization programs (6.9%) (CSO, Social Surveys Division. Supervisor: Baran 2007).

Resources earmarked for healthcare were chiefly spent by regional governments on combating alcoholism (68.3%), outpatient (11.1%), and hospital care (4.4%). Districts mostly spent their healthcare resources on hospitals (47.6%) and paying health insurance premiums and ensuring the healthcare of individuals not covered by health insurance (41.8%). Municipalities spent their resources on hospitals (37.5%), combating alcoholism (23.5%), paying health insurance premiums and ensuring the healthcare of individuals not covered by health insurance (13.1%), and outpatient care (9.2%). Finally, province (i.e., voivodeship) healthcare resources were spent mostly on hospitals (63.2%), medical specialization programs (10.0%), and occupational medicine (7.0%) (CSO, Social Surveys Division. Supervisor: Baran 2007).

Demographic Data

The percentage of women in the general population varies by country. Poland, Slovakia, Slovenia, and the Czech Republic all note that approximately 51.4% of their general population is made up of women. Slightly smaller percentages are found in France (51.3%) and Austria and Finland (51.2%, respectively). Higher percentages can be found in the Baltic States: 53.9% in Latvia, 53.4% in Estonia, and 52.8% in Lithuania. Lower percentages can be found throughout the European continent: 50.8% in the UK, 50.7% in Greece, 50.5% in Sweden and Denmark, 50.4% in the Netherlands, and 50.3% in Ireland (Final Report to the WHO 2007).

In 2006, life expectancy for women in Poland was 79.62 years, compared to 70.93 years for men. However, at age 75 years, this gender gap closes, with life expectancy reaching 11.31 years for women and 9.09 years for men.

Data relating to Poland shows that a higher percentage of women than men complete higher education (10.4% as opposed to 9.3%). However, the opposite is true for the 60 years and over age group, where only 3% of women, as compared to 77% of men, completed higher education (Concise Statistical Yearbook of Poland 2007).

Women are employed to a significantly lesser degree than men. In the 18-64 years age group, employment indicators are 45.7% for women and 61.3% for men. A comparison of employment rates for men and women finds that women are at relative disadvantage in the job market (Sztanderska & Grotowska 2007).

Employment indicators differ for men and women across all age groups. The general employment ratio of men to women is 1,565 in the 18-24 years age group, 1,376 in the 25-34 years age group, 1,243 in the 35-44 years age group, 1,180 in the 45-54 years age group, and 1,809 in the 55-64 years age group. Labor market participation rates for women aged over 45 years show that a significant percentage leave the it, taking advantage of early retirement, whereas better educated women remain professionally active. Polish women are determined to remain employed, explained by their later entry into employment and their desire to gain additional professional experience to qualify for retirement benefits. As a result, compared to men, they often agree to worse terms of employment and lower pay.

Employment rates for physically fit individuals are 49.3% for women and 67.1% for men. Childbearing also leads to decreases in female employment rates. Differences in male and female employment rates are greatest when children are in infancy, marking a period when women withdraw from the labor market (Sztanderska & Grotowska 2007).

In Poland and the Netherlands, there are currently 5.0 marriages per 1,000 individuals in the general population, 5.1 in France, Spain, and the UK,

respectively, and 6.8 in Denmark. Mean age at first marriage is 23.7 years in Poland and 23.6 years in Lithuania. Greater mean ages at first marriage can be found in Sweden (30.0 years), the Netherlands (29.1 years), Latvia (24.4 years), the Czech Republic (24.9 years), Hungary (24.7% years), and Slovakia (25.6 years). Divorce, as a percentage of all marriages, reached 24% in Poland. In other traditionally Catholic countries, this number reached 19% in Spain, 14% in Ireland, and 14% in Italy. Three times higher divorce rates have been observed in Lithuania (71%), Latvia (62%), the Czech Republic (61%), Hungary (56%), and Slovakia (41%) (Final Report to the WHO 2007).

Fertility

The responsibilities of public healthcare authorities in Poland include the complex healthcare of pregnant women. All pregnant women are guaranteed the option of taking advantage of publicly funded healthcare during the course of pregnancy as well as pre- and postnatal periods, irregardless of health insurance coverage. Labor laws protect pregnant and breastfeeding women from engaging in burdensome or health-damaging work.

Poland, the Czech Republic, and Latvia have some of the lowest fertility rates in Europe (i.e., 1.22-1.24). Fertility rates are on the same level in Italy, Spain, Belarus, and Bosnia and Herzegovina (i.e., 1.20-1.22). These low rates may be explained by difficulties caused by poor economic status and a lack of appropriate housing, the fear held by some women that having children will lead to job loss, and a lack of social policy support. Also significant is that women stay in school for longer and get married later. Yet there is a lack of empirical data to explain the complex nature of this problem.

In the last two decades, most all European countries, including those in Central-Eastern Europe, have observed a decrease in teenage fertility rates. For example, in Poland, this rate dropped from 28.0 in 1980 to 14.5 in 2003. Higher teenage fertility rates exist in Bulgaria (40.4), Hungary (20.8), Lithuania (20.6), Romania (34.0), and Slovakia (20.6). In comparison to such countries as Denmark (6.8), Italy (6.8), the Netherlands (7.7) and Sweden (6.0), differences can be explained by poor sexual education as well as particular cultural circumstances (e.g., religion) (Report 2007).

One study found that contemporary women take longer to decide to have their first child. This study examined the relationship between giving birth, place of residence, job activity, and subjective evaluation of one's material status. This research was conducted in a voluntary, anonymous, and random sample of 275 women at procreation age. The majority (61.5%) of these women had not given birth by age 29 years, with the remainder (38.5%) having already entered motherhood, by the age of 30 years. The average age of first childbirth was 23 years. Data analysis suggested that the necessity exists for providing children

with health education regarding parenthood, covering both biological and psycho-sociological aspects, with the aim of portraying maternity as one of life's highest values (Łepecka-Klusek et al. 2003).

Krawczyk (2004) studied 1000 women aged 17-42 years, admitted to the Medical University Hospital and other regional hospitals in Lublin Province. This voluntary and anonymous study was carried out on the basis of a questionnaire designed by the author. The results showed that more than half of respondents (69.6%) worked during pregnancy. Levels of exposure to most work-place risk factors depended on their level of education. Compared to lesser educated women, better educated women more often mentioned working with a computer and in an enforced body position. Compared to better educated women, those with lower levels of education more often mentioned being exposed to temperature changes and dust and air pollution. Assessing workload depended on education: lower levels of education were associated with harder work (Krawczyk et al. 2004).

Health Outcomes

The changes which took place in Europe towards the end of the 20th century yielded many long and short-term effects for the social status of women, directly and indirectly affecting their health status. Analyzing the social and political changes which took place in, for example, Poland suggests that women have yet to take full advantage of all the opportunities brought about by a new political and economic situation.

When compared to Western Europe, standardized all-cause mortality rates for women aged 15-49 years show that these rates are higher in Poland, as well as in other Central-Eastern European countries. Regional variability can be seen by the Czech Republic's lower death rate compared to Slovakia. Also, Poland and Slovakia report lower mortality rates than Lithuania, Estonia, Hungary, and Latvia. Standardized mortality rates for women aged 15-49 years, using malignant cancer as a cause of death, showed greater levels for Poland than for such other countries as Finland, Sweden, Austria, and Germany. However, data related to breast cancer paint a different picture. Mortality rates for breast cancer were relatively low, especially in Poland and Slovakia, followed by Sweden, Austria, the Czech Republic, and Finland. Highest rates were noted in Hungary, Latvia, and Lithuania, similar to the UK and the Netherlands (Final Report to the WHO 2007).

Standardized mortality rates for women aged 15-49, using cardiovascular disease as the cause of death, showed that Poland, the Czech Republic, and Slovenia had rates twice as high as Austria, Slovenia, Sweden, Spain, and France. This rate was even several times higher in comparison to Lithuania, Estonia, Hungary, and Latvia. Cause of death data from 2005 show that 429.3

men and 451.6 women per 100.000 citizens, respectively, died due to cardiovascular disease. Higher death rates in women were noted, in particular, for cerebrovascular disease (i.e. 113.2 vs. 90.5) and hypertension (i.e., 16.6 vs. 12.5) (Wojtyniak 2006).

At age 19 years, women are most often hospitalized because of respiratory complaints. At age 20-45 years, hospitalization most often results from prenatal, postnatal, and pregnancy complications as well as an increased incidence of urological complaints. From the age of 50 years onwards, hospitalization in women is dominated by cardiovascular complaints. Additionally, from the age of 80 years onwards, hospitalization is most often the result of cancer (www.statystyka.medstat.waw.pl/wyniki.htm).

Social determinants of women's position in society

The process of transformation led to rapid and wide ranging changes in societies which were previously associated with open borders, including a balancing-out of material and non-material differences at a cultural level. Transformation processes had brought different experiences for women and consequently affected their position in the labor market (e.g., an increased tendency for unemployment, especially for those aged 35 years and over). The position of women varies across Central-Eastern European societies, being an example of diverse health and social policies dependent on socio-political and religious factors (Ostrowska 1999; Ostrowska 2000; Tobiasz-Adamczyk 2006 a; Tobiasz-Adamczyk 2006 b).

Another change has been a shift in traditional sources of power (i.e., youth as power) (Kuciarska-Ciesielska 1999; Nowakowska 2000; Tobiasz-Adamczyk 2004 a; Tobiasz-Adamczyk 2004 b) Society began to identify more with Western images of health after "importing" standards emphasizing a beautiful, healthy, and youthful body, which led to a boom in fitness clubs and gyms. Associating youth with strength, energy, and adaptation to new social indicators took its toll on women aged over 30 years (e.g., job advertisements restricted to women under 35). The need to create new job positions led to the age of retirement being decreased for women to 55 years-of-age, eliminating them from the job market and limiting their activity to family affairs.

Comparisons with Western Europe confirm not only the existence of worse health indicators in Central-Eastern Europe, but also poor or lacking health education and poor health attitudes as well as health-related behaviour, including a poorly developed health promotion infrastructure.

Health Needs Assessment

In line with the WHO definition of health, meeting health needs is a function of accommodating the various dimensions of health (i.e., physical, psychological, and social), which is further dependent upon a number of overlapping socio-cultural determinants. This is done with the aim of building health capital, including the potential for health. According to the dynamic model of health and the life course approach, this is accomplished through the avoidance of documented risk factors which may lead to likely changes in health status or other deleterious effects.

‘Needs assessment’ is a systematic procedure for determining the nature and extent of problems experienced by a specified population, affecting their health either directly or indirectly. Needs assessments make use of epidemiologic, socio-demographic, and qualitative methods in an effort to describe the environmental, social, economic, and behavioral determinants of various health-related issues. The aim is to identify unmet healthcare needs and create recommendations about how to address these needs. This also includes identifying explicit health problems (e.g., untreated diseases) and ‘problems waiting to happen’ (e.g., inadequate housing, poor literacy, domestic violence, lack of access to long-term care). Needs assessments are either a routine or ad hoc activity in many local public health departments (Last 2001).

Keeping in mind the health needs of Central-Eastern European women, one must consider that there exist various female cohorts within women as a whole. As a result of their age, these cohorts find themselves in different social circumstances, are exposed to different levels of risk, and experience different socio-cultural influences.

The first cohort includes young, teenage girls who, as a result of initiating a variety of health-damaging behaviors, increase their likelihood of experiencing negative health effects in the immediate or distant future. The second cohort, though by no means homogenous, includes women of reproductive age who experience different environmental influences. The third cohort, also by no means uniform, reflects women who have already completed their desired reproductive function. This cohort includes those towards the younger end of the spectrum of older women, consequently excluding those of more advanced age (Wróblewska 2006).

How to meet the health needs of women may also be discerned by comparing and contrasting Western and Central-Eastern European countries. This may allow for answering how particular female age groups, also being members of the same culture group, develop health-promoting or health-damaging behaviors over time. This would include addressing the lifestyle choices as well as environmental influences affecting these choices. However, any such analysis is automatically restricted to a particular cohort of women

resident in the given country. Besides environmental changes, structural determinants should also be considered (e.g., education, place of residence), including the influence of these determinants on social privileges as well as social disadvantages.

Meeting individual health needs signifies life satisfaction, high quality of life, and security. Furthermore, this means living life in an environment conducive to good health and having access to quality healthcare. Reproductive health means that individuals are able to lead a satisfying and safe sexual life, are able to procreate, have the right to access appropriate healthcare services, have access to prenatal care and safe delivery options, and that offspring may remain healthy (Report 2007).

The ecological theory of health status raises the necessity of analyzing the health status of women, using a life course perspective, which takes into account modifiable risk factors. Cumulative risk influence and the cumulative effect of chronic disease is supported by data showing risk of mortality and disability in the general female population and an increased mortality risk, particularly in middle aged women (Tobiasz-Adamczyk 2007). The stages when health may be improved and/or chronic conditions prevented are exhibited in a life course approach, from prenatal life, through infancy and childhood, young adulthood, adulthood, and late adulthood (i.e., older age).

Age can be perceived as a key marker of the cumulative effect of risk factor exposure, with the potential for modifications. For example, childhood and adolescence interventions can significantly change the course of adult-stage cardiovascular disease pandemics. The development of cardiovascular disease can be seen as the cumulative effect of chronic disease risk factors, such as low birth-weight, obesity, smoking, lack of physical activity, poor diet, and double stress coming from the pairing of work and household responsibilities.

Barriers towards meeting the health needs of the general population include such social problems as unemployment, unequal distribution of income, improprieties in the healthcare system, and a lack of resources for preventative interventions. It is necessary to note, however, that there has been an increase in programs aimed at the early diagnosis of cardiovascular disease (e.g., hypertension) and breast (e.g., using mammography screening), cervical (e.g., using PAP smears), and colon cancer. Unfortunately, even individual invitations sent to the homes of those in higher-risk groups are not met with great interest.

Risk Factors Influenced Health Status: Lifestyle

During the period of transformation, society was characterized by a poor awareness of health needs. This included adopting a symptomatic approach to health (i.e., only in the event of a confirmed disease state did health assume any

significance). There was a lack of appreciation for the potential of preventative medicine. Most individuals professed a poor understanding of health-conscious behaviors, neglecting to pro-actively build one's health potential throughout life. Due to the high risk of unemployment and worsening socioeconomic status of certain groups, significant health-related issues decreased in popularity. Occupational health risks were disregarded, explained by the fact that securing employment was seen as an individual's highest priority. Also, one tended to disregard the potential for health-related risk, leading to an avoidance of screening studies, even when such studies were free and readily accessible to the public.

Considering the state of Poland's economy in the 1980s (e.g., empty store shelves, shortages of certain products), the period of transformation introduced many radical and drastic changes. A vast selection of food products, easy access to tobacco and alcohol, and a boom in automobile sales "forced" society to learn how to deal with the fruits of modern civilization. Taking advantage of consumer culture was seen as a democratic right. This period also led to health problems being dealt with in a different way, focusing more on prevention and health promotion. This meant that old and new public health challenges would have to be approached differently. "Old challenges" included working against poor dietary habits (e.g., high fat diets, consuming large amounts of red meat and/or small amounts of vegetables and fruits), alcohol abuse, and poor physical fitness. One may also include poor access to modern contraception in this group, leading to abortion procedures having been effectively used as a form of contraception.

The process of transformation offered ready access to a western lifestyle (interpreted both positively and negatively), reflective of such indicators as advertising for modern products and increased access to drugs. As a consequence of these changes, new potential risk factors had developed. This period is also characterized by access to modern mass media, computers, and the internet, as well as a new focus on the body as an element of social identity and hallmark of health.

The period of transformation led to a number of interventions aimed at changing then current lifestyle patterns, especially dietary habits, encouraging moving away from traditional Polish cooking, and discouraging other health-damaging forms of cooking. On the other hand, fast-food noted a tremendous gain in popularity, whereby going to McDonalds became extremely fashionable, especially amongst the younger age-group.

From 1995-2003 data from Poland showed that the percentage of female adult smokers decreased from 27% to 23%. A similar tendency can be observed in The Czech Republic. However, the percentage of women smokers increased in Hungary, from 22% in 1986 to 29% in 2003.

Furthermore, from 2002-2003, as a result of decreased financing for interventions aimed at curbing cigarette smoking, the frequency of everyday smoking remained unchanged in the adult female population (i.e., aged 20 years and over), remaining at approximately 25%. Yet in the period 1990-2003, a significant percentage of smokers stopped smoking, rising from 7.6% to 11.5%. According to the results of the National Health Program, positive attitudes towards smoking have ceased in recent years. The sudden drop in the frequency of smoking (i.e., from 50% to 25%) seen during the 1980s in younger female age groups (i.e., aged 20-29 years) has since reached a plateau (Zatoński 2006; Zatoński & Przewoźniak 2005).

According to Zatoński & Przewoźniak (2005), health promotion programs should also target women strongly addicted to smoking and of lower socio-economic status. Such programs should also focus on protecting the fetus from the effects of cigarette smoke. The “Program to restrict the health-damaging effects of smoking in Poland, Aims and challenges for 2008-2011” results from the Polish Government’s obligation to act in accordance with article 4 of legislation passed on November 9, 1995, concerning protecting health against the effects of smoking and other tobacco products. The aims of this program are in line with the WHO’s ‘Tobacco Free Europe’ program and EU health policy (e.g., ‘Europe Against Cancer’ program). Poland’s anti-nicotine interventions are grounded in the National Health Program (2007-2015), European Code for Combating Cancer, National Program to Combat Neoplastic Diseases, and Program to Restrict the Health-Damaging Effects of Smoking (2008-2011). Government-based interventions also include increasing the percentage of individuals who have never smoked: in the 8-10 years-old age group from 85% to 95%, in the 11-15 year-old adolescent age group (both girls and boys), from 60% to 70%, and from 64% to 75% in women aged 20-29 years.

Data from the National Health Program (1999-2005) show that women remain in large part responsible for household management. Also, despite improved dietary habits and increased access to quality food, a number of unhealthy dietary habits remain. Programs aimed at teaching healthy eating habits should focus on women. Specifically, attention should be devoted to decreasing the place of dietary fat as a source of energy (i.e., from 37% to 30% of daily caloric consumption) and increasing the consumption of fish, dairy products, vegetables, and pulses (legumes). Considering the negative influences of globalization, differences may also be observed based on socio-economic status within increasing trends in female obesity (Gajewski 2005; Sekuła & Szponar 2005).

The report on Women’s Health at Reproductive Age notes that:

1. Almost half of all 18 year-old girls finishing secondary school have already initiated sexual activity. Among sexually active females, every

eighth has had 3+ sexual partners, one in ten did not use any contraceptive method at last intercourse, and half use ineffective contraceptive methods.

2. Early sexual intercourse is linked with a higher risk of detrimental outcomes for girls resident in cities and girls studying in technical schools and specialist high schools.
3. In order to reduce the risks associated with sexual and reproductive health in young people, consensus must be reached concerning sex education in schools and ensuring access to 'adolescent friendly' medical facilities, in line with the European strategy for health and development in children and adolescents.

In general, Polish women very seldom (19%) use modern contraceptive methods (Izdebski 2006). Compared to other predominantly Catholic countries, 38.9% of women in Italy and 41% of women in Slovakia use modern methods. This percentage goes as high as 68.4% in Hungary, 71.8% in Germany, and 81% in the UK.

Concerning the sexual behavior of Polish adolescents, 20.6% of 16 year-olds and 47.3% of 18 year-olds have initiated sexual activity. Based on place of residence, this tendency is higher in urban (35.6%) as opposed to rural settings (26.9%). Sexual activity at less than 15 years-of-age was reported by 28.8% of 16 year-old and 13.9% of 18 year-old girls. This tendency is also higher in city residents (20.2%), compared to village residents (12.0%). Although most sexually active adolescent females report having had only one sexual partner (70.3% of 16 year-olds and 67.4% of 18 year-olds), noteworthy is that 12.9% of 16 year-olds and 13.3% of 18 year-olds reported having three or more partners (Woynarowska 2000).

Data coming from the Woynarowska study show that a relatively high percentage of participants (i.e., 73.5% of 16 year-old and 76.1% of 18 year-old females) reported using a condom at last intercourse. Whereas, a relatively small percentage of 16 year-olds reported using oral contraception (i.e., 13.9% of 16 year-olds vs. 33.2% of 18 year-olds). Natural methods were used by 19.2% of 16 year-olds and 12.6% of 18 year-olds. Not using any contraceptive method at last intercourse was reported by 13.2% of 16 year-olds and 7.3% of 18 year-olds.

Data focused on the rates of female HIV infection show that this phenomenon is relatively new for Central-Eastern Europe. In 1990, in the Czech Republic, Latvia, Lithuania, and Poland, there were no reported female cases of female HIV infection. With regards to the total infected population, in 2003, in the Czech Republic, Latvia, and Lithuania, the percentage of female HIV infections reached 11.1%, while in Poland this number reached 32.9% (Marzec-Bogusławska 2006).

Domestic Violence

For years, violence directed against women has been a taboo topic. Programs working against violence direct most of their attention to domestic violence affecting children and young women in particular. Currently, the Daphne II international program is working to deal with violence directed against older women in the home environment.

In Poland, 60% of divorced women reported being hit at least once by their ex-husbands and an additional 25% reported cases of repeat violence. In cases for which police were called to the home, 58.3% concerned women who were being attacked by members of their immediate family. Data from Hungary show that 13% of women who are or have been in a relationship reported being beaten by their husband/partner, 18% were afraid of being beaten, and 22% said their partner threatened them with physical force. In Lithuania, 42.4% of all married/cohabitating women have been victims of physical or sexual violence by their present partner, of which 10.6% of women reported the most serious incident to police.

Primary Prevention and Health Promotion in Central-Eastern Europe: the Example of Poland

Poland, similar to other Central-Eastern European countries, has noted an increasing interest in health promotion following its period of political-economic transformation. This relatively new concept of working towards good health was considered part of a new democratic reality.

Past decades have given rise to a new consciousness in society and among health professionals concerning health promotion and a transparent strategy for its implementation. Unfortunately, the dominant biomedical model of illness, aimed at primary and secondary prevention, has made implementing this strategy neither easy nor completely successful. Still, medical and public health professionals are unclear as to how the definition of health promotion should be applied in practice.

Social changes, as well as consequent new social challenges, meant that current health promotion interventions needed to be evaluated. The process of transformation instigated rapid changes in the system of obligatory norms and values, also bringing many changes to lifestyle. Access to a diverse array of food products allowed for the possibility of leading a more health-conscious lifestyle.

The main goals of health promotion in women should be focused on building their potential health resources:

1. Improving health knowledge, health awareness, and control over one's own health and life.
2. Health-promoting behaviors (e.g., healthy dietary habits, physical activity, breastfeeding).
3. Decreasing risk factors (e.g., smoking, smoking and drinking during pregnancy).
4. Actions against health damaging behaviors (e.g., drug abuse, suicide, attempted suicide, anorexia and bulimia).
5. Encouraging an active lifestyle in older age (e.g., Third Age Universities, social network functioning, balancing differences in access to such modern technology as computers, internet and mobile phones).
6. Improving mental health, psychological wellbeing, and treating symptoms of depression and other mental disorders.
7. Coping with abusive family situations, discrimination in the labor force and other dimensions of social life, including different forms of deprivation. (Report 2007)

The National Health Program (1996-2005) served as the predecessor for such other national programs as National Heart, Stroke Prevention and Treatment, Combating Cancer, Alcoholism Prevention and Treatment, Psychological Wellbeing, Preventing HIV, and Caring for Those Living with HIV programs. While analyzing the accomplishments of the National Health Program, goals for 1996-2005 included, among others, early diagnosis and care for those at risk for coronary heart disease, streamlining diagnosis and treatment for uterine and breast cancer, better efficiency in preventing infectious diseases and road accidents, improving the efficiency of emergency medical services, preventing premature births, and preventing dental problems in children, adolescents, and pregnant women.

This period also included goals aimed at increasing physical fitness, improving nutritional habits, minimizing the consumption of alcohol, restricting the use of psychoactive substances, and improving the efficiency of health education and health promotion efforts, including psychological health (Goryński, Wojtyniak & Kuszewski 2005; Goryński & Wojtyniak 2005; Wojtyniak 2005).

Calling to mind the example of breast cancer in women, awareness concerning this form of cancer is very high. This is the direct and indirect result of various prophylactic and health promoting interventions, which, through health education, have sensitized women to the risk of being diagnosed with this malignant disease, leading to increased self-care and remaining observant of any changes taking place in one's body.

However, there are few such health education interventions targeting cardiovascular disease. Existing programs are geared mostly towards eliminating high-risk, health-damaging behaviors (e.g., anti-smoking interventions, health dietary habits, physical fitness). Likewise, there is a lack of health education programs meant to increase awareness of one's own body. With respect to women, this aspect of health education was possibly ignored or poorly promoted. Reasons include the traditionally held notion that women, compared to men, take greater interest in their health, are better prepared to recognize changes in health status, and react more quickly to the symptoms of disease.

This image of women's illness behavior is altered by a lack of reliable data concerning unspecific symptoms which may act as reason enough to present to a physician. This is confirmed by a number of studies undertaken in groups of women treated for cardiovascular disease, whose subjective evaluation of bodily changes chiefly concerned altered mood, poor concentration, and fatigue, more so than specific pain symptoms.

Currently, a number of media campaigns are looking to convince women of the necessity to undergo prophylactic examinations, especially in cases when the individual is convinced they are not at any risk for disease. Some argue that negative attitudes towards population-wide screening studies can be attributed to popular views of a poorly functioning healthcare system, long waiting lists for specialist consultations, and difficulty accessing urgently needed healthcare.

As beneficiaries of the same cardiovascular disease treatment options, noteworthy is the fact that women, compared to men, experience more deleterious consequences. For example, various studies find that women report worse quality of life. Also, before initiating treatment, their quality of life was lower than that of men in similar health situations. While analyzing the behavior of women, one finds they tend to ignore the symptoms of cardiovascular disease, whereas positive changes in terms of their attitudes and behavior are noted in cases of suspected cancer (e.g., breast cancer). The structural aspects of a woman's position and quality of life in the period preceding her cardiovascular disease often serve to explain her worsened quality of life after treatment and worse long-term effects of treatment.

Health education programs aimed at women, which are meant to increase awareness concerning the meaning and consequences of cardiovascular disease in one's life, should thus systematically increase levels of knowledge concerning the first bodily signs and increase the potential for an early diagnosis by a qualified physician.

Cultural circumstances work against the comprehensive sexual education of teenagers, perceived as a taboo topic. In public life, discourse related to sexual education in school is largely restricted as a consequence of Catholic (religious) influences. Also, specific family situations, some of which apply the tradition of

not speaking openly about sex, tend to restrict communication on this topic between parents and adolescents.

Health Promotion among Older Women

Only a few programs focus on health promotion in older women. For example, 'Older Gentleman, Older Lady' is a pilot program aimed at older people (especially women) and their care-takers (related and not related). The aim of this program is to reduce the incidence of violence directed against older people by helping those who, as a result of their trouble in relating to the older person, may be prone to use violence. This program includes support groups, behavioural education for the older person and their care-takers, and individual consultations with lawyers, psychologists, psychiatrists, and social workers. The main goals are combating violence against older people (especially women) and supporting those in need.

Health Education as a Strategy for Health Promotion

Health education implies promoting the importance of screening methods used for the early detection of breast, cervical, and colon cancer. Health education should improve awareness of body perception, first symptoms, and quick decision making concerning when to seek professional help (Izdebski 2006). Conditions for health education should also be specially adapted to the needs of young teenagers, concerning how to avoid unplanned pregnancy as well as prevent sexually transmitted diseases (Kopacz 2008).

Data from a study which took place in Toruń showed that 77% of women performed breast self-exams. Though virtually all women were aware of breast self-exams, less than a half of village residents and women aged 40-60 years performed them. When broken down by demographic group, the inhabitants of cities were more likely to perform breast self-exams than the inhabitants of villages (91 % vs. 25%). Women with university education were more likely to perform breast self-exams than women with primary education (86% vs. 50%). Also, women aged over 60 years were more likely to perform breast self-exams than women aged 40-60 (71 % vs. 33%). In the Outpatient Clinic for Women in Toruń, breast cancer screening was conducted only in the case of some women. This study revealed that 52% of women over 60 have never had a clinical breast exam and 71% never underwent a mammography screening or breast ultrasound. Mammography and ultrasound examinations were performed only in half of women aged 50-60 years. The authors suggest it is not clear why breast cancer prevention concerned younger women more than older women (Grodzki et al. 2004).

Data from the report on Women's Health at Reproductive Age find that:

1. For example, between 1976 and 1999, there was a significant increase (by 58%) in the percentage of women declaring having been informed about cytologic testing. However, further inquiry finds that their knowledge concerning the prevention of endometrial cancer was lacking. This requires that efforts aimed at health education be continued. Such efforts should be led by health-care workers professionally trained for such a task. Mass media as well as introducing well-prepared educational materials stand to make a significant contribution in this regard.
2. Smaller, though statistically significant, changes were confirmed in terms of the health-behaviour of women concerning, for example, yearly check-ups. Presenting to a gynaecologist rose by 12% and undergoing cytologic testing rose by 7%. Further improvement, besides increasing awareness and pro-active behavior in women, should involve more intensive action by physicians in the secondary prevention of endometrial cancer.
3. The groups of women declaring the least amount of knowledge concerning cytologic testing, its role in the early detection of endometrial cancer, and presenting least often for prophylactic testing included older, less educated women, resident in the country-side. These groups should be the object of education and medical interventions, especially considering that many of them are already at an increased risk of endometrial cancer. (Report, 2007)

Indicators relating to the two main causes of death in women (i.e., cardiovascular disease and malignant carcinoma) are significantly higher in women aged over 50 years. Considering the effectiveness of health promotion and cancer prevention interventions, recommendations, including frequency of implementation, in women over 50 years of age (Wronkowski & Zwierno 2005) include increasing physical activity, decreasing exposure to known risk factors (e.g., unhealthy dietary habits, smoking, alcohol consumption, UV exposure), recognizing the warning signs/symptoms of malignant disease, regularly examining the state of one's own body, including skin, mucosa, and breasts, regularly presenting to one's physician for prophylactic healthcare, and participating in screening studies

Furthermore, improving the health of reproductive-aged women, newborns, and infants is a strategic goal of the National Health Program for 2007-2015. Differences in the health status of pregnant women, infants, children, and adolescents result from differences in the socioeconomic status of certain groups, varied behaviors within these groups, a lack of health consciousness on the part of certain groups of women (especially those with low-levels of education), and unequal access to medical services. The National Health Program aims to eliminate regional inequalities and improve the quality of healthcare. Provisions are also made for educational programs to change certain

behaviors in reproductive-aged women (National Health Program 2007-2015, 2007).

One effect of changing customs is that access to and distribution and consumption of certain products becomes equalized between men and women. This is especially evident in the sphere of alcohol consumption and smoking. Though most indicators remain greater in men than in women, should these trends continue, then any differences will cease to exist in the near future. This poses a challenge to prophylactic interventions, which should devote greater attention to young girls (Report 2007; Sierosławski 2007). The poor results of interventions aimed at preventing endometrial cancer are explained by the small percentage of women who actively participate in cytological screening, making up approximately 20% of the female population aged between 30 and 59 years.

Conclusion

Health promotion in women should be supported by official and nonofficial activities associated with building social capital and psychosocial resources for women. There should be a focus on increasing general quality of life, safe conditions of living, and giving women a real opportunity to make independent decisions in all dimensions of their lives.

References

- Concise Statistical Yearbook of Poland (2007) (Mały rocznik Statystyczny 2007): www.stat.gov.pl/gus/45_737_PLK_HTML.htm
- CSO, Social Surveys Division (2007): (GUS, Departament Badań Społecznych): Basic data on the health care system in 2006. Supervisor: Baran A. (Podstawowe dane z zakresu ochrony zdrowia w 2006r), Warszawa. www.stat.gov.pl/
- Final Report to the WHO Commission on Social Determinants of Health by the Women and Gender Equity Knowledge Network, September 2007. www.euro.who.int/gender
- Gajewski A. (2005): Improving physical fitness at a population level (Zwiększenie aktywności fizycznej ludności) In: Goryński, P., Wojtyniak B., Kuszewski K., red; Monitoring the anticipated effects of the National Health Program for 1996-2005 (Monitoring oczekiwanych efektów realizacji Narodowego Programu Zdrowia 1996-2005 – supplement). Państwowy Zakład Higieny Warszawa: 48-55.
- Goryński, P. and Wojtyniak B. (2005): National Health Program 1996-2005 – Conclusions, suggestions for the future (Narodowy Program Zdrowia w latach 1996-2005 - wnioski z jego realizacji, sugestie na przyszłość). In: Goryński, P., Wojtyniak B. and Kuszewski K., red. Monitoring the anticipated effects of the National Health Program for 1996-2005 (Monitoring oczekiwanych efektów realizacji Narodowego Programu Zdrowia 1996-2005 – supplement). Państwowy Zakład Higieny Warszawa: 7-11.

- Goryński P., Wojtyniak B. and Kuszewski K. (eds.) (2005): Monitoring the anticipated effects of the National Health Program for 1996-2005 (Monitoring oczekiwanych efektów realizacji Narodowego Programu Zdrowia 1996-2005). Państwowy Zakład Higieny, Warszawa
- Grodzki L., Łangowska-Grodzka B. and Ziółkowski M. (2004): Evaluation of secondary breast cancer prevention among the female inhabitants of Toruń (Ocena profilaktyki wtórnej raka piersi wśród mieszkank Torunia). *Zdrowie Publiczne* 114: 483-486.
- Izdebski, Z. (2006): Female sexual behaviors (Zachowania seksualne kobiet). In: Report: The health of women at reproductive age, 15-49 years (Raport: Zdrowie kobiet w wieku prokreacyjnym 15-49 lat). Polska: 87-88.
- Kopacz, M. (2008): A Health education program in Poland from the perspective of adolescent mothers. *Journal of Theory and Practice in Education*, 4 (1): 117-132.
- Korzeniewska, M. and Nowakowska U. (2000): Womens' Health (Zdrowie kobiet) In: Women in Poland in the 90s. Report from the Center of Women Rights. (Kobiety w Polsce w latach 90. Raport Centrum Praw Kobiet). Warszawa: 195-224.
- Krawczyk W., Latański M., Kulik T. B. and Pilewska A. (2004): Risk factors in the work environment of pregnant women (Zagrożenia dla ciężarnych kobiet w środowisku pracy). *Zdrowie Publiczne* 114: 155-158.
- Kuciarska-Ciesielska M. (1999): The health status of women in Poland (Stan zdrowia kobiet w Polsce). *Promocja Zdrowia. Nauki Społeczne i Medycyna, Rocznik VI*, 16: 115-130.
- Last J.M. (2001): A dictionary of epidemiology. IEA. Oxford, University Press, 121.
- Łepecka-Klusek C., Karuda M. and Bucholc M. (2003): Maternity among contemporary women (Macierzyństwo współczesnych kobiet). *Zdrowie Publiczne* 113: 277-279.
- Marzec-Bogusławska A. (2006): HIV/AIDS infections (Zakażenia HIV/AIDS). In: Report: The health of women at reproductive age, 15-49 years (Raport: Zdrowie kobiet w wieku prokreacyjnym 15-49 lat). Polska: 60-63.
- National Health Program 2007-2015 (2007): Narodowy Program Zdrowia na lata 2007-2015: www.mz.gov.pl/wwwfiles/ma_struktura/docs/zal_urm_npz_90_15052007p.pdf
- Niemiec K. T. (2006): Introduction (Wstęp). In: Report: The health of women at reproductive age, 15-49 years (Raport: Zdrowie kobiet w wieku prokreacyjnym 15-49 lat). Polska: 11-20.
- Nowakowska, U. (2000): Polish Women in the 90-ties - Introduction (Kobiety w Polsce w latach 90. Wprowadzenie). <http://free.ngo.pl/temidrapwpro.htm>.
- Ostrowska, A. (1999): Gender as a predictor of health differences (Płeć jako czynnik różnicowania zdrowia społeczeństwa). *Promocja Zdrowia. Nauki Społeczne i Medycyna, Rocznik VI*: 48-67.

- Ostrowska A. (2000): Social determinants of Health-related behavior (Społeczne czynniki warunkujące zachowania prozdrowotne – bilans dekady). *Promocja Zdrowia. Nauki Społeczne i Medycyna* 19: 46-65.
- Report (2007): The health of women at reproductive age, 15-49 years. Poland 2006. (Raport: Zdrowie kobiet w wieku prokreacyjnym 15-49 lat. Polska 2006) Editor: Program Narodów Zjednoczonych ds. Rozwoju, Warszawa.
- Sekuła W., Szponar L. (2005): Improving dietary habits and food quality at a population level (Poprawa sposobu żywienia ludności i jakości zdrowotnej żywności). In: Goryński, P., Wojtyniak B., Kuszewski K., red. *Monitoring the effects of the National Health Program for 1996-2005 (Monitoring oczekiwanych efektów realizacji Narodowego Programu Zdrowia 1996-2005 –supplement)*. Państwowy Zakład Higieny Warszawa: 56-63.
- Sierosławski J. (2007): Alcohol and drug use in school-aged children (Używanie alkoholu i narkotyków przez młodzież szkolną), Report from a national Polish survey in 2007 – A European survey study in espad schools (Raport z ogólnopolskich badań ankietowych zrealizowanych w 2007 r.- europejski program badań ankietowych w szkołach espad), Warszawa.
- Sztanderska U. and Grotowska G. (2007): The Employment and Unemployment of Women and Men (Zatrudnienie i bezrobocie kobiet i mężczyzn) In: Kotowska I., Sztanderska U., Wóycicka I., red. *Occupational and educational activity and family duties in Poland in empirical studies (Aktywność zawodowa i edukacyjna a obowiązki rodzinne w Polsce światło badań empirycznych)*. Wydawnictwo Naukowe SCHOLAR Warszawa: 171-217.
25. Titkow A. (1999): Historical and social determinants of women's identity in Poland. (Historyczno-społeczne uwarunkowania tożsamości kobiet w Polsce). *Promocja Zdrowia. Nauki Społeczne i Medycyna, Rocznik VI*, 16: 11-28.
- Tobiasz-Adamczyk B. (1999): Chosen elements of quality of life in elderly women (Wybrane elementy jakości życia kobiet starszych wiekiem). *Promocja Zdrowia. Nauki Społeczne i Medycyna, Rocznik VI*, 16: 68-83.
- Tobiasz- Adamczyk B. (2004 a): Psychosocial resources in the beginning of old age as predictors of healthy ageing. In: Syrkova D., Chytilo (Ed.): *Autonomie ve Stari. Strategie jejího zachovani. Zdravotne socialni fakulta. Ostravske univerzity v Ostrave*: 152-173.
- Tobiasz-Adamczyk B. (2004 b): Social determinants of quality of life in women at the beginning of older age (Społeczne uwarunkowania jakości życia kobiet u progu wieku podeszłego). Uniwersytet Jagielloński, Kraków.
- Tobiasz-Adamczyk B. (2006 a): Cultural Determinants of Social Position and Health Status of Older Women in Poland. In: Lasch V., Freitag W., Sonntag U. (eds.): *Gender, Health and Cultures – Networking for a better Future for Women within an enlarged Europe*. Kassel University Press: 193-209.
- Tobiasz-Adamczyk B. (2006 b): Social Resources and Health Status In Older Polish Women. In: Backes G. M., Lasch V., Reimann K. (eds.): *Gender, Health and Ageing – European Perspectives on Life Course, Health Issues and Social Challenges*. VS Verlag für Sozialwissenschaften, Wiesbaden: 139-156.

- Tobiasz-Adamczyk B. (2007): Social determinants of cardiovascular disease in women (Społeczne uwarunkowania chorób serca u kobiet). Podolec P., eds.. Guide book Polish Prophylactic Healthcare Forum Volume I (Podręcznik Polskiego Forum Profilaktyki tom I). Kraków: Medycyna Praktyczna.
- Wojciechowska U., Didkowska J., Tarnowski W. and Zatoński W. (2006): Malignant cancer in Poland in 2004 (Nowotwory złośliwe w Polsce w 2004 roku). Centrum Onkologii im M. Curie-Skłodowskiej, Warszawa.
- Wojtyniak B. (2005): The anticipated health effects of the National Health Program (Oczekiwane korzyści zdrowotne realizacji NPZ). In: Goryński, P., Wojtyniak B., Kuszewski K., red. Monitoring the anticipated effects of the National Health Program for 1996-2005 (Monitoring oczekiwanych efektów realizacji Narodowego Programu Zdrowia 1996-2005 –supplement). Państwowy Zakład Higieny Warszawa: 12-36.
- Wojtyniak B. (2006): Mortality in women aged 15-49 years (Umieralność kobiet w wieku 15–49 lat). In: Report: The health of women at reproductive age, 15-49 years (Raport: Zdrowie kobiet w wieku prokreacyjnym 15-49 lat). Polska: 32-47.
- Wojnarowska B. (2000): National Health Program in Poland 1987 – 2000. Genesis, history, evolution of concept, and possibilities for implementation (Narodowy Program Zdrowia w Polsce 1987-2000. Geneza, historia, ewolucja koncepcji i możliwości realizacji). Promocja Zdrowia. Nauki Społeczne i Medycyna 19: 34-45.
- Wronkowski Z. and Zwierno M. (2005): Making early diagnosis more efficient and enlarging the effectiveness of treating malignant cervical and breast carcinoma (Usprawnienie wczesnej diagnostyki i zwiększenie efektywności leczenia nowotworów złośliwych szyjki macicy i sutka). In: Goryński, P., Wojtyniak B., Kuszewski K., red. Monitoring oczekiwanych efektów realizacji Narodowego Programu Zdrowia 1996-2005 –supplement. Państwowy Zakład Higieny Warszawa: 232-269.
- Wróblewska W. (2006): Health-related quality of life in women (Jakość życia kobiet uwarunkowana stanem zdrowia). In: Report: The health of women at reproductive age, 15-49 years (Raport: Zdrowie kobiet w wieku prokreacyjnym 15-49 lat). Polska: 80-83. www.statystyka.medstat.waw.pl/wyniki.htm. Study on nosocomial infections (Badanie chorobowości szpitalnej ogólnej).
- Zatoński W. (2006): Psychoactive substances- Tobacco smoking (Substancje psychoaktywne- Palenie tytoniu). In: Report: The health of women at reproductive age, 15-49 years (Raport: Zdrowie kobiet w wieku prokreacyjnym 15-49 lat). Polska: 64-69.
- Zatoński W. and Przewoźniak K. (2005): Decreasing the prevalence of tobacco smoking (Zmniejszenie rozpowszechnienia palenia tytoniu). In: Goryński, P., Wojtyniak B., Kuszewski K., red. Monitoring oczekiwanych efektów realizacji Narodowego Programu Zdrowia 1996-2005 –supplement. Państwowy Zakład Higieny Warszawa: 64-76.

Notes on Contributors

Szilvia Ádám is Assistant Professor of Medical Sociology at the Semmelweis University, Institute of Behavioural Sciences. Her doctoral research focuses on psychosocial antecedents to and health-related consequences of work-family conflicts including burnout in different cultural and socio-demographic settings. Ms Ádám also spent six years as a consultant in gender mainstreaming and oversaw the development and implementation of national and international programmes on gender equity. Ms Ádám has published extensively in the field of stress research and she has also been serving as an ad hoc reviewer for the *Journal of Applied Psychology*. Contact: Prof. Dr. Szilvia Ádám, Semmelweis University, Institute of Behavioural Sciences Nagyváradi tér 4., HU-1089 Budapest, Hungary, E-mail: adaszil@net.sote.hu

Birgit Babitsch, Prof. Dr., graduated in social science and public health. Her current research activities are in gender and health, health services research and gender medicine. Since 2008 she is professor (Juniorprofessorin) at the Berlin School of Public Health at the Charité – Universitätsmedizin Berlin. Her department is focusing on health services research and gender/diversity. She conducted several national and international research projects. She is involved in teaching of medical as well as public health students. She has been publishing several articles covering the field of social inequality, gender and health and gender-sensitive health services research. Contact: Prof. Dr. Birgit Babitsch, MPH, Department Health Services Research, Berlin School of Public Health, Charité – Universitätsmedizin Berlin, Oudenarder Str. 16, 13347 Berlin, E-mail: birgit.babitsch@charite.de

Sabine Bohne, Dipl. päd. (educational scientist), is working at the Institute of Educational Science, University of Osnabrück, Germany. Together with Prof. Carol Hagemann-White she carried out the evaluation of the “European Women’s Health Network”, a study on health impact of violence and role of the health professionals, as well as the coordination of the project “Co-ordination Action on Human Rights Violations”, funded within the EC 6th framework (2004-2007). She was coordinator of the project “PRO TRAIN: Improving multi-professional and health care training in Europe - building on good practice in violence prevention (2007-2009), funded within the EC Daphne II Programme and is currently coordinating the Daphne III project “STAMINA:

Formation of non-violent behaviour in school and leisure time among youths from violent families (2009-2011)”. Since 2003 she gives lectures on gender based violence, human rights violations, violence against children/ youth and measures of intervention and prevention at University of Osnabrueck. Contact: Sabine Bohne, University of Osnabrueck, Institute of Educational Science, Heger-Tor-Wall 9, D-49069 Osnabrueck, E-mail: sbohne@uni-osnabrueck.de

Petra Brzank, MPH, Dipl.-Soz., Diploma Degree in Sociology, Master Public Health, Senior Scientist. Evaluation of the S.I.G.N.A.L.-Intervention programme for health care improvement of female DV-victims, in particular conduct and statistic analysis of prevalence survey; development and evaluation of S.I.G.N.A.L.-Working Materials, evaluation of the S.I.G.N.A.L.-Train the Trainer Seminars (all funded by German Ministry for Family, Senior Citizens, Women and Youth); statistical analysis and report of several quantitative surveys on women’s health issues (Department of Public Health Science at Technical University Berlin); Lecturer in Migration/Culture/Ethics and Health, Nurse Science, Health inequalities, Social Epidemiology. Working foci: Epidemiology, Methods, Social Science in Public Health, Violence against Women, Gender and Health, Migration and Health. Contact: Petra Brzank, University of Applied Sciences Fulda, Dept. Nursery and Health Sciences, Marquardstr. 35, D-36039 Fulda, E-mail: Petra.Brzank@pg.hs-fulda.de, Website: www.hs-fulda.de/index.php?id=1806

Mary Anne Burke, is President of *BIAS FREE* Co-operative, Inc, (www.biasfree.org). She has published widely in the areas of public policy, social conditions and human rights. She is also Assistant Professor (Status Only) of Sociology and Equity Studies at the Ontario Institute for Studies in Education at the University of Toronto and Senior Policy Analyst with the Canadian government. Contact: Mary Anne Burke, 22 Alder Crescent, Ottawa, ON K1B4X6, Canada, E-mail: biasfreeinc@biasfree.org, Website: www.biasfree.org

Julie Cwikel, Prof., is the founder and director of Israel's only academic center of women's health studies - The Ben Gurion University of the Negev Center for Women's Health Studies and Promotion. She is a social epidemiologist whose current research includes developing new technologies for women with infertility problems, developing theory on women's styles of coping and investigating mother-daughter transmission of health behaviours. Contact: Prof. Dr. Julie Cwikel, Center for Women's Health Studies and Promotion, Ben Gurion University of the Negev, POB 653, Beer Sheva, 84105, Israel, E-mail: jcwikel@bgu.ac.il

Notes on Contributors

Margrit Eichler is Professor of Sociology and Equity Studies at the Ontario Institute for Studies in Education at the University of Toronto. Her over 200 publications deal with feminist, policy and environmental sustainability issues. She was elected a member of the Royal Society of Canada and of the European Academy of Sciences. She is Vice-president of BIAS FREE Co-operative Inc. Contact: Prof. Dr. Margrit Eichler, Dept. of Sociology and Equity Studies in Education, OISE/UT, 252 Bloor St. W., Toronto, ON M5S 1V6, E-mail: margrit.eichler@utoronto.ca

Zsuzsa Györffy is Assistant Professor of Medical Sociology at the Semmelweis University, Institute of Behavioural Sciences in Budapest, Hungary. Her interest mostly is in the area of female physician's somatic and mental health, especially the gynaecological health status of female physicians, work-family conflict and work related stress. Her PhD project focuses on morbidity and stressor predictors among the Hungarian female physicians. Her special subject is the gender studies, she lead gender and health courses at the Semmelweis University. Contact: Prof. Dr. Zsuzsa Györffy, Semmelweis University, Institute of Behavioural Sciences, Nagyvárad tér 4., HU-1089 Budapest, Hungary, E-mail: gyorffy@chello.hu

Hildegard Hellbernd, MPH, Dipl. Päd., Diploma Degree of Science in Education, Master of Public Health. Evaluation and Monitoring of Pilot Project S.I.G.N.A.L.-intervention programme against domestic violence (Department of Public Health Science at Technical University Berlin), trainings for health care professionals on domestic violence and health care, Development of training manual for trainers, Train-the-Trainer seminars. Since 2008 project coordinator of SIGNAL e. V. within the pilot project "MIGG - Medical Intervention against Violence" which aims to develop and test an intervention program for private practice (GPs and gynaecologists), funded by Ministry for Families, Senior Citizens, Women and Youth in Germany. Working foci: Violence against Women, Gender and Health, Migration and Health. Contact: Hildegard Hellbernd, SIGNAL e. V., Rungestr. 22- 24, 10179 Berlin, E-mail: hellbernd@sophi-berlin.de, Website: www.signal-intervention.de, www.migg-frauen.de

Maria Kopp, Professor MD, PhD medical doctor and clinical psychologist by profession. She received her Phd in Medical Sciences in 1982, and the Doctor of Hungarian Academy of Sciences degree in 1999. She was the founder and first director of Institute of Behavioural Sciences at Semmelweis University since 1993. Since 2007 July she is vice-director of the Institute of Behavioural

Sciences and director of Mental Health Sciences Academic Research Group. Earlier he served as the head of clinical epidemiology and psychophysiology research laboratories in the Department of Psychiatry of the Semmelweis University and she was the founder of behavioural medicine outpatient department at Psychiatry. She has published 268 scientific publications, 9 books, among others Behavioural Sciences in a Changing Society (1996) (co-author: Árpád Skrabski), edited 'Heart Disease: Environment, Stress and Gender', Volume 327 NATO Science Series, Life and Behavioural Sciences (with G. Weidner and M. Kristenson). She serves as Hungarian coordinator in EAAD „European Alliance against Depression”, in IMPHA „Implementing Mental Health Promotion Action”. European Public Health programmes, in CAMHEE-EU-5 (2007-2009) Child and adolescent mental health in enlarged Europe: development of effective policies and practices as Hungarian, coordinator, Contact: Prof. Dr. Maria Kopp, Semmelweis University, Institute of Behavioural Sciences, Nagyvárad tér 4., HU-1089 Budapest, Hungary, E-mail: kopmar@net.sote.hu

Vera Lasch, Dr. rer. pol., since 2006 management KulturNetz Kassel e.V., until 2006 research fellow at University of Kassel, Unit Gender Research. Research topics: women, work and health; ageing, health and gender; higher education, gender and the Bologna process in Germany. Her publications include Gender, Health and Cultures. Networking for a better Future for Women within an enlarged Europe, kassel university press, 2006 (edited with Walburga Freitag and Ute Sonntag). Contact: Dr. Vera Lasch, KulturNetz e.V., Untere Königsstr. 46 a, 34117 Kassel, E-mail: lasch@kulturnetz-kassel.de

Krisztina D. László, MSc has a background in Psychology and in Economy. She works at the Institute of Behavioural Sciences of the Semmelweis University, Budapest, Hungary and at the Department of Public Health Sciences of the Karolinska Institute, Stockholm, Sweden. Her research interests include the relationship between psychosocial factors and health, with special focus on work stress, cardiovascular and gynaecological health. Contact: Krisztina D. László, Semmelweis University, Institute of Behavioural Sciences, Nagyvárad tér 4., HU-1089 Budapest, Hungary, E-mail: neckri@net.sote.hu

Ulrike Maschewsky-Schneider, Dr.phil., Dipl. Soz., is Professor for Public Health (Social Epidemiology and Health Sociology) at the Berlin School of Public Health at the Charité-Universitätsmedizin Berlin (BSPH) since 2007 and director of the BSPH. She is Head of the Master of Public Health and Co-Head of the Master of Science in Public Health programme “Health & Society –

International Gender Studies Berlin". Between 1996-2006 she was Professor for Health Sociology at the Institute of Public Health Sciences, Technical University Berlin, Germany, and director of the Institute from 1997-2002. She was Head of the Berlin Center Public Health from 1998-2006. She is teaching in the Master of Public Health and Master of Science in Epidemiology programmes. Her research areas include: Social sciences and public health; evaluation of health promotion and prevention; women's health and gender and health; gender-sensitive health research; health reports; health care services research, in particular: health care for abused women; women's work and health; women's health in East and West Germany. She did several studies on women and smoking. She was the former Head of the Department of Epidemiology at the Bremen Institute for Prevention and Social Medicine (1986-1996). She is member of the Board of the German as well as the Berlin Network for Health Promotion. Contact: Prof. Dr. Ulrike Maschewsky-Schneider, Berlin School of Public Health, Charité – Universitätsmedizin Berlin, Gebäude A, Aufgang 9, 4. OG., Oudenarder Str. 16, 13347 Berlin, E-mail: ulrike.maschewsky-schneider@charite.de, Website: www.bsph.charite.de

Piroska Östlin, Dr., Ph.D., is Associate Professor in Public Health at the Karolinska Institutet in Sweden with a Ph.D. in Medical Science from the University of Uppsala. During the last ten years, she has been working extensively for the World Health Organization (WHO) as an adviser on gender and health equity issues. Östlin was coordinator of two WHO task forces (in 2004 and 2009) on Research Priorities for Equity in Health. Together with Gita Sen, Östlin was coordinator of the Women and Gender Equity Knowledge Network of the WHO Commission on Social Determinants of Health (CSDH). Since 2009, Östlin is Member of the WHO Scientific Group on Equity Analysis and Research. Her former positions include Secretary of the Swedish Public Health Commission, Expert in International and Global Health at the Swedish National Institute of Public Health and Member of Board of the Nordic School of Public Health. Her publications include 'Gender Inequalities in Health: A Swedish Perspective', Harvard University Press, 2001 (with Danielsson M, Diderichsen et al.), 'Engendering International Health: The Challenge of Equity', MIT Press, 2002 (with Sen G and George A) and 'Gender Equity in Health: The Shifting Frontiers of Evidence and Action', Routledge, 2010 (with Sen G). Since February 2010 she is adviser in the field of social determinants of health in the WHO Regional Office for Europe. Contact: Prof. Dr. Piroska Östlin, WHO Regional Office for Europe, Scherfigsvej 8, Copenhagen 2100, Denmark, E-mail: pio@euro.who.int

Notes on Contributors

Annemiek (J.M.) Richters is professor of culture, health and illness at Leiden University Medical Center. She is a physician and medical anthropologist. Her research and teaching focus in particular on issues in the area of health and human rights; gender violence, trauma and healing, and socio-cultural diversity in health and health care in the Netherlands. Contact: Prof. Dr. Annemiek Richters, Leiden University Medical Center, Department of Public Health and Primary Care, P.O. Box 9600, 2300 RC Leiden, E-mail: j.m.richters@umail.leidenuniv.nl

Ute Sonntag, Dr. p. h., is psychologist, working in the field of health promotion. She has been involved in building up women's health networks on local, regional, national and European level. She is deputy managing director of the Association for Health Promotion and Academy for Social Medicine in Lower Saxony in Germany. Her working fields are gender and health, health promoting universities, networking in the field of health and health promotion in the health system. Her publications include 'Gender, Health and Cultures. Networking for a better Future for Women within an enlarged Europe', kassel university press, 2006 (edited with Vera Lasch and Walburga Freitag). Contact: Dr. Ute Sonntag, Landesvereinigung für Gesundheit und Akademie für Sozialmedizin Niedersachsen e.V., Fenskeweg 2, 30165 Hannover, E-mail: ute.sonntag@gesundheit-nds.de

Beata Tobiasz-Adamczyk, Professor, PhD is medical sociologist and social epidemiologist, Head, Chair of Epidemiology and Preventive Medicine, Dpt. of Medical Sociology, Jagiellonian University, Medical College, Cracow, Poland. Main topic of research activity: quality of life in older people (the role of subjective health, social network, social support), social determinants of quality of life in women, illness behaviours and gender-related differences in health, maltreatment and quality of life in older life, quality of life in cancer patients. She is author of over 250 publications/chapters in books. Contact: Prof. Dr. Beata Tobiasz-Adamczyk, E-mail: mytobias@cyf-kr.edu.pl



