Gender and Health
A call for action for EU policy mainstreaming

A Roundtable co-organised by the Centre of Health and Ethics in Society (CHES), the European Institute for Women's Health (EIWH) and the European Men's Health Forum (EMHF)

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This paper was prepared to serve as background information for a Roundtable organised jointly by the European Institute for Women's Health (EIWH) and the European Men's Health Forum (EMHF) and the Centre for Health Ethics in Society (CHES) in Brussels on 28 October 2004.

It contains essential information about the need to mainstream gender equity in all EU policy areas that have an impact, either direct or indirect, on the health of EU citizens.

The document is organised as follows:

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- Gender and health
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- Mainstreaming gender equity in health and the role of EU policy

Introduction

The WHO Constitution states that: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, gender, religion, political belief, economic or social condition". However, despite extensive investment in the prevention, screening and treatment of diseases in both men and women, global indicators of population health suggest significant and persistent inequalities in health status.
In every European country, women spend a greater proportion of their lives in a state of poor health and have lower disability-free life expectancy. Men have a lower life-expectancy and are more likely to die than women at almost all ages.

The proportion of the population receiving health screening for specific diseases and

having access to effective treatment varies as a function of both gender[1] and pathology. Further gender differences are also observed in biological vulnerability to specific diseases, clinical effectiveness of a variety of treatments, access to treatment and treatment compliance. Taking into account such gender differences in research and health policy will optimise health investments, reduce gender inequities and increase overall population health.

Mainstreaming gender equity in health refers to *political strategies designed to increase understanding of gender-related health issues, assure equal opportunities for the maintenance of good health and encourage (maintain comparable progression in) the reduction of mortality and morbidity for both men and women.*
Gender equity should not be confused with either feminism or sexual discrimination lobbying. Its principal aim is the improvement of global population health by a better understanding of gender-specific health factors, of which the reduction of health inequalities represents only one aspect.

Gender and health

The relationship of gender to health is complex and changes across the life-span, between cultures and over time. Public health policy on the other hand is relatively static, and in attempting to ensure equality by the universal application of a single rule, often produces inequalities due to failure to recognise biological and social differences. In this introduction some of the issues are briefly examined, i.e.

- Biological, social and environmental diversity
- Differences for men and women in access to treatment
- changing patterns of disease over time

Biological, social and environmental diversity:

Women and men are differentially vulnerable to specific illnesses both through genetic causes (for example diseases linked to the sex chromosomes, frequency of mutations, differing distributions in patterns of genetic coding or polymorphisms), environmental exposures (for example dangers in the work-place, bacterial exposure, nutrition, violence, poverty, cultural mutilation, life-style) and combinations of the two, or epigenetic regulation (silent genes switched on by an environmental event).

The result is differing patterns of disease prevalence, differing degrees of severity and different patterns of mortality and morbidity. While men have a higher death rate from autoimmune illnesses such as diabetes and multiple sclerosis, the prevalence of these conditions is higher in women than in men. Older women have greater susceptibility to cardiovascular disease (CVD) than men while men are much more biologically vulnerable to CVD overall

Prevention and treatment:

Effective therapeutic intervention depends on accurate determination of groups likely

[1] while the term sex differences is generally used to refer to differences between men and women related to their biological functioning, gender differences refers more widely to the social and cultural roles and functions specific to men and women

to be at risk, availability of effective screening programmes, willingness and ability to undertake protective measures, existence of appropriate treatment and access to treatment. Significant differences in women and men exist in relation to each of these factors. For example, early screening programmes for breast cancer in women have significantly improved overall female life expectancy with this disorder. Breast cancer in men has been largely ignored due to its much lower frequency (less than 1% compared to 15%) and low public awareness of its early signs. Lack of information, differential clinical progression, and absence of sex specific screening result in higher mortality rates in male breast cancer.

Another example is sexually transmitted infections which often give rise to fewer symptoms in women, and are thus less likely to be recognised and treated. Stigma associated HIV/AIDS is a major factor preventing many women and men from accessing health services. Women may be particularly affected by stigma and discrimination because of social norms concerning acceptable social behaviour in women.

Changing patterns of disease over time:

Many pathologies are commonly considered to be sex-specific diseases with the result that prevention and treatment programmes are tailored to target only the male or female population. Changes in the gender patterns of disease are often not accompanied by modifications in public health practice. For example, cardiovascular disease has commonly been considered a male disorder and screening programmes have been developed around male-specific symptomatology.
Death rates in women have risen steadily and women are known to have experienced difficulties in obtaining the correct diagnosis and treatment due to lack of information concerning the clinical presentation and risk factors for this disorder that are specific to women.
In reverse, mental health problems are still predominantly perceived as a woman's disease. Misdiagnosis and under-reporting of these conditions in males is therefore frequent. In European countries, suicide rates are 4.5 times higher amongst men particularly in the younger groups (16-35). Suicide is the single most important cause of deaths in European young men (16-35). Women report depression and anxiety about twice as often as men and statistics show increasing rates of unsuccessful suicide attempts.

Another example is lung cancer. While more men are diagnosed with and die from lung cancer than women, around 9% of all cancer deaths in women are now attributable to lung cancer and the female mortality rate for the disease has risen by 45% since 1970.

This narrowing of the gap between men and women is in large part a reflection of social trends and lifestyle choices. The impact of changes in 'lifestyle' has received increasing attention in current statistical compilations, notably poor nutrition, smoking, lack of exercise and excessive alcohol consumption, however there is very little sex-disaggregated data available at EU level for the differentiation of risk factors and for monitoring differential gender changes across time.

Health, gender and public health policy

Public health policy is strongly influenced by the population indicators used to evaluate the health of a nation. Mortality rates have traditionally been considered to be the main reference point for public health policy and to this end the major targets have been those pathologies which are life-threatening, notably cancer and cardiovascular disease.
As an increasing proportion of the population reach old age there has been an increased interest in morbidity, notably chronic illness and pain, and public health researchers have pointed to the need in recent years to focus on the reduction of disability caused by disease. (Should this not read "disability caused by disease". I do not know what health related disability is)
The essential dilemma for policy makers has been that while medical technology has greatly increased survival, it has simultaneously extended the proportion of life spent in states of disability, pain and mental suffering. While survival rates have usually been the gold standard for monitoring the health status of the European states, new synthetic indicators are now appearing such as DALYs and QALYs which examine the state of health of survivors, measuring healthy life expectancy and not just life expectancy.

This change in focus has revealed more complex relations between gender and health. For example, we now know that, while women have higher life expectancy, they also spend greater proportions of their life in states of chronic illness and disability at all ages. Unless tackled early rises in incidence rates for diseases such as osteoporosis could, expected increases in male life expectancy, lead to levels of disability in men comparable to that of women.
Measuring the impact of public health policy in terms of morbidity as well as mortality will help address gender imbalances. It will also broaden health targets for pathologies with high mortality (such as cancer and heart disease) so as to include diseases with high morbidity (such as arthritis and osteoporosis).

Mainstreaming gender equity in health and the role of EU policy

The WHO definition of gender mainstreaming states: '...the process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, in any area and at all levels. Mainstreaming gender equity in health is a strategy for making women's as well as men's concerns and experiences an integral dimension in the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and social spheres, such that inequality between men and women is not perpetuated. The ultimate goal is to achieve gender equality".

Examining the impact of gender on health cannot thus be limited to appreciation of the biological differences between women and men. It must also recognise the role of differential social, cultural and environmental factors in determining health status and access to care. This is a strategy that promotes the integration of gender concerns into the formulation, monitoring, implementation and analysis of policies, programmes and projects, with the objective of ensuring that women and men achieve the best possible health status.
A mainstreaming strategy should ensure that policies shape health goals, research, care provision and population monitoring to maximize the probability of each European citizen to achieve the best possible health state for him or her - whatever

that potential may be.

At a policy level there is now growing recognition that gender is an important modulator of health status, and international organisations and national governments have begun to prepare gender action plans that include health-related objectives (e.g. Beijing Platform).

Many Member States have endorsed international agreements recognising gender as a determinant of health. However, there are very few countries in the European Region where political commitment has been translated into clear policy and implementation.

In the wider context, the promotion of gender equity has, nonetheless, been a longstanding theme in the policies of the EU. As the scope of EU activities has broadened, equal opportunities issues have received increasing attention, notably in employment policies and instruments.
The EU institutions have committed themselves to incorporating equal treatment of women and men in all EU policies and activities[2]. A recent example is a proposal for a Council Directive implementing the principle of equal treatment between men and women in the access to and supply of goods and services COM (2003) 657. The proposal, still being debated by the Council, aims to reduce gender-based discrimination in the provision of goods and services, including health care services and the calculation of insurance benefits and premiums for private insurance pension schemes.
To fulfil EU Treaty obligations in the field of equality between men and women, the Commission proposed earlier this year an instrument to financially support projects from organisations actively promoting equality between genders COM (2003) 279 which was adopted by the Parliament.

Based on evidence from the EU programme “Europe Against Cancer”, another proposal recommends the development of main screening tests as well as other tests[3]. The Parliament, when debating this proposal, pointed out that screening policy must be conscious of men and women’s different health challenges and needs, adding that particular attention should be paid to men's uptake of screening programmes for colorectal cancer.

Bearing in mind that health involves both a collective and individual responsibility, including gender considerations in the broader understanding of the determinants of a healthy lifestyle such as nutrition, socio economic status, employment, education, social networks, housing, and environment, is important. The recently published Reflection Paper for a new EU Health Strategy by Commissioner Byrne points the way: “Good health is a shared responsibility, requiring widest cooperation between different groups.”

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[2] Towards a Community Framework Strategy on Gender Equality (2001 – 2004) COM (2000) 335 final and its related Annual Work programmes
[3] COM (2003) 0230