



Gender mainstreaming and good health for all EU citizens

This paper was prepared by the European Men's Health Forum (EMHF) in response to the invitation by Commissioner Byrne to participate in a reflection process on what the EU should do to enable good health for all.

This document advocates for the need to mainstream gender equity in EU policy and presents a call for action in all EU policy areas having an impact either directly or indirectly on the health of EU citizens.

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The European Men's Health Forum is an independent, non-governmental, non-profit making organisation established to raise male awareness across Europe. It aims to promote collaboration between interested individuals and organisations on the development and application of health policies, research, education and prevention programmes. EMHF provides a unique platform for non-discriminatory co-operation and information exchange within Europe and with other countries worldwide.

Introduction

All women and men have the right to live without discrimination in all spheres of life, including access to better health. 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".

As highlighted by Commissioner Byrne, policies have to recognise that in order to achieve the highest standard of health, biological as well as gender based differences between women and men must be acknowledged and taken into consideration in all EU policies that affect health, either directly or indirectly.

There is growing national and international recognition that gender is an important indicator of health differences, and gender is crucial to the development of effective health policy and practice. In response to these pressures, international organisations and national governments have prepared gender action plans that include health-related objectives. This is in line with the Beijing Platform that recommended 'an active and visible policy of mainstreaming a gender perspective in all policies and programmes.' In 2001, the World Health Organisation's "Madrid Statement" urged Member States "actively [to] integrate gender mainstreaming into public health policies that determine health". In 2002, the International Conference on Gender and health took place in Vienna that reaffirmed this principle, and in 2003 a Gender and Health Summit gathered under the auspices of the British King's Fund further established the role of gender as crucial for health improvement.

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. More is needed. And gender mainstreaming in all EU policies remains a most important target if health for all EU citizens is to be improved.

Gender and sex what is the difference?

The classification of people, men and women, is based on biological differences, in particular those relating to reproductive functions. However, these biological differences take on very different social manifestations as a response to the societal conditions and expectations.

Sex is the term generally given when differences between women and men appear to be primarily biological.

Gender is the term given to the social construction of roles allocated to men and women. These roles vary geographically and change over time. There is now a much wider understanding that gender refers to both men and women, and the relations between them. The term 'gender' was initially used during the 1960's to challenge the prevailing belief that gender differences between women and men were fixed and immovable. It signalled a shift away from the biological genetic model, which perceived these differences as naturally occurring, to a growing awareness of the impact of social factors, which could be addressed and changed. Recent proposals for the development of gender-sensitive perspectives have drawn attention to gender relations, arguing that we need to 'move away from women and men as isolated categories to looking at the social relationships through which they are mutually constituted as unequal categories' (Kabeer 1999). This might include examining in greater detail the impact of men on women's health and women on men's health, through the wide variety of personal, family and professional relationships that exist between the two.(Alan White, Oonagh O'Brien 2003)

Isn't gender all about women?

The term gender was originally used to argue that the different roles of men and women were capable of sustained change. Interest in these issues came from the feminists who argued that inequality lay at the heart of the differences between men and women. The focus was therefore on redressing the unequal power relations experienced by women. Feminist debate over the recent years has shifted from a focus on women to a gender approach, with an interest in the dynamic of relations between men and women. This inevitable led to conclusions that men could also be disadvantaged by their sex and their gendered identity, particularly when examining health issues such as cardiovascular disease and accidents.

It is still the case that in many settings, gender is used to imply 'women'. However, there is now a much wider understanding that gender refers to both men and women, and the relations between them. In the health arena, the recent growth of men's health organisations joining those led by women in drawing attention to the links between gender, health and healthcare has been a welcome sign of this shift in understanding and emphasis.

The impact of gender on health

There needs to be a clearer awareness of the links between sex, gender roles and health status. Women and men are biologically vulnerable to certain illnesses in differing degrees and severity and at different times over their life span. In every European country, men are more likely to die than women at almost all ages. Men are diagnosed with a majority of cancers and have a greater rate of premature death across all nearly all disease states, except those of the musculo-skeletal system, skin and connective tissue, where women's death rate is higher across all age groups (White and Cash 2003)

Cardiovascular disease

Men are much more biologically vulnerable to cardiovascular disease (CVD) than women. However, older women are also susceptible to CVD. Nethertheless, there is a prevailing assumption among public and health professionals that this is primarily a male disease, and women are known to have experienced difficulties in obtaining the correct diagnosis and treatment (Lockyer and Bury, 2002).

Autoimmune diseases

Even though men have a higher death rate from autoimmune illnesses such as diabetes and multiple sclerosis, these conditions affect more women than men. But the relapsing intermittent form of multiple sclerosis affects men more severely than women.

Cancer

There are also significant biologically-driven differences in the patterns found in the two groups. Breast cancer for instance, is a predominantly female disease. It causes more than 20% of all female (cancer) deaths and a woman living in the EU has a 2-3% chance of developing the disease during her lifetime (Commission 1997). The cervix is the second most common site accounting for 2% of all cancer deaths.

Only men are at risk of prostate and testicular causing around 17% of cancer deaths per year. The incidence of prostate cancer is overtaking that of lung cancer in many countries.

The allocation of resources for research and treatment of these different cancers poses considerable challenges but it is important that gender equity be one of the criteria used in making these decisions. And prevention strategies will also need to be "gendered" in response.

More men are diagnosed with and die from lung cancer than women, but 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, especially changes in the smoking habits of both groups.

HIV/AIDS

Men account for more than three quarters of HIV prevalence in Western Europe. However the gap with women is now narrowing. There are important differences between men and women in the underlying mechanisms of infection. While some of these mechanisms are biologically driven, most are direct consequences of pressures arising from societal norms and expectations. The presence of untreated sexually transmitted disease in an individual can make that person up to 10 times more likely to both get and transmit HIV. Since the majority of sexually transmitted infections do not give rise to any symptoms in women, they are less likely to be recognised and treated.

A result of pressures created by societal norms, stigma associated HIV/AIDS is a major factor preventing many women and men from accessing health services. Women may be more affected by stigma and discrimination than men because of social norms concerning acceptable social behaviour in women. Other health areas are also intrinsically linked to social factors. As well as recognising the diversity of women and men, it is also essential that EU and national health policy makes clear links between "gendered" patterns of individual behaviour and the social and economic variables that shape them.

Lifestyle issues

The impact of 'lifestyle' receives some attention in current statistical compilations. Poor nutrition, smoking and lack of exercise have all been identified as causes of disease as has excessive alcohol consumption (Eurostat 1998). However there is very little sex-disaggregated data available at EU level. This gap will need to be filled if the different pressures on women and men to make unhealthy choices are to be properly understood. Diabetes is also linked to lifestyle factors, such as increasing levels of obesity, physical inactivity and poor diet (Tringham and Davies 2002).

Violence

Violence is the major gender-driven cause of death and injury for women globally. Violence towards men is usually initiated by other men but little attention has been paid to the impact of gender on the health of men (Cameron & Bernardes 1998). However new research is now emerging about the potential hazards of masculinity for health. The World Report on Violence and Health (WHO 2002) also highlights the death toll among men globally and acknowledges the considerable problem of unreported violence and injury that men face and the lack of research in this area. Violence is gender specific and imposes a huge health burden on women and men. The need to constantly reinforce masculinity results in high death rates through car accidents, murder and dangerous sporting activities. An unwillingness to appear 'weak' may also explain why many men are unwilling to seek help for physical or mental health problems (Doyal 2001; Griffiths 1996).

Mental health

In most countries women report depression and anxiety about twice as often as men (Desjarlais et al. 1995) but more men commit suicide, particularly in the younger groups where on average it is 4.5 times higher, reaching up to 12 times in some countries. The World Mental Health Report has highlighted the increasing burden of psychological illness and its impact on women in particular (Desjarlais et al. 1995). However there is currently no system for monitoring these problems across the EU and the lack of disaggregated data is especially problematic in this context.

Morbidity and ageing

Compilations of EU-wide statistics currently offer little in the way of sex and gender disaggregated

information. This is especially problematic in the context of morbidity data. While men are more likely than women to die prematurely, women tend to experience more chronic ill health, distress and disability, especially in old age (W.H.O. 1998).

The health needs of both women and men will also vary over the life cycle yet such needs are not accounted for in any EU information systems. EU data currently gives us very little information about women (or men) at either end of the age range. There is very little information available about the reproductive health of younger women for example, despite the very high rates of teenage pregnancy found across the EU. Older women too are largely invisible, despite the major impact of the biological and social aspects of aging on their health (Arber & Ginn 1995; Ginn & Arber 1994)

While it is clear that gender is as much a key determinant of health outcome, as social and economic status, environment, education, or working conditions, there have been relatively few efforts to incorporate these insights into policy making.

Mainstreaming gender equity in health

A gender approach in health does not just look at biological differences between women and men, but also recognises that social and cultural factors as well as power relations between women and men play a role in promoting health and wellbeing and determining health status.

Mainstreaming gender in health is recognised as the most effective strategy to achieve gender equity. 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 highest health status. A mainstreaming strategy does not preclude initiatives specifically directed towards either women or men or towards equality between them. Such positive initiatives are necessary and complementary to a mainstreaming strategy.

The meaning of 'gender equity' in a public health context often deserves clarification. The most obvious definition would be the achievement of the same life expectancy and health status for women and for men. However measuring health inequalities solely through differences in life expectations has many pitfalls.

Individuals differ enormously in their genetic inheritance. While women have the biological potential to live longer than men, and all men or women do not have the same longevity potential. Differences in social class and economic status, environment, working conditions and access to health services are naturally additional factors contributing to life expectancy gaps both within and between sexes.

Life expectancy in itself is not an indicator quality of life and does not reflect the respective degree and duration of morbidity and disability throughout life between groups. On the contrary, it may contribute to reinforce the public perception that the health of men and women should be considered as separate issues, mindless of the strong interactions they exert on each other.

Hence realistic strategies for gender equity cannot be focussed on equalising longevity or health outcomes. Instead they must ensure that women and men have equal access to the resources they need to realise their potential for health - whatever that potential may be (Doyal 2000).

These resources will include high quality, appropriate medical care. They will also include the range of social, economic and cultural goods that individuals need to promote their own wellbeing. Many of these resources will be common to both women and men. However there are also significant differences between the two groups in their health needs and in their access to the relevant resources. These differences will need to be identified and acted upon if health policies are to be equitable.

Gender mainstreaming, EU policy and “good health for all”

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. Commissioner Byrne’s Reflection Paper for a new EU Health Strategy points the way: “Good health is a shared responsibility, requiring widest cooperation between different groups.” There is therefore much benefit in including gender considerations in all areas of EU policy.

Promoting gender mainstreaming in EU policy

Citizens’ choices are based on a number of factors ranging from knowledge and information to socio-economic determinants. European citizens need reliable and "user friendly" information about how to stay in good health and about the effects of lifestyle on health. When they fall ill, they need authoritative information about their condition and treatment options to help them take decisions. “Enabling citizens to make the right choices is indispensable”(Commissioner Byrne 2004)

Utilising its current programmes, the EU must create a comprehensive knowledge base, so that the scope and potential for health improvement of its citizens, men and women can be better understood. In order to foster healthier lifestyles and reduce inequalities, policy makers at EU and national level will need access to the appropriate information to formulate and implement effective health promotion programmes. This will need more detailed and sophisticated sex-disaggregated data on the broader determinants of health, not just morbidity and mortality, together with the further development of indicators and monitoring systems to measure the health impact within and between populations.

The EU should also encourage training on developing an understanding of the impact of sex and gender on health issues both within its institutions and within its Member States. It should promote collaboration on the uptake of gender sensitive targets across the broad range of its remit and Member States should be encouraged to adopt clear policies recognising gender as a key health determinant.

More multidisciplinary research will be needed in FP7, to include social, psychosocial and economic sectors. The new programme should be more aware of sex and gender as a key variables and health determinants, and further develop the current understanding of their impact on specific health issues.

From EU to national levels

The principle of subsidiarity guarantees autonomy for governments in the delivery of national healthcare systems. Open method of co-ordination (OMC) is one instrument the Commission suggests as a way towards harmonising quality care amongst Member States. This communication is entitled “Modernising social protection for the development of high-quality, accessible and sustainable health care and long-term care: support for the national strategies using the “open” method of co-ordination”

This sets out four basic objectives that the Commission would like all Member States agreement before end of 2004. These are:

- Ensuring access to high-quality care based on the principles of universal access, fairness and solidarity.
- The promotion of high quality care
- Providing a safety net against poverty or social exclusion associated with ill health, accident, disability or old age for both the beneficiaries of care and their families.

- The financial sustainability of high-quality care accessible to all.

Once an agreement is reached on the above, the Commission would initiate methods to identify the possible indicators, against which, Member States could measure their own position. Gender should be included as a key indicator.

OMC would provide a multi-sectoral platform, involving wide partnership opportunities that would increase information exchanges, knowledge of models of best practice and the necessary integrated approaches required by health care systems and their positive development in times where there are growing pressures on the quality and level of care and a background of reducing resources.

Tackling immediate challenges

While these measures can most effectively contribute to tackling these issues upstream and to benefit European populations in the longer term, the EU must also grant immediate focus and remedial actions to gender-related health issues faced today. Appropriate guidelines should be offered to all Member States in dealing with today's public health challenges, by increasing EU support for activities that create or increase opportunities for exchanges of information and models of good practice in the health promotion and prevention areas. In particular, screening techniques leading to earlier diagnosis and improvement of health outcomes should be recommended to Member States, and existing reliable healthcare information channelled effectively to EU men and women according to their respective gender-driven characteristics of health literacy mode.

Call for action

- Greater consideration should be given to gender and health in the agenda of EU institutions, and health targets should be made more gender specific. The Commission should clearly reflect its commitment to the improvement of health for all and the reduction of health inequalities by ensuring that its proposals truly take account of gender differences. Gender must become as obvious a subject for inclusion as the health of minority ethnic communities or the health of socially disadvantaged groups.
- Training on developing an understanding of the impact of sex and gender on health should be widely available across EU institutions and within Member States. A consensus must be developed among all stakeholders that 'one size' does not 'fit all': just as social class, ethnicity and race are key variables, so is gender. All policy makers at all levels need to be more aware and active on these issues. MEPs must be more informed and aware of the gender and health dimension in decision making and of the need to ensure it is included in all policies at EU and national levels.
- Health care resources appropriate to the respective needs of both men and women must be earmarked to help prevent and diagnose health conditions earlier. The development of conclusive research providing guidance on EU cancer screening programmes for prostate would be a logical complement to actions already taken for breast, cervical and colorectal cancer.
- The Commission should strive to ensure that health concerns specific to men (notably Prostate, erectile dysfunction and other sexual and reproductive health problems) are given the same priority as concerns that are of proportionate relevance to the whole of the population.
- Gender and health is not just an issue for health policy. It is a cross-cutting issue across several policy areas such as environment, education, working conditions, ethnicity and migration-related issues. An integrated approach is required in order to tackle a wider range of health determinants. Gender mainstreaming to be implemented successfully must be intersectoral and part of all policy processes.
- The situation in Eastern Europe needs out attention too. Beside the need for improved access to health care resources in these countries, fast changing economic conditions seem to have a particular detrimental effect on men and on their families.
- If gender differences are to be properly understood, systems need to be developed for monitoring gender differences in patterns of health and illness across the lifecycle. A comprehensive information base is needed for a clear understanding that 'gender' analysis in health includes looking at gender inequalities that affect both women and men.
- EU support is needed to develop additional research to examine in further details the causes of these inequalities and to monitor the progression of the health situation by gender. Gender must be made a key variable and sex routinely identified in sampling.

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