Towards a simple framework for monitoring the integration of gender concerns in public health policies:

Case studies from seven European Member States of the World Health Organization: Croatia, Ireland, Kyrgyzstan, the Netherlands, the United Kingdom, Tajikistan and Turkey

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Dr. Joke A.Haafkens, project manager

Introduction to the report

The task of the WHO Regional Office for Europe is to support Member States in the European Region in developing health policies, health systems and public health programmes both to improve people's health and to reduce inequities in health within and between countries.

Many Member States in the European Region have endorsed international treaties which identify the reduction of gender inequity as one of the goals of health policy and gender mainstreaming as a strategy to achieve this goal. The most explicit of these treaties is the Global Platform for Action, adopted at the Fourth World Conference on Women in Beijing 1995.[1] The Treaty of Amsterdam formalizes the gender mainstreaming commitment at the level of the European Union, as it explicitly mentions the elimination of inequalities and the promotion of equality between women and men among the tasks and objectives of the Community. (Article 2 and 3)

The gender mainstreaming strategy aims to make women's as well as men's concerns and experiences an integral dimension in the design, implementation, monitoring and evaluation of all policies.[2] Guiding principles for gender mainstreaming policies in the health sector are the recognition that:

- Men and women differ in terms of sex and gender. "Sex" refers to the biological and physiological characteristics that define men and women. "Gender" refers to the socially constructed roles, behaviors and activities, and attributes that a given society considers appropriate for men and women.
- Sex differences have an impact on health as a result of which man and women may have different health needs.
- Gender differences have an impact on health as a result of which men and women have different health needs and may face different constraints to meet their health needs.
- Gender equality in health means that women and men have equal access to those resources which they need to realize their full potential for health.
- Gender equity means fairness and justice in the distribution of benefits, power, resources and responsibilities between men and women. The concept recognizes that women and men have different needs, access to and control over resources and that these differences should be addressed in a manner that rectifies the imbalance between the sexes. Gender inequity in health refers to those inequalities between women and men in health status and health care, which are unjust and avoidable. Gender equity strategies are used to eventually attain equality.

1. The Beijing Platform of Action (Article 105) states that "In addressing inequalities in health status and unequal access to and inadequate health-care services for women and men, Governments and other actors should promote an active and visible policy of mainstreaming a gender perspective in all policies and programmes, so that, before decisions are taken, an analysis is made for women and men, respectively.

2. The ECOSOC Resolution defines mainstreaming gender as "...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. It 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". (E/1997/L.30 Para Adopted by ECOSOC 14.7.97.)

- By taking account of the different health needs of men and women and the constraints they face to achieve those needs, policy makers can ensure better policy targeting, more effective health services for men and women, and greater equality.[3]

The ultimate goal of gender mainstreaming in health is ensuring that men and women can achieve their highest potential for health.

In line with its focus on health equity, and the decisions that gender mainstreaming must become standard practice across the United Nations System[4] and WHO[5], the WHO Regional Office for Europe supports Member States in the Region in their effort to mainstream gender into public health policies. The Gender Mainstreaming and Women's Health Programme (GEM) is responsible for this task.

The Madrid Statement, following a seminar organized by GEM (Madrid, September 14, 2001), recognized that few European Member States of WHO had implemented their international political commitments to mainstreaming gender in health policy at a county level. They acknowledged that there was a need to move forward and asked WHO for a flexible guideline and tools which could support them in this process.[6]

In response to this request GEM initiated a number of projects in collaboration with donors and Member States in the European Region. The aim of these projects was to develop evidence based recommendations for health policy makers in the European Region on how the gender mainstreaming strategy could be applied in the development of health policies and programmes at a country level.

In a first project, GEM developed a *WHO/EURO guideline for gender mainstreaming health policy and programmes at country level.*[7] This guideline, which is still a draft, explains the theoretical basis of gender mainstreaming, reviews a number of earlier guidelines and provides a comprehensive framework for the implementation of the strategy. Parts of the guideline were piloted in Hungary and Kazakhstan.

In a second project, GEM conducted a pilot study in five European countries with an existing national women's or gender and health programme or policy: Ireland, Iceland, Malta, the Netherlands and Switzerland. It was thought that the presence of national women's or gender and health policies or programmes would facilitate the implementation of a gender mainstreaming strategy in other health

3. For further information on gender equity in health see: L.Doyal, 2000.Gender equity in health: debates and dilemmas. Social Science and Medicine 51;6:931-939. For review of the theory and tools for gender mainstreaming in health: WHO,2002. Gender Analysis in health: a review of selected tools. Pan-American Health Organization, Regional Office of the World Health Organization, 2003. Annotated bibliography on gender mainstreaming and analysis resources for health programmers. PAHO: Gender and Health Unit.

4. E/1997/L.30 Para Adopted by ECOSOC 14.7.97.

5. World Health Organization, 2002, Integrating gender perspectives in the work of WHO: WHO gender policy. Geneva: WHO

6. World Health Organization Regional Office for Europe, 2002, The Madrid Statement: Mainstreaming gender equity in Health: The need to move forward, Copenhagen. WHO Regional Office for Europe: Gender Mainstreaming Programme.

7. G. Krantz, 2002, WHO/EURO guideline for gender mainstreaming health policy and programmes at country level (Draft). Copenhagen: WHO/EURO/GEM

policy areas. Consequently, the aim of this pilot study was to identify which conditions are important for the development of a national gender policy in the field of health.[8]

The present report presents the results of the third project in this series, titled "towards a framework for monitoring the integration of a gender perspective into public health policy". It was part of a larger project that was conducted at the GEM Office in Copenhagen in 2003-2004 and financed by the Dutch Organization for Health Research and Development (ZonMw).[9]

The idea behind this project was that regular monitoring is an important component of gender mainstreaming. It gives insight in factors that may hinder or facilitate the implementation of the strategy. This project focused on monitoring the integration of gender concerns in existing public health policies. A review of the literature suggested that a simple framework for monitoring or analyzing if and how gender concerns are integrated into existing health policies is not readily available. Most existing frameworks are rather theoretical or comprehensive. Because health policy makers are generally faced with time limitations in which they have to address many different issues, GEM assumed that a simple monitoring device would facilitate their work in the area of gender mainstreaming.

Consequently, this project had the following objectives:

- To develop a simple framework for analyzing the implementation of gender concerns into national public health policies.
- To test this framework through case studies in seven countries.
- To evaluate the usefulness of the framework.

The framework was developed by the project manager and members of the Glasgow WHO Collaborating Centre for Policy and Practice. It consisted of a topic list of open questions that were meant to identify obstacles and enabling factors for the integration of gender considerations into different parts of a policy: the problem definition, the policy planning (targets), the implementation strategies and the evaluation of outputs and outcomes.

To test the framework, case studies were conducted by national project teams from seven countries: Croatia, Ireland, Kyrgyzstan, the Netherlands, the United Kingdom, Tajikistan and Turkey. The Croatian, Dutch, Irish and British (England) teams analyzed national policies on the treatment and prevention of cardiovascular disease. The Kyrgyz, Tajik and Turkish studies investigated national policies on family planning. These policies were chosen because evidence from health research suggests that for both areas a gender approach could be particularly relevant.

The usefulness of the framework was evaluated by all project participants and a number of invited consultants in a final project meeting.

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8. Gender mainstreaming Programme World Health Organization Regional Office for Europe, 2002, Success criteria for the planning and implementation of gender sensitive health policies: Draft Report. The study reveals that some common enabling conditions for the development of national policies on gender or women's health were: the share of female members of parliament, the availability of a ministry for gender equity, the active involvement of the ministry of health, the allocation of sufficient resources, time and the formulation of targets.

9. The title of this project is "Gender and Health: link between Evidence and Policy"

In general, the framework was received favorably and provided useful reference points for undertaking a gender analysis of public health policies.

Part one of this report provides a description of the framework and the work process that was adopted during the project, summarizes the results of the case studies and evaluates the framework. Part two presents the full reports of each case study.

Part 1

Summary: Framework for a gender analysis of health policies and case studies

1

Methods: framework and case studies

This chapter describes our framework for monitoring the integration of gender concerns into health policy and the process by which it was piloted and evaluated.

The framework

Policy
To monitor the integration of gender concerns in health policy, one needs to be clear about what health policy is. Building on previous work commissioned by GEM, we conceptualized policy as a process or a cycle that consists of a number of contingent stages: problem definition and agenda setting, policy formulation, policy implementation and policy monitoring and implementation. At each stage several distinct tasks need to be accomplished:

The *problem definition and agenda setting* stage identifies the health situation the policy wants to address. Major health problems are identified, including exposure to health risks, health seeking behaviour, responsiveness of health care services. This requires scrutinizing available public health data, information from health research and from stakeholders.
At the stage of *policy formulation*, objectives and desired outcomes of the policy are formulated, target groups are specified, and budget allocations (inputs) are considered.
The *implementation* stage includes the planning of strategies and activities that will be used to meet the stated objectives of the policy, and the actual implementation of these strategies and activities.
The *monitoring* stage includes the continuous and periodic surveillance over implementing the policy.
Evaluation of the policy includes the independent assessment of the impact and relevance of the programme/project, usually undertaken by external collaborators.

The outcomes of the stages of policy development are usually reflected in key policy documents. Table 2.1 shows the aforementioned stages in the policy process and suggests, for each stage, which activities may be useful to ensure that the concerns of men and women are adequately addressed.

Table 2.1

Table 1. Stages in the process of policy development and actions that are needed to address gender concerns during these stages (1)

What is needed for gender sensitive policy development?	Stages of policy development
Sex disaggregated data Gender statistics Gender analysis of problems	Problem definition and agenda setting
Gender analysis of problems Gender planning (target)	Policy formulation
Gender planning (strategies) Gender sensitive indicators	Policy implementation
Gender sensitive indicators	Policy monitoring
	Policy evaluation

Framework

Our purpose was to develop a simple framework for monitoring the integration of gender concerns into health policy. Based on a review of existing frameworks for gender mainstreaming, and previous experiences of the members of the Glasgow WHO Collaborating Centre for Policy and Practice with gender analysis of public health policy, we agreed that the following topic list would be useful to this end. It contains questions about the wider political context of the policy, each stage of the policy process, and the underlying processes that may have encouraged or hampered attention to gender issues in the policy.

1. This Table is adapted from G. Krantz, 2002, WHO/EURO guideline for gender mainstreaming health policy and programmes at country level (Draft). Copenhagen: WHO/EURO/GEM: 59-60

Topic list for monitoring the integration of gender concerns in selected health policies

In relation to each policy the following information is required:

1. Name of the selected policy or set of guidelines
2. Date of implementation.
3. What are the problems the policy wants to address?
4. What are the objectives of the policy?
5. Do the policy objectives specify what the policy seeks to achieve in relation to men's health, women's health or gender equity?

The next questions are focused on the different stages of policy development:

Problem definition

6. Has the problem analysis for this policy assessed health status, risk profiles, health problems, health behaviour, health needs or use of health services by gender, age or social groups?
7. Has the problem analysis for this policy assessed any other qualitative or quantitative evidence on sex and gender issues pertaining to the policy?

Policy formulation

9. What are the target groups for the policy?
10. Have any potential sex or gender differences been taken into account in the definition of the target groups?
11. What are the proposed measures (activities) for implementing the policy?
12. Do any of these measures (activities) take differential needs of men and women into account? If yes, describe?
13. What are the resources available for the implementation of this policy?
14. Are there any financial provisions for targeting men and/or women? If yes, describe?

Implementation

15. At which level is the policy implemented: national, regional, local?
16. Who are the key actors in implementing the policy? (health services, social services, education, other)
17. What are the criteria for success for the policy (targets)?
18. To what extent are these engendered?

Monitoring

19. Does regular progress monitoring of the policy take place?
20. If yes, do the results allow for actions to be modified?
21. Do the monitoring reports include gender specific quantitative and/or qualitative information? If yes, describe.

Evaluation

22. Do you know how well the success criteria of the policy have been met? (Describe successes and problems)
23. Do you have any data on the effects of the policy on men and women?

The next questions are focused on the process of policy making: answers may be found in policy documents. If not, they may be found by interviewing key informants.

24. Have any experts on men's or women's health been involved in the development of this policy?
25. Is there a department, committee or focal point present with responsibility for ensuring the inclusion of gender concerns in this policy?

Other data to review

- Is there any quantitative or qualitative sex disaggregated data available that are relevant for the selected policy?
- If yes, please describe?

(Answers to the latter two questions may be found by consulting national health databases)

Key informants

Not all policy documents may provide sufficient information to answer the questions we seek to answer. Interviews with key informants may be used to get information about unanswered questions or to check written information from the documents.

Case studies

The checklist was piloted through case studies in seven countries: Croatia, Ireland, Kyrgyzstan, the Netherlands, Tajikistan and Turkey and the United Kingdom. National teams of gender and health experts conducted the studies. In the first six countries, the teams were recruited with the support of WHO Country Offices and gender focal points appointed at the Ministries of Health. The study in the United Kingdom (England) was initiated by the European Men's Health Development Foundation.[2]

Process
To coordinate the case study work, two meetings were held at the WHO Regional Office for Europe in Copenhagen, with two participants from each country team, invited technical officers of WHO, consultants, the project secretary and the project manager. During the first planning meeting (February 26-27, 2004) the participants discussed the methodology of the case studies and the country teams identified the specific public health policy they were going to analyze. During the second meeting (May 28-29, 2004) the findings from the case studies in each country were presented, an assessment was made of the utility of the framework provided by GEM for future work on other policies or in other countries and agreement was reached on the format for reporting the results of the individual case studies and the project. All case study reports were submitted in July 2004. Subsequently the manuscripts were edited and summarized for the purpose of this report.

Guideline
The Croatian, Dutch, Irish and British (England) teams analyzed current national policies on the prevention and treatment of cardiovascular disease. The Kyrgyz, Tajik and Turkish studies investigated national policies on family planning.

The teams were asked to use the above mentioned topic list to assess relevant documents with respect to the selected policy and to use additional materials (statistics) or interviews if needed. The purpose of the assessment was to answer to the following questions:

- Have gender concerns been included in the problem analysis, problem formulation, implementation, monitoring or evaluation of the selected policy?
- What were enabling factors to include gender concerns in any of the aforementioned stages of policy development?
- What were the barriers for including gender concerns into the aforementioned stages of policy development?

To assist the organization and the analysis of the data the teams were suggested to use the following matrix.

2. See Annex 2 for list of participants

Table 2. Matrix for reporting results of the assessment of attention to gender considerations in the development of specific health policies

Title of the policy				
	Gender considerations included	**Enabling Factors**	**Gender considerations not included**	**Bariers**
Objectives				
Stages of policy development				
• **Problem description**				
• **Problem formuation (planning)**				
• **Implementation**				
• **Monitoring**				
Process characteristics • **Gender experts included in policy development**				

Three country teams deviated from the proposed methodology for the case studies. The country teams from Tajikistan and Kyrgyzstan shifted the focus of their study from a policy analysis to an analysis of the actual implementation of the policy in health practices. The reason for this was that, in these countries, the integration of gender considerations into national documents, including those on family planning, has become standard practice so that an implementation study was considered more relevant. In contrast, the case study from the UK (England) did not use the proposed methodology because an earlier study had shown that no gender considerations are included in the recent NHS policies on cardiovascular health. For this reason this study focused on why this could happen and which changes are needed.

The results of the individual case studies were presented at the last inter-country meeting and the participants agreed on a more or less common framework for structuring their results. During this meeting all participants of the case study project took part in an evaluation of the strengths and weaknesses of the framework and each country team was asked to specify their evaluation of the framework in the written country report. In addition common recommendations were formulated for National Governments and WHO, based on the experiences in this project.

Limitations and strengths

Although most participating countries used the GEM framework as common point of departure for their case study, the project should not be seen as a comparative study. The participating countries vary greatly in terms of history, politics, geography, population size, national income, health care system. They also vary in the degree in which health care systems are centralized. For this reason alone comparison between countries would have been difficult. The main purpose of this case study project was to develop a simple framework that might support countries in identifying factors that enable or hinder the integration of gender concerns in health policy development.

2

Summary of case studies on the integration of a gender perspective in cardiovascular health policies from Croatia, Ireland, the Netherlands and the United Kingdom (England)

Four countries -Ireland, the Netherlands, Croatia and the UK- applied the GEM framework as a point of reference to analyze and report on the incorporation of a gender perspective in recent policies on the prevention of cardiovascular disease. This chapter describes why cardiovascular health policies have been chosen as a topic for analysis and summarizes some key findings from the country reports.

The relevance of gender mainstreaming for cardiovascular health policies
Cardiovascular disease (CVD) refers to any condition or disease, which involve the heart and the bloodvessels. Such diseases include ischeamic heart disease and cerebrovascular disease.

According to data from the WHO Health For All Data Base, ischeamic heart disease and cerebrovascular disease are the leading causes of morbidity and mortality for women and men in most of the member states in WHO's European Region.

For a long time CVD was thought of as a male disease and research has mainly been focused on the male population. However, since it has been acknowledged that, in many countries, CVD is also the main cause of morbidity and mortality in women, health research has produced many new data on sex and gender differences in CVD. (See box 1) This has led to the recognition that a gender specific approach to the prevention, diagnosis and treatment of CVD may improve the quality of care and health outcomes for both men and women.
Many European member states of WHO, have identified the reduction of the incidence and impact of cardiovascular diseases among the population as one of the national public health priority areas, including Ireland, Croatia, the Netherlands and the UK.
Given the clear and increasing evidence of gender differences in CVD, the teams from these member states have chosen to use the GEM framework to explore if and how gender considerations were incorporated in recently developed cardiovascular health policies in their country.

Table 2.1 Some data on sex and differences in CVD

- RISK FACTORS [1]
  - Smoking is a major cause of cardiovascular heart disease among women and men. Women who smoke have an increased risk for ischemic stroke and subarachnoid hemorrhage. Constant exposure to others' tobacco smoke (secondhand smoke) at work or at home also increases the risk, even for nonsmokers. Women smokers who use birth control pills have a higher risk of heart attack and stroke than nonsmokers who use them.

1. With acknowledgement to the American Heart Association

- High blood cholesterol is a major risk factor for heart disease and also increases the risk of stroke. Studies show that women's cholesterol is higher than men's from age 45 on. High levels of LDL (low-density lipoprotein) cholesterol (the "bad" cholesterol) raise the risk of heart disease and heart attack. High levels of HDL (high-density lipoprotein) cholesterol (the "good" cholesterol) lower the risk of heart disease. Research has shown that low levels of HDL cholesterol seem to be a stronger risk factor for women than for men.
- High blood pressure — High blood pressure is a major risk factor for heart attack and the most important risk factor for stroke. Women have an increased risk of developing high blood pressure if they are obese, have a family history of high blood pressure, are pregnant, take certain types of birth control pills or have reached menopause.
- Lack of physical activity is a risk factor for heart disease and indirectly increases the risk of stroke. Overall, they found that heart disease is almost twice as likely to develop in inactive people than in those who are more active.
- Obesity and overweight increases the risk for health problems, including high blood pressure, high blood cholesterol, high triglycerides, diabetes, heart disease and stroke.
- Diabetes mellitus — Compared to women without diabetes, women with diabetes have a two to six times greater risk of heart disease and heart attack and are at much greater risk of having a stroke.

- DIAGNOSIS
  - Chest pain is not as common a symptom of a heart attack in women as it is in men.[2]
  - Women are more prone to experience so-called "atypical" symptoms such as nausea, indigestion or fatigue before and during a heart attack.
  - In women, many prodromal (pre-heart attack) symptoms are the same as "atypical" acute symptoms.
  - Many women fail to recognize that they may be at risk for CVD.
  - Gender stereotypes may also influence doctors and clinical decision making.

2. See fore instance:
McSweeney JC, Crane PB. Challenging the rules: women's prodromal and acute symptoms of myocardial infarction. Res Nurs Health. 2000;23:135-146.

McSweeney JC, Cody M, O'Sullivan P, et al. Women's early warning symptoms of acute myocardial infarction. Circulation. 2003;108:2619-2623.

Goldberg RJ, O'Donnell C, Yarzebski J, et al. Sex differences in symptom presentation associated with acute myocardial infarction: a population-based perspective. Am Heart J. 1998;136:189-195.

Meischke H, Larsen MP, Eisenberg MS. Gender differences in reported symptoms for acute myocardial infarction: impact on prehospital delay time interval. Am J Emerg Med. 1998;16:363-366.

Milner KA, Funk M, Richards S, et al. Gender differences in symptom presentation associated with coronary heart disease. Am J Cardiol. 1999;84:396-399.

Sarlani E, Farooq N, Greenspan JD. Gender and laterality differences in thermosensation throughout the perceptible range. Pain. 2003;106:9-18.

D'Antono B, Dupuis G, Fleet R, Marchand A, Burelle D. Sex differences in chest pain and prediction of exercise-induced ischemia. Can J Cardiol. 2003;19:515-522.

Granot M, Goldstein-Ferber S, Azzam ZS. Gender differences in the perception of chest pain. J Pain Symptom Manage. 2004;27:149-155.

Chesterton LS, Barlas P, Foster NE, Baxter GD, Wright CC. Gender differences in pressure pain threshold in healthy humans. Pain. 2003;101:259-266.

- Many heart attack patients, especially women, wait 2 hours or more after their symptoms begin before they seek medical help.
- This delay can result in death or lasting heart damage, and accounts in part for the worse outcomes that women experience after a heart attack compared with men.[3]
- Recognizing heart attack symptoms and getting help early can prevent lasting heart damage due to a heart attack.

- TREATMENT
  - After a heart attack, women are more likely to die in the hospital than men.
  - Women are less likely to receive cardiac catheterization-a key test to determine optimal treatment.
  - Hyperensive men are more likely to undergo a cardiac rehabilitation programme than men.[4]
- PREVENTION
  - Different cessation strategies may work best for male and female smokers.[5]
  - Different strategies for weight reduction and exercise may work best for women and men.

The broader policy context for integrating a gender perspective in national health policies
The first focus of the case studies was on the broader policy context for gender mainstreaming in the country. Did this context foster the integration of a gender perspective into a specific public health policy? To answer this question all country teams reported on the extent to which their countries had ratified international policies on gender equality and how this had been incorporated into the national legislative framework. Table 2.1 summarizes the results.

All four countries had made international commitments to ensure gender equality through their policies, by signing the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and by committing themselves to the follow up of the Beijing Platform for Action and the Beijing +5 outcome document. Furthermore, the three EU Member States (Ireland, Netherlands, UK) had also signed the Treaty of Amsterdam (1999), which requires them to eliminate inequalities and to promote equality between men and women.

In addition to these international commitments, all countries had passed national laws on gender equality. As a result of the requirements of the Treaty of Amsterdam, the EU countries had also adopted additional national policies by which they committed themselves to employ gender mainstreaming perspectives in the development of *all* government policies and programmes. In these countries special agencies had been established at Government level (usually at the Ministry of Social Affairs) to support and monitor the progress of gender mainstreaming in all Ministries.

Only in Croatia a national government policy on women's health had been adopted. This policy focuses mainly on reproductive health and the prevention of violence against women. In Ireland and

3. Gijsbers van Wijk, C. Vilet, P., Kolk, A. (1996) Gender perspectives and quality of care:towards appropriate and adequate health care for women, Social Science and Medicine 43;5:707-720

4. Raine R, Hutchings A & Black N (2004) Is publicly funded health care really distributed according to need? The example of cardiac rehabilitation in the UK Health Policy 67 (2) 227-235

5. Perkins, K.A. (2001), 'Smoking cessation in women. Special considerations.' CNS Drugs, 15, 5, 391-411.

the Netherlands previously existing national policies on women's health were not extended after these countries had signed the Treaty of Amsterdam.

Only in Ireland and Croatia, "overarching" national *health* policies or plans included sections in which gender equality was mentioned as an over all policy objective, such as the new plan on health measures in Croatia.
At the Ministries of Health in Croatia, the Netherlands and the UK no gender experts were designated to support policy development. In contrast, in Ireland, the Minister for Health and Children had appointed a special statutory body to advice on women's health issues: The Women's Health Council. In 2004, only in Ireland initial steps were taken towards the gender proofing of health policies.

It has been proven that, in most societies, women are at a greater disadvantage to realize their full potential for health than men. However, a gender mainstreaming approach is meant to address the concerns of both sexes. In recent years, the European men's health movement has put forward that the health sector should pay more attention to men's health concerns.[6] However, the case studies showed that this was not yet reflected in health policy documents or measures in the four countries. Only at the Irish Ministry of Health there was some recognition that health policy should address specific health needs of men. In the UK a debate about the inclusion of men's concerns in health policy had recently started.

Together these data show that in all four countries, legislative frameworks for adopting a gender mainstreaming perspective in policy development are in place. However, there are variations across the countries in the extent to which the Ministries of Health were committed to implementing a gender mainstreaming strategy. Ireland seems to be most advanced in this respect. It is the only country where a special advisory board has been established to advice the Minister of Health on women's or gender and health issues, which is a first step towards implementation.

6. The Strategic Action Plan for the Health of Women in Europe, which was endorsed by 35 Members States of WHO in February 2001, recognizes the establishment of national coordinating committees on gender and health and national action plan as important prerequisites for the integration of gender concerns into the health sector and health policies. These conditions were not met in three of the participating Member States (NL,UK,CR) and only partly in one (IRE).

Table 3.1 Broader policy context for the integration of a gender perspective in health policy

	Ireland	**Netherlands**	**Croatia**	**UK (England)**
Broader policy context				
International level				
UN treaties on gender equality endorsed?	Yes	Yes	Yes	Yes
Signatory to treaty of Amsterdam?	Yes	Yes	No	Yes
National level				
National gender equality legislation in place?	Yes	Yes	Yes	Yes
National policy on gender mainstreaming of Government policies and programmes in place?	Yes	Yes	No	Yes
National mechanism for monitoring gender mainstreaming of Government policies in place?	Yes	Yes	No	Yes
Has gender proofing of health policy taken place?	More or less	No	No	No
National health policy				
National policy on Women's/Gender and Health in place?	Expired 1999	Expired 2001	Yes: Focused plans on women's health (violence and reproductive health)	NHS: No
Commitment to gender mainstreaming specifically stated in documents of overarching national health policies?	Some	No	Health care plan: No Health measure plan: women	NHS: No
Advisory body on women's or gender and health in place at Ministry of Health?	Yes	No	No	MOH: no NHS: No
Explicit attention to men's health in policy documents?	Has recently become an issue	No	No	NHS: No Some debate

The integration of gender consideration into policies on cardiovascular health

How have women's and men's needs been considered in the objectives, problem description, planning, implementation and monitoring of recent policies on cardiovascular health? To answer this question the four participating countries conducted a content analysis of documents regarding the most recent national policies on cardiovascular health in their countries and interviewed a number of stakeholders who were involved in the development of the policy. As was mention earlier the UK team did not apply the GEM framework very strictly but took a somewhat different approach to make a case. Table 2.2 lists the policy documents that were analyzed.

Table 2.2 Overview of analyzed policy documents on cardiovascular health

Ireland:	Building Healthier Hearts, 1999
	First Progress Report, 2001
	Second Progress Report, 2003
Croatia:	National Cardiovascular Disease Prevention Programme, 2003
Netherlands:	Towards a longer and healthier life 2004-2007: a matter of healthy behaviour, 2003
United Kingdom:	The National Service Framework for Coronary Heart Disease, 2000

Table 2.3 summarizes the key findings from the analysis of the policy documents for each country.
In all four countries the *general objectives* of the cardiovascular health policies were stated in a gender neutral manner. However, the objectives section of the Irish policy document mentioned explicitly that gender should not restrict access to care.
In the Irish, Croatian and Dutch policy documents the sections describing key *problems* in the area of cardiovascular health presented sex disaggregated data on cardiovascular morbidity and mortality. The Irish and Dutch documents provided also some sex disaggregated data on risk factors for CVD. However, in both countries the presentation of gender data was very rough and not consistent. For instance data on social class, age, or other characteristics that are considered risk factors for cardiovascular diseases, were not subdivided for men and women.
While most policy documents provided some gender statistics in the problem description, attention to gender issues in the *planning* sections was very limited. Only in the Irish document some gender facts were mentioned regarding suboptimal treatment for women, but not drawn out in strategy. In the Dutch, Croatian and English policy no gender specific measures or targets were planned. However, in the Dutch policy documents specific measures were planned for other groups: young people and people with low social economic status.
The Dutch and Croatian cardiovascular health policies had not been *implemented* at the time of the study and additional policy documents on this issue were still in preparation. The British case study did not provide information regarding the implementation of the cardiovascular health policy. In the Irish documents on the implementation of the policy in two cases there was specific attention to gender issues: firstly, equitable access to services was an overall implementation goal and, secondly, teenage girls were considered a specific target group for anti-smoking campaigns.
Finally, in none of the countries, the policy documents mentioned gender specific indicators for the *monitoring* and evaluation of the outputs and outcomes of the policies.

Table 2.3 Summary of results of the assessment of attention to gender considerations into specific stages of selected policies in Ireland, Croatia, the Netherlands and England

	Ireland	Croatia	Netherlands	UK (England)
General objectives policy	**Improve, prevention, management and service provision for cardiovascular health**	**Improve prevention CVD**	**Improve healthy life styles to prevent CVD and other lifestyle related conditions**	**Improve prevention treatment and rehabilitation strategies CVD**
Gender considerations mentioned in general objectives policy	**income, place of residence, age, gender should not restrict access to care**	**None**	**None**	**None**
Stages of policy development				
• **Problem description**	**sex disaggregated data on mortality, morbidity, diet. Focus on sub group analyses by class rather than gender.**	**sex disaggregated data on cvd mortality**	**sex disaggregated data on life expectancy, smoking, obesity, alcohol use. Focus on social class rather than gender.**	
• **Planning**	**some gender facts were mentioned about suboptimal treatment for women, but not drawn out into strategy**	**no gender specific strategies planned (e.g. for prevention): some focus on young people and people with low SES**	**no gender specific strategies planned**	**no gender specific strategies plannned**
• **Implementation**	**teenage girls targeted for anti smoking campaign Equitable access to services target**	**policy not implemented**	**policy not implemented**	
• **Monitoring**	**No gender specific indicators planned**	**No gender specific indicators planned**	**No gender specific indicators planned**	**No gender specific indicators planned**
Process characteristics				
• **Who designed policy**	**MOH**	**MOH**	**MOH**	**MOH/NHS**
• **Gender experts included in policy development**	**No**	**Yes, only problem definition**	**No**	**No**

The case studies demonstrated that the countries were at different stages in the development process of their cardiovascular health policies. In some countries the policy plans had been drafted, but the implementation had not started. In others a start had been made with the implementation and monitoring of their policies. However, overall, the results from the case studies suggest that attention to sex and gender differences in recent cardiovascular health policies is very limited.

By using the GEM framework (see chapter 1) as a point of departure, each of the country teams was able to identify a range of specific enabling and constraining factors for paying attention to gender concerns in cardiovascular health policies in their country. Based on these analyses, specific recommendations were formulated in the closing section of each case study (see part 2). This was not a comparative study and each case study stood on its own. Nevertheless, some common conclusions can be drawn.

What were enabling factors for paying attention to gender concerns in cardiovascular health policies?

1. All countries had endorsed international commitments and adopted national policies on gender equality and gender mainstreaming. This was considered a potentially enabling condition for addressing gender concerns in *any* national policy, including health policy.
2. Only in one country (Ireland) the Ministry of Health had taken concrete measures to ensure attention to gender issues in health policy development. The presence of a special advisory body on gender and health at the level of the Ministry of Health was considered an important enabling condition for developing gender sensitive health policies.
3. In all countries, tackling social inequalities in heart health was mentioned as an over all policy goal. This might be a first step towards the acknowledgement of gender as a determinant of inequalities in cardiovascular health. This is considered as an essential enabling condition for integrating a gender perspective into cardiovascular health policies.
4. In all countries sex-disaggregated data were available which are relevant in relation to cardiovascular health. This was considered an enabling condition for addressing gender concerns in cardiovascular health policies.
5. In almost all countries some of these data were presented in the problem analysis section of the policy documents and some other section. This was considered as first step towards the integration of gender concerns in cardiovascular health policy.

What were obstacles for paying attention to gender concerns in cardiovascular health policies?

1. Country based coordinating committees for gender and health were not established in three of the four countries.
2. Comprehensive country based action plans for gender and health were not drawn up in three of the four countries.[7]
3. Insufficient understanding of or commitment to a gender mainstreaming approach at the Ministries of Health.

7. The Strategic Action Plan for the Health of Women in Europe, which was endorsed by 35 Members States of WHO in February 2001, recognizes the establishment of national coordinating committees on gender and health and national action plan as important prerequisites for the integration of gender concerns into the health sector and health policies. These conditions were not met in three of the participating Member States (NL,UK,CR) and only partly in one (IRE).

4. Gender and health experts were not consulted in drafting the various stages of the policy.
5. The conclusions from current health research on sex and gender differences in the prevention, treatment and management of cardiovascular disease were not available at the time the policies were developed or they were insufficiently recognized by policy makers.
6. Gender was not recognized as an important determinant of cardiovascular health. Consequently:
   a. Available national data in relation to the prevention, treatment and management of cardiovascular disease across the life span were not *systematically* analyzed and represented for men and women. Such analyses could provide essential baseline information for the planning of effective gender sensitive policy strategies and policy targets.
   b. The available information on sex and gender differences in cardiovascular health was not translated into practical strategies and policy targets.
   c. No specific arrangements (indicators) were made for the gender proofing of cardiovascular health policies.

Most of the countries had a mechanism for reporting back the findings of these case studies to the ministerial departments.
In relation to the WHO Regional Office for Europe, there was consensus among the participants of these case studies that the Gender Mainstreaming and Women's Health Programme had a key, ongoing role in supporting gender mainstreaming of health policies within countries.
The following specific suggestions were made with regard to cardiovascular health policies:

- WHO should encourage governments in the European Region to recognize gender as a cross cutting variable in heart health, that underlies all other social and health issues such as age, ethnic origin and socio-economic status.
- WHO should support countries in the translation of evidence on sex and gender differences in cardiovascular health into clear policy strategies and targets.
- WHO should support countries to develop gender sensitive indicators to monitor and evaluate policy outcomes.
- WHO should support countries in the development of a gender frame for the collection and analysis of health data to inform gender specific prevention, detection, treatment and rehabilitation programmes in the field of cardiovascular health.

Finally, as the authors of the Irish case study remarked, public health policies are not set in stone but open to adaptations. Hopefully these case studies will elicit some changes.

3

Summary of case studies on the integration of a gender perspective in family planning policies from Kyrgyzstan, Tajikistan and Turkey

How are gender issues addressed in national policies and programmes in relation to family planning? What has enhanced or hindered attention to these issues? These questions were taken up in the case studies from Turkey, Tajikistan and Kyrgyzstan. The Turkish team focused on policy documents and explored if and how gender issues were addressed in the objectives, problem description, planning, and implementation of five essential pieces of national legislation on family planning. The Tajik and Kyrgyz teams put the emphasis of their case studies on family planning *practices*. In addition to a short review of the legal setting for family planning, both country teams conducted an interview study among clients and personnel of family planning services to explore if and how reproductive health needs of both men and women are met by health services.
This chapter provides some background information on why these countries decided to focus their case studies on policies and practices in the area of family planning and summarizes some major findings.
For data from the Tajik and Kyrgyz interview studies we refer to the case study reports in part II of this report. In a follow up study, funded by UNFPA, the Turkish team also extended their policy analysis with a field study of how gender issues are addressed in family planning *practices* and *services*. A report of this very interesting follow up study can be obtained from the authors.[1]

The relevance of integration of a gender perspective in family planning policies and programmes
Sexual and reproductive health (SRH) is an area of concern in WHO's European Region, especially in countries in the economically less developed Eastern part of the Region. While the GDP and health expenditures per capita of the population and the healthy life expectancy at birth are much lower in countries in the Eastern part of the Region than in those in the Western part, the fertility rates are often higher and other reproductive health indicators such as maternal mortality rates and perinatal and neonatal infant mortality and morbidity rates are less favorable. Table 3.1 provides some comparative data for Turkey, Tajikistan, Kyrgyzstan and the EU Member States. Furthermore, within the countries in the Eastern part of the Region, the reproductive health situation is often the least favorable for the poorest and least educated parts of the population. WHO strives to reduce this gap between and within countries in the Region.

1. Akin, A., Bahar-Ozvaris S., 2004. Gender Mainstreaming on the ground: In: Case Study on the Integration of Gender Perspective in Health Policy in Turkey. Ankara, HUWRIC

Table 3.1 Some statistics for Turkey, Tajikistan, Kyrgyzstan and former EU Member States (1)

	Turkey	Tajikistan	Kyrgyzstan	EU Member States
GDP per capita $ US	6.448	1.418	2.685	23.878
Total health expenditure per capita $ US	420	47	117	2128.88
Healthy life expectancy at birth m/f	61.2/73.0	53.1/63.00	52.1/58.4	70.74 (2)
Fertility rate per woman, 2003	2.4	3.0	2.5	1.5
Maternal mortality, per 100.000 births	49.2 (3)	44.99	58.41	5.17

(1) Based on data from Health For All Data base, WHO Regional Office for Europe
(2) No sex disaggregated data available for this indicator
(3) Based on information Turkish team.

In 2001 the WHO Regional Office for Europe launched the WHO European Strategy on Sexual and Reproductive Health, with the aim to support Member States in their efforts to ensure sexual and reproductive rights and improve the SRH status of the people.[2] Ensuring gender equity is a cross cutting issue in this strategy. This means, among other things, that the strategy promotes equal attention to men's and women's SRH needs in public education and services and the involvement of both men and women in reproductive choices.
Turkey, Tajikistan and Kyrgyzstan have endorsed this strategy, which includes many objectives and targets for the fields of reproductive choice, making pregnancy safer, STI/HIV control, sexual abuse and violence, trafficking of women, breast cancer, adolescents' SRH, refugees and displaced persons, migrant populations and aging people.
According to the research teams from Turkey, Tajikistan and Kyrgyzstan, one important gender related problem in the area of SRH in their countries is that the gender-based power balance favors men, so that the decision making power on SRH issues often lies with men. For that reason, they wanted to explore how the issue of gender equality in reproductive choices is addressed in current reproductive health policies. Due to the time limitations of the study, the countries restricted themselves to policies related to one area of SRH: family planning.

The broader policy context
How did the broader policy context foster the integration of a gender perspective into national policies with respect to family planning? To answer this question all country teams reported on the extent to which their countries had ratified international policies on gender equality and how this had been incorporated into the national legislative framework. Table 3.2 summarizes the results.

2. WHO Regional Office for Europe, 2001, WHO regional strategy on sexual and reproductive health.

Table 3.1 Broader policy context for the integration of a gender perspective in public health policy

	Turkey	**Tajikistan**	**Kyrgyzstan**
Broader policy context			
International level			
UN treaties on gender equality endorsed?	Yes	Yes	Yes
International agreements on reproductive health endorsed?	Yes	Yes	Yes
National level			
National gender equality legislation in place?	Yes	Yes	Yes
National agency for gender statistics in place?	Yes	No	No
National Program of Action to ensure gender equality in place?	No	Yes	Yes
National Program of Action to improve the situation of women in place ?	Yes	Yes	Yes
National health policy			
National policy on women's or gender and Health in place?	Yes, women's health	Yes, directed to men's and women's health	Yes, directed to men's and women's health
National reproductive health policy			
National legislation on reproductive rights in place, with attention to men and women?	Yes	Yes, new law under construction	Yes
National Program of Action for reproductive health in place?	Yes	Yes	Yes
Explicit attention to men's health in national programs of action on reproductive health?	Little	Some	Some
Regular gender proofing of reproductive health policy?	Yes, occasionally by national monitoring agencies Focus on sex disaggregated data	To some extent by international organizations and NGOs. Not by government	To some extent by international organizations and NGOs. Not by government.
Gender experts available at government level to advice on health policy?	Yes some. External consultants	No External consultants	Yes

All three countries made international commitments to ensure gender equality through their policies by signing the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and by committing themselves to the follow up of the Beijing Platform for Action and the Beijing +5 outcome document.

In addition, the countries approved other international agreements or documents which are specifically relevant for the improvement of gender equity in sexual and reproductive health: the World Health Declaration, adopted at the Fifty First World Health Assembly in May 1998; Health21, the health for all policy framework for the WHO European Region (WHO, Copenhagen 1999); the Programme of Action of the International Conference on Population and Development (Cairo, September 1994).

In addition all three countries passed laws on equal rights and opportunities for both genders in all spheres of human activity. The laws in Tajikistan and Kyrgyzstan are of a recent date and they are drafted with reference to the international agreements these countries have signed.

To implement this legislation, Tajikistan and Kyrgyzstan had adopted national programmes to ensure equal rights and opportunities to men and women and all three countries had national programmes of action to enhance the situation of women, also in the area of health.

Turkey had also a specific national strategic plan to improve the health of women. In Tajikistan and Kyrgyzstan similar programmes exist as part of the above mentioned larger national programmes of action to ensure equal rights for men and women. Theoretically these programmes are focused on men and women.

In Kyrgyzstan a law on reproductive rights was passed by Legislative Assembly of Parliament of the Kyrgyz Republic on December 20, 1999, and enforced on May 21, 2000. This law recognizes the reproductive rights of all citizens. It provides a legal base for equal access to family planning services for men and women. In Turkey a similar law had been passed, which was the topic of investigation of the Turkish case study. In Tajikistan a new law was under construction.

In addition to this all countries had reproductive health action programmes, which are mainly focused on women. The Tajik Government was planning to rephrase the programme so that men's needs would be more specifically addressed.

Finally, in Tajikistan and Kyrgyzstan improvements in the health status of men and women were regularly monitored by international organizations (UNDP, UNFPA, World Bank), but not by the government. In contrast, in Turkey, the government was monitoring the progress of the reproductive health policy regularly, using sex disaggregated data (see below). However, in all countries *gender sensitive indicators* for monitoring reproductive health policies and programmes were *not* available.

In Kyrgyzstan, a team of gender experts was appointed to advice the Government on gender related aspects of all policies, including health policy. In Tajikistan and Turkey the Ministry of Health had not officially appointed special gender experts to advice on policy issues. However, some external experts were consulted on an irregular basis.

Over all, these data suggest that in all three countries there are broader legislative frameworks and programmes in place that foster attention to the concerns of men and women in specific national family planning policies. In Kyrgyzstan and Tajikistan human rights legislation and health legislation are of a recent date, and these legislations reflect internationally agreed commitments to gender mainstreaming.
In the view of the Kyrgyz and Tajik research teams, the legislative structure in their countries did not present an major obstacle for paying attention to women's and men's needs in the area of family planning. For that reason, they decided to focus their case studies on the implementation of the policies by service providers and not on an further analysis of specific aspects of the policy documents.

The integration of gender consideration into policies on family planning

How have women's and men's needs been considered in the objectives, problem description, planning, implementation and monitoring of recent policies on family planning? Only the Turkish team has tried to seek a detailed answer to these questions, using the GEM framework as a point of reference for their analysis. In Turkey, the legislative framework with respect to family planning has changed several times in the past decades. Moreover, several different policies are relevant with respect to reproductive choice. For that reason the Turkish team analyzed five pieces of legislation:

- The Main Constitution, 1982.
- The Law on General Hygiene (# 1593), 1930.
- Health Law on Socialization of the Health Care Services (# 224), 1961.
- First Population Planning Law (# 557), 1965.
- Second Population Planning Law (# 2827), 1982.

One of the findings of this analysis was that the legislations were adopted in response to changing views in Turkey regarding population planning. The first law, issued in 1930, reflects the "pronatalist" perspective which was widely advocated in the 1930's; the second law, issued in 1965, reflects the "population planning" perspective which became popular in 1960's; and the third law, issued in 1982, reflects the "family planning" and "reproductive health" perspectives which became accepted after 1980's. Another interesting finding is that the assumption that the sexual health and reproductive health of a woman are mainly linked to her role as a mother is underlying *all* pieces of legislation. The most recent law on population planning addresses family planning, the production and distribution of contraceptives, abortion and surgical sterilization. In its *objectives*, the law states specifically that women have the right to make their own decisions regarding family planning and abortion. Furthermore the law states that the right to get an abortion is not only restricted to married women. In contrast to previous laws, this law confirms women's rights to make choices in relation to family planning, but it makes no reference to men.

In the section *describing the problem* the policy wants to address, sex specific quantitative data were used, and males and females aged 15-49 are clearly defined as a target group for strategies aimed at reducing unwanted pregnancies and maternal mortality. In the *planning section* of the policy document it is stated that contraceptive methods need to be available for everyone. The proposed strategies regarding family planning and abortion are still in the process of *implementation*. This process is regularly *monitored* by a government agency through health surveys. In contrast to earlier evaluations of the implementation of the policy, the most recent evaluations did not only include data regarding married women and men, but also regarding unmarried men and women. In the development and monitoring of this policy gender sensitive scientists have been included as advisers. In contrast to previous laws this law does not restrict reproductive choice for any group of women. However, throughout the document relatively few references are made to men's reproductive health and family planning needs and their role in the reproductive health of women. In this sense, the document does not reflect an understanding of how socially or culturally constructed gender roles and relations may determine family planning practices and services.

Enabling factors to include attention to men and women into this law were:

- The availability of scientific studies and sex disaggregated data.
- The activities of advocacy groups.
- Resource allocation to facilitate implementation.

- The fact that Turkey signed international treaties which acknowledge the importance of gender issues for family planning and the freedom of reproductive choice for everyone.
- The availability of gender experts at the department of Maternal and Child Health and Population Planning of the Ministry of health.
- Gender experts at university centers and women's groups.

Obstacles for integrating a complete gender perspective into this policy were:
- Gender issues were not well understood and recognized at the time the policy was developed.
- Lack of gender specific data, explaining the impact of men's and women's social and cultural roles on reproductive health.
- A conservative and traditional approach to women's health.

Some conclusions from the interview studies
Despite the fact that the legislation with respect to family planning does not present serious obstacles for addressing the specific needs of men and women, the data from the interview studies in the three countries demonstrated that the implementation of a gender mainstreaming perspective in family planning *practices* has still a long way to go.

The Tajik case study concluded: (see Part 2 of this report)
- The government of the Republic of Tajikistan deserves credit for attempting to align its (reproductive) health legislation with international standards regarding gender mainstreaming.
- However, the system for monitoring legislation and programme success is weak and fails to consider gender.
- The population has received inadequate information on the adopted laws and programmes.
- Due to a lack of knowledge and training, the personnel in the Reproductive Health Centers (RCH) does not provide gender sensitive services.
- The infrastructure of these centers is underdeveloped and therefore it does not provide men and women with the necessary contraceptives, informative materials and services.
- In a country where adequate funding for essential (reproductive) health services is lacking, the concern for gender issues is not considered a priority issue among the population and service providers.

One of the Kyrgyz case studies concluded: (See part 2)
- The health care statistical data currently used do not always adequately reflect gender related problems.
- With regard to reproductive health, the major gender focus is on supporting female fertility. The "health of women" has become synonymous with reproductive health. The consequences become strikingly obvious in policy and scientific research. Outside reproductive health, other initiatives regarding women's health are predominantly focused on married women of child bearing age. They mostly ignore the health status of adolescent girls and unmarried and/or childless and older women.
- With regard to reproductive health, differences between males and females are ignored, including differences in life cycle.
- Vertical segregation and a gender imbalance exist in the health care system among professional workers who provide services to the population. Fewer women than men work in (reproductive) health care centers, particularly in higher positions.

- The programme for broadening the male involvement in reproductive health is impeded by a lack of current information on the positions, knowledge and habits of men towards family planning and reproductive health.

The Turkish team observed (see note 1):
Despite the fact that the law ensures equal access to public primary health care services, including family planning and abortion services, to all people (and if needed free of charge), the interviews showed that almost all of the programmes run by NGOs or the public sector and universities are primarily targeting married women. The two exceptions were the Adolescent Reproductive Health Clinics within the university health care system in Ankara and Diyarbakir. Some NGO programmes did try to include husbands through their wives, but in general male participation in the reproductive health programmes was very low.
It can be argued that fertility regulation services in Turkey reflect the general cultural background. Pre-marital and extra-marital sexual relations for women are still strong taboos. In a survey conducted among university students in 1992, 85% of the males indicated they considered a girl's virginity as an important prerequisite for marriage. More recent studies confirm the value attributed to the virginity status of girls, albeit with somewhat lower proportions. In this environment, tailoring the services for the most demanding group (that is married women) was an initial logical step for family planning services in Turkey. However also in Turkey norms are changing. This is reflected in the adolescent study which found that young and unmarried people have important needs in the area of reproductive health. The more reproductive health services are provided only for women, the more men will see it as women's responsibility and the more unmarried people are left out, the more traditional cultural norms will be reinforced. However, all of the respondents in this research were favoring increased participation of men in family planning and programme designers from different sectors (Ministry of Health, universities and NGOs) stated that future plans for family planning services needed to involve men.

On the basis of these studies, some of the recommendations to WHO were:
- Provide gender expertise to legislators and policy makers, especially when policy documents are at the planning phase and at completion.
- Standard definitions of sex and gender related aspects of health are not always clear. Provide a standardized terminology, which can then be adapted to the country or region specific terminology.
- Gender sensitive health indicators should be developed and tested.
- Provide technical assistance to the Ministry of Health and to reproductive health centers in the development of gender training programmes for the managerial staff and health personnel.
- Provide assistance in the development of textbooks, guidelines, methodical recommendations which include a gender approach.
- Help pilot countries to overcome any gender and age bias in the information they distribute on reproductive and sexual health, and family planning.

4

Evaluation of the framework and recommendations

Gender mainstreaming is an internationally accepted strategy for making women's and men's concerns an integral dimension in the design, implementation, monitoring and evaluation of policies. Regular monitoring is an important component of the process of gender mainstreaming. It gives insight in factors that may hinder or facilitate the implementation of the strategy.
In recent years an increasing number of guidelines for monitoring the process and the outcomes of gender mainstreaming have become available in the health sector. However, many of those guidelines are rather encyclopedic and not easily applicable in practice. Building on previous work carried out by the Gender Mainstreaming and Women's Health Programme of the WHO Regional Office for Europe, in this project we developed a simple framework for analyzing the implementation of gender concerns into existing national public health policies. The framework consists of a list of topics (questions) that may be useful for a gender analysis of policy documents and a matrix for organizing the results (see chapter1). It was used in six of the seven case studies described in this report: those from Croatia, Ireland, the Netherlands, Turkey, Kyrgyzstan, Tajikistan. In the case studies from Kyrgyzstan and Tajikistan additional interview studies were carried out to enable a more in-depth investigation of how policies were implemented in practice. The case study from the UK used a somewhat different methodology. This chapter describes how the participants in this project evaluated the framework and which recommendations they made for improvements and future work.

In general, the framework was received favorably and the questions in the topic list provided useful reference points for undertaking the work.

Strengths

- The framework allowed participants to analyze and report on the extent to which their countries had ratified international policies on gender equality, how this had been incorporated into the national legislative framework and the extent to which attention to gender issues has been embedded in the policy identified for the case study.
- It allowed participants to identify gaps in the attention to gender issues in subsequent parts of the policy documents: objective, problem description, planning, implementation, monitoring.
- It allowed participants to identify (to some extent) what may be needed to fill these gaps.
- It could be applied in a flexible manner, so that adaptations could be made to meet the needs of the users.
- By using the framework, most participants gained a better understanding of the steps that are needed to integrate attention to gender issues in mainstream public health policies.
- The framework is adequate for an analysis of published national policies and programmes.
- The framework enables a relatively quick gender analysis of policies and the formulation of evidence based recommendations.
- The experience with using the framework suggests that the initial stages of policy development, problem analysis and the planning of targets, are key stages for the inclusion of gender considerations in policy. If gender considerations are included in these stages, this will in turn ensure that they will be included in implementation and monitoring and evaluation stages.

- The framework enabled GEM to initiate a process of concrete reflection on what gender mainstreaming means, both within and between countries. This has brought a greater understanding and appreciation of this strategy even among gender and health experts.

Weaknesses

- The framework assumes that policy analysts have a sufficient understanding of what is meant by concepts such as sex, gender, gender mainstreaming or gender sensitivity. This is not always the case.
- The framework focuses on the identification of problems (gender gaps) in the policy and less on the resolution of those problems.
- Information on political processes that have led to policy documents cannot (only) be located in those documents, but require interviews with stakeholders. Due to time limitations in this project, most participants had not enough time to conduct interviews.
- It appears that countries are at different stages of policy development according to the definition of the framework. Therefore the framework could not always be applied equally or as easily across all countries.
- The translation from policies targets into actual services is an important condition for the implementation of any policy. This framework focuses mainly on the analysis of published national policies and programmes. Some participants indicated the need to extend the suggested questions to the implementation of policies and to focus particularly on perceptions of the service providers. This has implications for its future implementation.
- It was suggested that more explanation would be helpful to accompany the framework especially in how to record the results in the matrix.
- It was noted that the framework would benefit from being more concise with fewer questions.

Recommendations to WHO/EURO

- The framework should be slightly revised (a more concise description of the relevant terminology, use of the matrix and if possible fewer questions).
- The slightly revised framework should be validated in different countries and on different health topics where ample evidence exists of significant sex and gender differences. (e.g. mental health, cancer).
- The framework should be part of a toolkit/guideline for the gender mainstreaming of health policies in Europe.
- The framework should be published and used in the training for health policy makers in the European Region.
- In addition to this framework, the development of gender-sensitive health indicators with special emphasis on gender as opposed to sex variables is needed, both to set baseline information for policy development and to monitor outcomes.

Part 2

Case studies on the integration of gender concerns in public health policy: Country reports

Introduction

In 2004, the Gender Mainstreaming Programme of the WHO Regional Office for Europe invited seven European Member States to conduct a case study which was aimed at examining how gender considerations are taken into account into contemporary public health policy in their country. Part I provided a summary of these case studies. This part is intended to complement Part 1 and presents the extended country reports of the case studies. In annex 3 some key health indicators by gender for each of the seven countries, are given.

5

Integration of a gender perspective in cardiovascular health policy in Ireland

The Women's Health Council, Ireland

Ensuring that men and women are given equal opportunities to realise their potential for health is an important goal of the WHO and one that fits well with the mission of the Women's Health Council (WHC). A crucial strategy to achieve this goal is the gender mainstreaming of national health policies. This entails integrating attention to sex and gender differences in *all* stages of health policy development: problem definition and agenda setting; policy design; decision making; policy implementation and monitoring. The purpose of this project was to move towards mainstreaming gender within health policy and strategy by carrying out a gender analysis of one national health policy and examining the extent to which gender has been included in it.

The WHC identified Ireland's national Cardiovascular Health policy as an ideal area for a gender sensitive health policy study. The Irish National Cardiovascular Health Strategy *Building Healthier Hearts* (Department of Health and Children Cardiovascular Health Strategy Group, 1999) is the key document here. Cardiovascular disease including heart disease, stroke and circulatory diseases is the single largest cause of death among women and men in Ireland, representing 40% of all deaths in 2001. In addition, the WHC felt that cardiovascular health is an area that could benefit greatly from the incorporation of a gender perspective. Over their lifetimes women are as affected as men by the disease, and have higher rates of the disease at older ages. In spite of this, however, heart disease has traditionally been thought of as typical to men. This is probably because men are more likely than women to die prematurely (under the age of 65) from the disease (Codd, 2001). It may also be explained by the historical lack of clinical research focusing on or including women's cardiovascular health. Women can have quite different symptoms of disease than men, something the literature describes as women's 'atypical' experience of heart disease, with men's symptoms being perceived as 'normal'. The WHC recently carried out a piece of work on *Women and Cardiovascular Health* in Ireland (Annex 1). This research drew attention to significant gender bias in current thinking about cardiovascular disease, and found gaps in both knowledge and in the provision of services to women. This growing evidence about the impact of gender on cardiovascular health provides the rationale for ensuring that the national cardiovascular health strategy services to women, is gender sensitive and that gender is built in from the development stages of the document.

This case study aimed to describe the extent to which gender was included in the national cardiovascular health policy and its follow-up reports, and to assess the extent to which gender was taken into account in the development of the strategy.

The aims of this chapter are:

- To describe the case study and results.
- To make recommendations for future work/policy options for Ireland and the WHO.

Methodology

The key focus of the study was the original cardiovascular health strategy document *Building Healthier Hearts* (Department of Health and Children Cardiovascular Health Strategy Group, 1999). Two follow-up reports on the strategy were also analysed, namely the *Heart Health Task Force First Progress Report July 1999-June 2001* (Heart Health Task Force, 2001) and *Ireland's Changing Heart; Second Report on the Implementation of the Cardiovascular Health Strategy 1999-2002* (Heart Health Task Force, 2003). Together, these documents present national policy on prevention, management and service provisions for cardiovascular health in Ireland. The reports were analysed with reference to the outline matrix and guidelines provided by the Gender Mainstreaming Programme of the WHO Regional Office for Europe (GEM). Content analysis was used to examine the Strategy and Progress Reports from a gender perspective. The use and non-use of the words 'gender', 'male', 'female', 'equality', 'equity' and other related words were noted, and the implications of this use/non-use were drawn out with reference to epidemiological and other relevant research findings (see Annex 2).

Epidemiological and other research data on cardiovascular health for Ireland were also drawn upon for this study. These included the data mentioned in the Cardiovascular Health Strategy reports themselves, data from the Irish National Health and Lifestyle surveys (SLÁN) (Kelleher et al., 2003, Friel et al., 1999), Eurostat statistics (Eurostat, 2002), material produced by the Irish Heart Foundation (Codd, 2001), and data from the Central Statistics Office. This covered data available during the time the Strategy and progress reports were developed, as well as statistics not used in these reports. Reference was also made to the WHC's recently published *Women and Cardiovascular Health report* (Women's Health Council, 2003), which drew on international research studies in the area.

The National Heart Health Advisor, Dr Emer Shelley, was interviewed as part of the study in order to answer some of the questions left after the analysis of the Strategy documents, and in particular to expand on the process of developing the Cardiovascular Strategy. The Interview guide used for the interview is attached in Annex 3.

The findings of a conference held by the WHC in connection with the Health Promotion Unit of the Department of Health and Children on *Women, Disadvantage and Cardiovascular Disease: Policy Implications* were also used to feed into the study. The conference was held on the April 22, 2004, and included contributions from the international research community, statutory and voluntary agencies within the Republic of Ireland as well as those responsible for policy implementation. During the day cutting edge international research findings were presented and a number of inter-sectoral discussions took place. The proceedings are available on the WHC website (http://www.whc.ie) in the near future. The recommendations made at the conference informed the recommendations made in the present report.

Results

The broader context

In order to set the context for the study, Ireland's national gender policy and its gender and health policy were also explored.

A. Irish policies on gender equality

International commitments on gender:
The Irish government is a signatory to the United Nation's Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) since 1985. In addition, in line with its obligation arising from the Platform for Action of the United Nations Beijing Conference on Women, the Irish Government has produced a draft National Action Plan for Women. All of the international commitments made under the Beijing Agreement have not, as yet, been given full recognition by Irish law however. Women's health was identified as an area for action in Ireland's commitments in the Government Report to the United Nations under the 1995 Beijing Platform for Action (Department of Justice Equality and Law Reform, 2002), and individual chapters on both men's and women's health are included in the most recent Irish national health strategy (Department of Health & Children, 2001). The Department of Justice Equality and Law Reform identified the hosting by the Women's Health Council of a National Forum of stakeholders to chart future action as an anti-discrimination measure in Ireland's most recent report to the UN on eliminating discrimination against women (Department of Justice, Equality & Law Reform, 2003).

Ireland is a signatory to the EC (Amsterdam) Treaty 1999. Article 2 of the Treaty states that the promotion of equality between men and women is a task of the European Community, and Article 13 provides for the incorporation of the EU equality directives. The treaty also states that:

> *'In all its activities the Community shall aim to eliminate inequalities and to promote equality between men and women.'*

Ireland participates in a number of EU committees on gender equality, including the High Level Group on Gender Mainstreaming; the Advisory Committee on Equality between Women and Men, and the Management Committee of the Programme relating to the EU Gender Equality Programme, 2001-2005. Ireland is also represented on the Council of Europe Committee for Equality between Women and Men (CDEG).

Gender Policy in Ireland
One of the first documents addressing the concept of 'equality proofing' in Ireland was Equality Proofing Issues published by the National Economic and Social Forum in 1996. It focused particularly on women, people with disabilities and Travellers, although recognising that other groups such as the long-term unemployed, and older people, also suffer from disadvantage.
The report stated that:

> *'Equality of opportunity and equality of participation are vital steps to the achievement of greater equality for all individuals and marginalised groups in our society; seeking to achieve equality of outcome in employment and in the provision of goods and services by the public and private sectors should also be a central policy aim.'*

Many of the recommendations made by the National Economic and Social Forum in this report have now been implemented. These included introducing legislation prohibiting discrimination and the establishment of an Equality Authority. Some progress has also been made towards the goal of

putting equality proofing procedures in place to address the impact of Government policies and programmes, although this is certainly an area which the Women's Health Council considers as needing more attention.

Equality Legislation

Equality is formally set out in legislation in Ireland under the terms of the Employment Equality Act, 1998 and the Equal Status Act, 2000. These outlaw discrimination in employment, vocational training, advertising, collective agreements, the provision of goods and services and other opportunities to which the public generally have access on nine distinct grounds. These are:

- Gender.
- Marital status.
- Family status.
- Age.
- Disability.
- Race.
- Sexual orientation.
- Religious belief.
- Membership of the Travelling Community.

Discrimination is described in legislation as the treatment of a person in a less favourable way than another person is, has been or would be treated on any of the above grounds.

The Equal Status Act 2000 enabled Ireland to ratify the UN Convention on the Elimination of all Forms of Racial Discrimination and to lift our reserve on the UN Convention on the Elimination of all Forms of Discrimination against Women.

Department of Justice, Equality and Law Reform

Much of the work on gender equality and proofing in Ireland has been carried out under the aegis of the Department of Justice, Equality and Law Reform. In 1999, the Department of Justice, Equality and Law Reform published a report on Gender Proofing and the European Structural Funds. Its specific focus was on women 'because women continue to be disadvantaged as a group' (p. 7). The report described gender proofing as a mainstreaming approach to gender equality, which has, at its heart, a concern that the target group should participate in the policy-making process.

NDP Gender Equality Unit

The NDP Gender Equality Unit provides an advisory, training and information service on issues relating to gender and the National Development Plan. It was established to support all implementing Departments and delivery agencies to meet the equal opportunity objective in their programmes, measures and initiatives. It also provides assistance to the Department of Justice, Equality & Law Reform in carrying out Gender Impact Assessments of policy proposals drawn up in the context of the National Development Plan (NDP). Funding of Ir£4 million has been allocated from the NDP for this purpose. The Unit's website contains information on mainstreaming of equality at policy level and has a databank of gender disaggregated statistics on areas covered by the National Development Plan. It can be found at: http://www.irlgov.ie/justice/equality/gender.

National Development Plan:
The National Development Plan 1994-1999 took an important first step towards gender proofing policies by requiring participation rates on particular programmes to be recorded by gender. However, gaps still existed which prevented gender proofing from being fully implemented in policy:

- It was unclear what criteria were to be used to assess the gender relevance of funded programmes and initiatives.
- The emphasis was on equality of opportunity rather than equality of outcome.
- The National Development Plan only related to structural programmes so data was only collected.

on gender in a limited number of 'relevant' programmes. From this, the impression was that gender issues were only relevant to human resources, training and local development issues; gender was not addressed in wider policy areas such as transport, tourism, agriculture or energy policy.

According to the NDP Gender Equality Unit of the Department of Justice, Equality and Law Reform, the new National Development Plan 2000-2006 should go about addressing some of these issues:
'It is Government policy that the National Development Plan 2000-2006 which involves the spending of over Ir£40 billion should support the achievement of equal opportunities between men and women. The goal of gender equality covers the whole Plan including infrastructure and productive investment as well as the regional, human resources and peace programmes. The Plan provides that project selection criteria must have regard to the equal opportunities objective.'[1]

Gender Impact Assessment Guidelines for the National Development Plan 2000-2006:
A set of Gender Impact Assessment Guidelines was adopted by the Cabinet in March 2000, which stated that the following steps must be completed with respect to almost every area of expenditure under the National Development Plan:

1. The current position of women and men in the area that the expenditure activity will address must be outlined.
2. The factors leading to women and men being affected differentially in the area to be addressed by the expenditure activity must also be covered.
3. Ways in which the factors leading to women or men being affected differentially could be addressed and changed should also be explored.

Department of Enterprise, Trade and Employment
The *Programme for Prosperity and Fairness* [2], published by the Department of Enterprise, Trade and Employment in February 2000, also contains a commitment to equality proofing.

Objectives identified in the Programme relating to equality include:

- The development of an effective equality infrastructure to support the achievement of equality objectives in the nine categories covered by equality legislation.
- Ensuring that the necessary institutional structures are in place and that they are enabled to play their role in eliminating discrimination and promoting equality.
- The development of arrangements, including administrative procedures, for mainstreaming equality issues.

1. Communication from Deirdre Blake of the NDP Gender Equality Unit, 04.05.01.
2. http://www.irlgov.ie/taoiseach/publication/default.htm

- Providing a range of supports for groups experiencing disadvantage and inequality.

Monitoring of outcomes from an equality perspective was one of the key requirements for equality proofing under the Programme. Gender equality, mainstreaming gender equality and the importance of collecting disaggregated data are specifically mentioned in the Programme. Issues around pay differentials between men and women and measures tackling gender segregation in the labour market are also covered in the Programme.

Gaps:
While the foundations for gender proofing of policy in Ireland have been laid, much remains to be done in order to ensure equality between the sexes, particularly in the area of health. The following barriers must be resolved in order to fully achieve this aim:

- Lack of sufficient funding to promote gender mainstreaming – insufficient investment in the development of a body of expertise across the policy making system which would enable gender mainstreaming to be fully and properly implemented.
- Need for comprehensive collection of gender disaggregated data, in order to make the situations of both men and women clear.
- More attention should be paid to the monitoring of gender equality within Irish national health policy. Specific targets should be developed, and time scales for their achievement and indicators of progress should be set.

B. Irish national policy on gender and health

Gender Specific Health Policy in Ireland
In 1993, the Second Commission on the Status of Women recommended that the Department of Health should respond to the concern that women's health needs were not always being met by the health services by publishing a policy document specifically on women's health.

A discussion document, *Developing a Policy for Women's Health* was published by the Department of Health in June, 1995. It looked at the health services from women's point of view and analysed the health status of women living in Ireland. It examined mortality and morbidity rates among women living in Ireland and identified ways of preventing premature mortality and increasing health and social gain for women. The priorities suggested in the document were:
- a reduction in smoking.
- the introduction of national screening programmes for breast and cervical cancer.
- improvements in the maternity services.
- better services for victims of domestic violence and rape.
- better access by Traveller women to health services.
- increased representation of women in the health services.
- increased research on many aspects of women's health.

The discussion document was used as the basis of a wide-ranging public consultation with organisations and individual women in 1995-6. The national consultation process on women's health

was initiated at national level on June 30, 1995, when a conference on the subject was held in Dublin by the Department of Health. Consultation at regional and local level was organised by Health Boards, in collaboration with the National Women's Council of Ireland (NWCI), the national representative organisation for women and women's groups in Ireland.

The Plan for Women's Health 1997-1999

The Plan for Women's Health 1997-1999 was the first specific policy aimed at taking gender considerations into account in health policy in Ireland. With its publication in 1997 by the Department of Health, Ireland became only the second country internationally, after Australia, to have a national policy specifically dealing with women's health.

The Plan for Women's Health 1997-1999 identified four main objectives:

- To maximise the health and social gain of Irish women.
- To create a woman-friendly health service.
- To increase consultation and representation of women in the health services.
- To enhance the contribution of the health services to promoting women's health in the developing world.

The Plan comprised a mix of affirmations of support for existing government strategies, broad aspirations for the development of women's health services and specific recommendations. For the most part, however, it did not contain timeframes for implementation or measures for the monitoring and evaluation of actions. Without indicators of success, accurate costing or explicit ring-fenced funding the Plan read as aspirational rather than as a blueprint for targeted action.

Since the Plan's timeframe ran out in 1999, no further government policy has been put in place specifically aimed at women's health. Instead, sections on women's and men's health have been included in mainstream National Health Strategy and policy documents, for example in *Quality and Fairness; A Health System for You Health Strategy (2000) and in the National Health Promotion Strategy 2000-2005*.

The Women's Health Council

One of the recommendations in the Plan was that a Women's Health Council be set up as 'a centre of expertise on women's health issues, to foster research into women's health, evaluate the success of this Plan in improving women's health and advise the Minister for Health on women's issues generally.'

The Women's Health Council is a statutory body established in 1997 to advise the Minister for Health and Children on all aspects of women's health. The mission of the Women's Health Council is to inform and influence the development of health policy to ensure the maximum health and social gain for women in Ireland. Its membership is representative of a wide range of expertise and interest in women's health.

The Women's Health Council has five functions detailed in its Statutory Instruments:

1. Advising the Minister for Health and Children on all aspects of women's health
2. Assisting the development of national and regional policies and strategies designed to increase health gain and social gain for women.

3. Developing expertise on women's health within the health services.
4. Liaising with other relevant international bodies which have similar functions as the Council.
5. Advising other Government Ministers at their request.

The work of the Women's Health Council is guided by three principles:
- Equity based on diversity – the need to develop flexible and accessible services which respond equitably to the diverse needs and situations of women.
- Quality in the provision and delivery of health services to all women throughout their lives.
- Relevance to women's health needs.

In carrying out its statutory functions, the Women's Health Council has adopted the WHO definition of health, a measure reiterated in the Department of Health's 'Quality and Fairness' document (2001). This definition states that 'Health is a state of complete physical, mental and social well being'.

Men's Health Policy

The first specific mention of men's health was made in the National Health Strategy, *Quality and Fairness*, published by the Department of Health & Children in 2001. The Strategy called for a policy on men's health and health promotion to be developed. The National Health Promotion Strategy 2000-2005 also identified the development of a national plan for men's health as an important initiative. Research carried out in the North Eastern Health Board in 2001 indicated a need to raise awareness about men's health issues and to encourage men to actively seek screening and to seek timely medical help. The Department of Health and Children have taken the lead role in beginning to prepare a policy for men's health in partnership with the health boards and other agencies. Work commenced on the development of this policy in January 2004, when a consultation meeting was convened in association with the relevant stakeholders.

Men's Health Forum

The Men's Health Forum in Ireland (MHFI) is an important stakeholder in this process. It is a voluntary network of individuals and organisations, men and women, working to collate the key concerns relating to men's health on the island of Ireland and to increase understanding of these issues. The mission of the MHFI is to promote, influence and enhance all aspects of the health and well-being of men and boys on the island of Ireland.

Its principal objectives are:
- the advancement of the education of the general public in all matters relating to men's health and in particular, but not exclusively, by providing information, commissioning and disseminating research, and providing education on men's health and associated issues to health professionals and the general public.
- the preservation and protection of men's health.

The Forum recognises the right of everyone to good health regardless of age, gender, sexual orientation, disability, race, culture, religious or political affiliations.
In January 2004 the Forum published *Men's Health in Ireland*, a comprehensive overview of key statistics on men's health on the island of Ireland. Key findings of the report included the fact that men in Ireland die, on average, nearly six years younger than women do, and have higher death rates

at all ages, and for all leading causes of death (McEvoy & Richardson, 2004). Evidence of sex differences in the incidence, symptoms, and prognosis of a wide range of health problems were documented. The report also noted that men engage in a range of risk behaviours that can be seriously hazardous to their health and that many men do not seek help for any health problems they may be experiencing unless prompted to do so by female relatives/spouses.

National Planning Forum on Women's Health

The National Planning Forum for Women's Health was established in 2002 in the period following the publication of the Women's Health Council position paper *Promoting Women's Health*. The position paper critically reviewed the *Plan for Women's Health (1997-99)* and made proposals to focus the women's health agenda for the 21st century. Central among the proposals was a new orientation to ensure gender equity in health services and initiatives. This gender mainstreaming approach marked a departure from the previous emphasis on a national plan specific to women's (or men's) health.

This approach meant that rather than specifically focusing on women's health alone, the Forum explored the significance of integrating a gender dimension into policies, programmes and projects at national and regional level. It confirmed the need to integrate a gender dimension into policy-making at a high level and at a policymaking level. However, while work is continuing on the inclusion of a gender dimension in health planning and delivery, the Forum recommended that this should take place alongside positive actions or women/men-only actions, as part of a twin-track approach to main-streaming gender considerations across health policy. The Forum considered this measure necessary in light of the timescale needed to properly establish and evaluate gender mainstreaming protocols.

The Forum identified gender impact assessment as a new and urgent need in gender mainstreaming strategies in health policy, planning and programmes.

The availability of data on sex differences in health risks, health policies and health outcomes was given particular attention as a mode of quantifying the rationale for gender impact assessment. The Forum recommended having the maximum feasible volume of gender disaggregated data in all spheres of health policy and programmes of research, promotion, care and treatment. Once gendered data becomes available, it will be possible to form gender-specific programme/service/activity targets for programmes in quantifiable terms of users/patients/activity rates/plans.

The difficulty in making the 'business case' for application of gender policies in the health services in the absence of gender disaggregated data was noted by Forum members. Performance indicators were viewed as crucial in delivering a more responsive and effective health service to the entirety of populations served. Paradoxically, in the absence of gender disaggregated data, performance indicators are difficult to construct. Forum participants expected performance indicators for gender to be present, or in development, at this significant moment of health service restructuring and publications of health service reviews. At the time of the Forum's discussions, there was no evidence to confirm that such a development process was occurring, despite Ireland's commitment to gender mainstreaming.

In its Interim report, submitted to the Minister for Health & Children in December 2003, the Forum insisted on the importance of gender impact assessment, gendered performance indicators and

gender-disaggregated data to advance the increased consideration of gender in health policy. This was integrally linked to the need for Performance Indicators in the gender and health field. However, it is not possible to have Performance Indicators without gender disaggregated data being available as a first step in the gender impact assessment process.

The integration of attention to gender in cardiovascular health policy

The Cardiovascular Health Strategy

The Cardiovascular Health Strategy Group was established by the then Minister for Health and Children, Mr. Brian Cowen, T.D., in March 1998:

> *'…to develop a strategic approach to reduce avoidable death and illness caused by cardiovascular disease. The Group will engage in a wide-ranging consultation process and make recommendations on the development and implementation of an integrated strategy to improve cardiovascular health.*'

The establishment of the Cardiovascular Health Strategy Group was part of an overall initiative on cardiovascular health and cardiac services announced by the Minister in January 1998. The Group was made up of twelve members, six men and six women, mainly working in the field of health. It included cardiologists, a GP, a nurse, a hospital manager, a specialist in public health medicine, a professor and a manager of health promotion, a coordinator of cardiac rehabilitation, and three civil servants from the Department of Health & Children. The establishment of the Cardiovascular Health Strategy Group to investigate heart health in Ireland and develop a policy to deal with the high levels of mortality was an innovative move at the time.

Policy Context

The national health strategy, *Shaping a Healthier Future* (1994), set out the principles and provided direction for the development of the strategy for cardiovascular health. It stressed the importance of equity of access to health care, the provision of a high quality service and of accountability. In line with *Shaping a Healthier Future* the recommendations of the Cardiovascular Health Strategy Group were guided by the following basic principles:

- Health and Social Gain.
- Equity of Access.
- Quality.
- Effectiveness and Efficiency.
- Accountability and Audit.

Working Methods

As part of its brief to develop a national policy on cardiovascular health, the Group engaged in a consultation process that aimed to include stakeholder groups in the area. Written submissions were invited and representatives from many organisations met with the Group. In addition, members of the Group made a number of site visits. Questionnaires were circulated to hospitals caring for patients with cardiac problems inquiring about the type and volume of diagnostic and treatment services provided and about the level of cardiology staffing. An Implementation Group was established within

the Department of Health and Children in order to facilitate the work of the Strategy Group and the implementation of its recommendations.

The two progress reports were produced by the Heart Health Task Force, the group set up to review the objectives proposed and to monitor the implementation of the recommendations contained in the Strategy. The Task Force was made up of a total of twenty-nine members, seven of whom were women. Members were drawn from several government departments, including Health & Children; Finance; Social, Community & Family Affairs; Education & Science; Tourism Sport & Recreation; also CEOs of Health Boards, representatives from relevant voluntary sector organisations, and trade union, employer, public and academic interests.

The Strategy

Building Healthier Hearts, the Irish National Strategy on Cardiovascular Health, was published in July 1999 by the Department of Health & Children. The full report contained 150 pages of text, complete with 211 recommendations and full references. The report was made up of ten chapters. The first five set out the background to the Strategy and relevant issues around cardiovascular disease in Ireland. The next five chapters set out the situation for each sector with a role in cardiovascular disease management. The 211 recommendations made by the Group were divided into four areas:

1. Standardise care in the pre-hospital and hospital settings across health boards
2. Establish a protocol for appropriate primary care
3. Ensure an effective surveillance system
4. Expand or put in place settings-based health promotion programmes

The two Progress reports, *Heart Health Task Force First Progress Report July 1999-June 2001* and *Ireland's Changing Heart; Second Report on the Implementation of the Cardiovascular Health Strategy 1999-2002*, were structured in much the same way as the original strategy document. *Heart Health Task Force First Progress Report July 1999-June 2001* contained 44 pages of text including appendices, and focused solely on setting out progress on each of the recommendations in the two years since the Strategy was launched. *Ireland's Changing Heart* was a more substantial document, with a total of 128 pages broken into similar chapter headings as the original *Building Healthier Hearts* document.

Gender analysis of the Irish National Strategy for cardiovascular health: Findings

Both *Building Healthier Hearts* and *Ireland's Changing Heart* included detailed gender disaggregated data on many of the important variables in the area of heart health. For example, *Building Healthier Hearts* presented detailed gender specific data on mortality and morbidity rates of cardiovascular disease in Ireland and in the different regions in the country in chapter 4. The report noted, for example, that in 1997 cardiovascular disease was the main cause of death for men under the age of 65 and the second highest cause of death in women under 65. It also noted that death rates were 16% and 15% lower in men and women respectively in 1991- 1993 compared to 1970 - 1972. *Ireland's Changing Heart* provided updated figures for these variables and also presented detailed gender disaggregated data on people discharged with a diagnosis of CHD and on surgical procedures for CHD in a series of tables and graphs in chapter 2. The *Heart Health Task Force First Progress Report* was a less detailed document, but in describing the NICO anti-smoking campaign it demonstrated that health promotion initiatives were drawing on the gender-disaggregated research data available. The NICO anti-smoking campaign was developed in response

to the increased prevalence of smoking among teenage girls and young women in Ireland at the time.

In spite of the amount of gender disaggregated data available, however, content analysis of the *Building Healthier Hearts* document, together with its two follow-up reports, revealed that the Irish cardiovascular health strategy did not appear to have been developed with gender in mind (full analysis is included in Annex 2). No references to gender were included in any of the recommendations made in the reports and the language used was gender neutral for the most part. In the text, 'men' and 'women' were replaced by 'patients', 'clients', 'individuals' and 'consumers'.

The Appendices of the *Heart Health Task Force First Progress Report July 1999-June 2001* included a summary of the actions taken as a result of the recommendations made in *Building Healthier Hearts*. This showed clearly that gender was not a consideration in the recommendations. The only section that made any reference to gender was the NICO anti-smoking campaign, and that was specifically targeted at young women alone, rather than considering the needs of young women and young men.

The second progress report, *Ireland's Changing Heart*, seemed to have concentrated more on socio-economic than gender considerations, focusing on inequalities due to social class rather than due to gender. Although 'Reducing Inequalities' was identified as a Future Challenge for the Strategy, it referred to inequalities caused by poverty and not by gender. 'Targeting disadvantage' was a goal of Health Promotion, but this referred to 'disadvantaged communities', 'people on low incomes', 'people from disadvantaged areas', 'Travellers', 'asylum seekers', 'disadvantaged people' with no reference to gender.

The interview with the National Heart Health Advisor confirmed that gender was not a concept that was systematically taken into account in developing the Strategy and that gender experts were not involved in the development of the Strategy. It emerged from the interview that geographical access rather than gender considerations was at the heart of the commitment to 'Equity of Access' presented in the *Building Healthier Hearts* document. The lack of services for cardiovascular health available in Ireland at the time should be taken into account in this regard. At the time the policy was developed service provision in Ireland was relatively poor for both women and men, and there was considerable variation in service provision across different regions in Ireland - access to services was particularly bad in the Western region. This meant that the most pressing need from the point of view of the policy-makers was geographic equity and improving service provision generally, and this was reflected in the original strategy document, and hence in the progress reports. The Cardiovascular Strategy was an innovative document at the time, particularly in respect to the holistic approach it took to cardiovascular health service provision. As well as addressing the acute care needs of cardiovascular patients, the Strategy also addressed needs in the primary care and rehabilitation areas, something that had not previously been done in Ireland.

A breakdown of the results is presented in the Matrix below. Full analysis is included in the Annex 2 to this report.

Matrix for reporting results of assessment of the attention to gender considerations in the development of specific health policies

Title of the policy: Building Healthier Hearts (1999)				
	Gender considerations included	**Enabling factors**	**Gender considerations not included**	**Barriers**
Objectives	'Equity' was one of the factors the Cardiovascular Health Strategy Group was expected to take into account on advising on services.	Principles set out *in Shaping a Healthier Future* (National Health Strategy, 1994) included Equity of Access. Thus *Building Healthier Hearts* stated that "Access to services should be on the basis of need. Patients should not be restricted in their access to a service because of their income or ability to pay, or because of their place of residence, gender or age" (p10).	Gender was not built in to the Strategy as a baseline measure. Rather it was one of a range of factors (including income, place of residence and age) that had to be considered.	Seems to have been a lack of awareness of the importance of gender as a determinant of health at the time (late 1990s).
Stages of policy development • **Problem Description**	Referred to CVD as an important cause of sickness and death "in Irish men and women" (p14). No specific reference to gender Concern at the time was with equity of access to services and with expanding a previously underdeveloped cardiovascular health service base.	Strategy presents rich gender-specific information on mortality and morbidity rates and detailed discussion of the health service structures put in place to deal with the disease. E.g. The majority of the data presented in Chapters 4 (Cardiovascular Diseases in Ireland) & 5 (Health Promotion) were broken down according to gender.	- Strategy document made no attempt to debunk the common notion of cardiovascular disease as a mainly male phenomenon E.g. Male symptoms are quoted as being the norm: "In the typical history, there has been severe and sustained chest pain or discomfort" (p.15). Women may not experience chest pain, but rather a range of conditions such as neck, shoulder or abdominal discomfort, dyspnea, fatigue, nausea or vomiting. - Gender disaggregated data not available for all variables discussed	- Gaps still exist in the availability of gender-specific research/data in the area of cardiovascular health - Lack of awareness of women's experiences of CVD (perhaps also partly explained by the lack of research/data). - Lack of awareness of the importance of gender as a determinant of health
• **Planning**	Gender is not included in any consistent way, although differences between men and women are noted in some places. E.g. "In a 1992 study of Irish CCUs it was shown that…men received thrombolytic treatment more often than women…" (p95) "HIPE data show lower provision of angiography, PTCA and CABG for women compared to men. This may be partly accounted for by lower need for	Gender-disaggregated data seems to be available for most of the variables relating to services (e.g. mortality, treatment rates, hospitalisation rates etc).	Although many of the chapters contained detailed data on the different experiences of women and men around cardiovascular health and health services, the implications of these differences were not drawn out. **No references to gender/gender differences were included in any of the recommendations made in the Strategy.**	Lack of awareness of the importance of gender as a determinant of health.

	these procedures in women compared to men, particularly in younger age groups. It is recognised that women have higher in-hospital mortality than men after AMI even after adjustment has been made for age and other baseline characteristics. At least some of these differences are likely to reflect the sub-optimal treatment of women compared to men" (p105)			
• **Implementation**	No	N/A	No specific reference to gender in any of the implementation measures put forward in the document	Lack of awareness of the importance of gender as a determinant of health.
• **Monitoring**	Not explicitly	Gender differences were referred to in the text of the Strategy in a number of chapters, and Chapter 5 referred to the need for health impact assessment to be carried out when other government departments & agencies are formulating policy. It would thus only be one step further to introduce the notion of gender impact assessment for future policy in the area	No specific reference to ensuring gender-proofing of data and research on the area of cardiovascular health was included.	Lack of awareness of the importance of gender as a determinant of health.
Process Characteristics • **Gender experts included in policy development**	No	The Cardiovascular Health Strategy Group was balanced according to gender – 6 men and 6 women	Submissions were invited from key stakeholders but existing gender-based groups (e.g. the National Women's Council of Ireland) were not included	- The Cardiovascular Health Strategy Group was made up of mainly medical personnel - Lack of awareness of the importance of gender as a determinant of health

Title of the policy: Heart Health Task Force First Progress Report July 1999-June 2001 (2001)				
	Gender considerations included	**Enabling factors**	**Gender considerations not included**	**Barriers**
Objectives	No	*Building Healthier Hearts* contained a commitment to 'equity of access' :	Report aimed solely at presenting progress made on implementing the recommendations of the *Building Healthier Hearts* report.	Recommendations in *Building Healthier Hearts* did not contain any specific reference to gender, therefore this report did not either.
Stages of policy development • **Problem Description**	No specific reference to gender	A National Conference for stakeholders was held in Dublin Castle on 5th Nov. 1999, to discuss the *Building Healthier Hearts* report. 'Eliminating equalities' was one of the workshop topics on the day but it is not clear if gender inequalities were specifically mentioned.	As for *Building Healthier Hearts* report	As above
• **Planning**	No	N/A	As for *Building Healthier Hearts* report	As above
• **Implementation**	NICO anti-smoking campaign – 'Given the concern about the increased prevalence of smoking among teenage girls and young women, a special component of the Break the Habit campaign was developed during 2000 to target teenage girls and was partly funded by the Strategy.' (p15).	Gender specific data was presented to provide a rationale for the campaign: - by the age of 15 years more girls smoke than boys - girls are less likely to quit when they are addicted - by the age of 17, 40% of girls (28% of boys) from low income backgrounds are smokers	No specific reference to gender in any other implementation measures	Since *Building Healthier Hearts* did not contain any specific reference to gender, therefore overall this report did not either.
• **Monitoring**	No	N/A	No reference to ensuring that gender was a concern when monitoring progress in the area.	As above – lack of emphasis on gender in the original Strategy document meant that it was not a concern for the progress report either.
Process Characteristics • **Gender experts**	No	N/A	Gender balance of the Heart Health Task Force was not as even as that of the Cardiovascular Health Strategy Group	N/A

Title of the policy: Ireland's Changing Heart; Second Report on the Implementation of the Cardiovascular Health Strategy 1999-2002 (2003)				
	Gender considerations included	**Enabling factors**	**Gender considerations not included**	**Barriers**
Objectives	- No specific commitment to 'equity' in this report, but it presumed that the principles set out in the other documents were apply here too. - No specific reference to gender.	*Building Healthier Hearts* stated that "Patients should not be restricted in their access to a service because of their income or ability to pay, or because of their place of residence, gender or age" (p10).	As with the Building Healthier Hearts document, gender was not built in to Ireland's Changing Heart as a baseline measure	Lack of emphasis on gender in the original Strategy document meant that it was not a priority for this progress report either.
Stages of policy development • **Problem Description**	No specific reference to gender	Presents gender-specific information on mortality and morbidity rates - the majority of the data presented in Ch. 2 (Epidemiology of cardiovascular diseases in Ireland) is gender disaggregated Some gender-specific information is also presented in Ch.4 (Health Promotion). E.g. Under Diet and Nutrition, the report noted that in 2001/2002 the focus of the National Healthy Eating Campaign 'was specifically on heart health and aimed to raise awareness among women in particular' (p50).	- Gender disaggregated data not presented for all variables discussed e.g. prescriptions, overweight, physical activity, alcohol, blood pressure, schools, targeting disadvantage, etc. In some cases this information would have been available from the SLÁN study. - Section on Inequalities under *Implications of Changing Epidemiology*, but focuses on inequalities due to social class rather than due to gender: '…in the south of Ireland death rates from circulatory diseases were almost three times higher in the semi- and unskilled working classes compared to professionals' (p27). Report also noted that 'the prevalence of heart failure in the oldest age groups has increased greatly' but did not note the implications this has for women, who live longer than men - There was no information on men's needs in relation to healthy eating, in spite of the fact that Building Healthier Hearts had noted that 'one in three young unskilled males frequently ate fried food' (1999: 55) and that 'Groups in need of nutrition advice and support are likely to be young men, those in manual occupations, those on low incomes and disadvantaged minorities'.	- Gender-specific research/data still not available for all variables? - Continuing lack of recognition of the importance of gender as a determinant of health

• **Planning**	No	In Ch.4 (Health Promotion), under 'Resources and their Management' the report states that the findings of health and lifestyle surveys of the population (e.g. SLÁN) to be used 'for planning and evaluation of health promotion interventions' (p44). There is no specific reference to the gender differences noted in the SLÁN study, however.	No references to gender/gender differences were included	- Continuing lack of recognition of the importance of gender as a determinant of health - Lack of emphasis on gender in the original Strategy document
• **Implementation**	No	-'The first three years of implementing the Cardiovascular Health Strategy has seen a substantial increase in cardiology prevention and treatment services. Through the implementation of the Strategy, these services are already making a difference, providing more accessible, equitable, better quality care for patients with cardiac conditions' (p103). No reference to gender considerations, however. -'Reduce Inequalities and 'Equitable Access to Services' put forward as key challenges facing the future implementation of the Cardiovascular Health Strategy (p104).	- No specific reference to gender in any of the implementation measures put forward in the document -No explicit mention made of reducing inequalities between men and women or of ensuring the men and women have equal access to services.	As above
• **Monitoring**	Not explicitly	N/A	Ch. 10 includes a section on "The Way Forward: Monitoring, Evaluation and Consultation" but within this there is no specific reference to ensuring gender-proofing of data and research on the area of cardiovascular health was included.	As above
Process Characteristics • **Gender experts included**	No	N/A	Gender balance of the Heart Health Task Force was not as even as that of the Cardiovascular Health Strategy Group	Continuing lack of recognition of the importance of gender

Discussion and conclusions

The *Building Healthier Hearts* Strategy document and its two follow up reports are valuable resources in considering patterns of cardiovascular disease in Ireland. They present rich gender-specific information on mortality and morbidity rates from the disease and detailed discussion of the health service structures put in place to deal with the disease. As this is a retrospective study of the Strategy, it is important to note the context in which it was developed. At the time, cardiovascular health services in Ireland were relatively undeveloped, with wide variation in service provision in different areas of the country. This meant that geographical equity of access to services was the over-riding concern of policy-makers at the time.

The overall conclusion reached after completing the content analysis, however, was that the Strategy was limited in its consideration of gender. Although many of the sections of the reports contained detailed data on the different experiences of women and men around cardiovascular health and health services, the implications of these differences were not drawn out in the Strategy. No references to gender were included in any of the recommendations. This meant that there was a significant gap between the information regarding gender differences presented in the documents and the practical recommendations made in Ireland's Cardiovascular Health Strategy.

In addition, gaps in gender-specific information were also found to exist in some areas of the strategy, suggesting that further gender-specific and gender-disaggregated research is required in Ireland. A significant cause for concern here was the neglect of women's experience of the symptoms of cardiovascular disease. The report focused almost exclusively on 'chest pain' to the neglect of any of the range of conditions women can experience as indicators of the disease, such as neck, shoulder or abdominal discomfort, dyspnea, fatigue, nausea or vomiting. Sections on "Information Systems, Audit and Research" were included in all three reports, but no specific reference was made to ensuring that data and research on the area of cardiovascular health were gender-proofed/sensitive.

The fact that gender was not a baseline concern for either of the progress reports is probably a reflection of the lack of emphasis on gender in the original *Building Healthier Hearts* document. It demonstrates the importance of building in gender from the beginning of the policy/strategy development – if gender is not included in the initial strategy document then it is unlikely to be an issue for any follow-up actions or reports.

There are reasons for optimism, however. The Cardiovascular Strategy in Ireland is not set in stone, but seems to be quite flexible and open to improvement. The National Heart Health Advisor recently announced that a new Cardiovascular Health strategy is currently in development, presenting a key opportunity for the findings of the present study to be incorporated into policy making in a meaningful way. In line with other areas of health policy in Ireland, the focus of the new Cardiovascular Strategy may be on inequalities in health, particularly those related to socio-economic concerns. This being the case, it will be important to point out the 'gendered face' of poverty, and again draw attention to the need to include the gender dimension in developing policy. In addition, both *Building Healthier Hearts* and *Ireland's Changing Heart* referred to the need for health impact assessment to be carried out when formulating policy, so it would only be one step further to introduce the notion of gender impact assessment for future policy in the area.

Since the original cardiovascular health strategy document was developed and published, the Women's Health Council has expanded, and the Men's Health Forum in Ireland has been set up. Both are working to promote gendered notions of health and will continue to contribute to raising awareness in the area. The Women's Health Council has fed the findings of its *Women and Cardiovascular Health* report and of the *Women, Disadvantage and Cardiovascular Disease: Policy Implications* conference into the Department of Health & Children and to key relevant stakeholders in the area. The Council recently contributed to a document being produced for the EU Council of Ministers, and pointed out the importance of including gender in cardiovascular health policy. The Council stated that:

> *"Recent international research found gender to have a significant biological and social effect on the incidence of cardiovascular disease across the life course. An inverse relationship was also found to exist between disadvantage and cardiovascular disease.*
> *The importance of gender and the different patterns of risk for men and women across the life - course should be taken into account in addressing cardiovascular disease including early life influences. An inter-sectoral approach using gender sensitive polices is required to address the link between cardiovascular disease and disadvantage."*

It is hoped that all of this work, together with an increased awareness overall of the importance of mainstreaming gender within health policy, will lead to an improved situation in the future. The present work of the WHO in developing a tool kit for gender mainstreaming will make a substantial and much-needed contribution towards this goal.

Limitations of the present study:
The timeframe presented a distinct limitation to the present study. If more time had been available, many other documents could have been included, for example health board heart health documents, Health Promotion Department heart health materials, additional reports drawn up by the Heart Health Task Force and by the Advisory Forum on Cardiovascular Health and materials from two other conferences on heart health held in Ireland recently. Time limitations also meant that only one interview was possible – interviewing additional stakeholders for example staff of Heartwatch (general practice prevention programme), or from other stakeholder groups might have produced other interesting findings.

Recommendations

To the Irish Government:

- It is essential that gender is recognised as a health determinant that is as significant as social origin, economic situation and ethnic origin. In order to achieve the maximum efficiency, policy/strategy/programmes must be developed in a gender sensitive manner.
- Effective targets and timetables for action on Gender Mainstreaming must be clearly established within a specially formulated implementation strategy. Gender mainstreaming policy measures already endorsed by Government must be fully resourced and implemented across all government departments/agencies without delay.

- Attention must be paid to gender equity in relation to the prevention, treatment and management of cardiovascular disease. Measures must be put in place to increase awareness about the incidence of cardiovascular disease among women, for both women themselves and their physicians. Appropriate gender sensitive diagnostic measures should be introduced.
- All research should be carried out in a gender sensitive manner and results should be fully disaggregated by gender.

To the WHO:

- The WHO should encourage Governments to recognise gender as a cross-cutting variable that underlies all other social and health issues, such as disadvantage or ethnic/social origins.
- More work is required to develop effective tools for the implementation of gendered policies. Since Gender Mainstreaming has the ability to transform systems rather than tailor them to individual circumstances, work is necessary to connect this process to communities on the ground.
- The gender balance of sampling frames within clinical research on cardiovascular disease nationally and internationally needs to be addressed so that data can be gathered to inform gender specific prevention, detection, treatment and rehabilitation programmes. All research should be carried out in a gender sensitive manner and its results should be fully disaggregated by gender.

6

Integrating a gender perspective into cardiovascular health policy in Croatia

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In the Republic of Croatia, gender equity is one of the fundamental precepts of the constitution. It is promoted by a number of national laws that regulate specific activities, such as work, health care, pension insurance, etc. In July 2003, the Gender Equality Act was signed. The government also signed the international Convention on the Abolition of Every Type of Discrimination Against Women (CEDAW) and ratified the Supplementary Facultative Protocol of this convention in 2001. Provisions banning sex discrimination have been incorporated into the Agreement on Stabilization and Association with the EU.
In its national legislation and international agreement policies, (including health policies) the Croatian government is committed to promoting gender equality. Until recently, the main focus of gender and health policy has been on the improvement of *women's* health (reproductive health) and violence prevention. Indeed, some important improvements have been made. However, there is as yet little experience with the "gender mainstreaming" of policies in other areas of public health.
In the last decade, cardiovascular diseases have been the leading cause of death in Croatia for both men and women. For this reason, the Croatian Institute of Public Health (the main source of health information in the country and important in health policy development and implementation) saw fit to look at gender in cardiovascular health in order to assess the role gender equity plays in health policy. As in other European countries, several recent policies and programmes have been developed to promote cardiovascular health and to prevent premature mortality. However, gender mainstreaming was not a deliberate strategy during the development of these policies and programmes. This project seeks to assess what is needed to draw attention to sex and gender issues in further developments on existing cardiovascular health policies and programmes.

Methodology

The methodology used in this project was suggested by the guidelines received from WHO. Current cardiovascular health policies and programmes in Croatia were analyzed using the following questions:

1. What data were available on sex and gender differences in cardiovascular disease (CVD) during the development of the policies and programmes? (e.g, on mortality, morbidity and risk factors for CVD)
2. How have gender issues been included in the development, implementation and subsequent monitoring of the National CVD Prevention Programme?
3. What were obstacles for acknowledging gender issues?
4. What recommendation can be made based on the results of this study to integrate an awareness of gender into cardiovascular health policy and practice?

To answer the first question, epidemiological data on age and sex specific CVD related mortality and hospitalization rates were reviewed. These data were found in the Croatian Institute of Public Health and in the family medicine case register. Some results from the National health survey on risk factors for CVD were also available. Most of this information was available at the time when the cardiovascular health policies were drafted.

To answer the second question, a content analysis of the main documents on current cardiovascular health policies in Croatia was conducted. These policies include: The Health Care Plan, the Croatian Health Care Measure Programme, and the National Cardiovascular Diseases Prevention Programme.

To answer the third question, interviews were conducted with leading experts on cardiovascular health who were involved in the preparation of the National Cardiovascular Disease Prevention Programme. A special questionnaire was prepared to interview these experts about their observations on gender differences in CVDs and about their opinions on the necessity of a gender specific cardiovascular health policy (see annex 1).

The answer to the fourth question, the recommendations made based on the results of the study, is available at the end of this paper.

Questions One:
What data are available on sex and gender differences in cardiovascular health?

CVD mortality and morbidity in Croatia
In 2002, the leading causes of death in Croatia were cardiovascular diseases (52.8% of the overall mortality), neoplasms (24.0%), injuries and poisoning (5,4%), diseases of the digestive system (4.7%) and diseases of the respiratory system (4.2%).

The *"years of life lost"* (YLL) indicator, or the years lost to a premature death, allows one to differentiate between the causes of premature deaths in adults. In 2002, the greatest number of years were lost to neoplasms– 105195 years (M 46,366, F 49,214). The corresponding mortality rates were 274.0, (M 333.2, F 219.0) per 100,000 (Table 1) Although the YLL for cardiovascular diseases (T 99622, M 46,224, F 43,301) were similar to those for neoplasms, cardiovascular mortality rates were considerably higher, i.e., 601.6 (M 560.8, F 639.5) per 100,000 population. The indicators imply that people dying of neoplasms were younger on average than those dying of cardiovascular diseases. The next leading YLL indicators were injuries (54,557 years; 61.0 mortality rate) and traffic accident injuries (20,557 years; 14.4 mortality rate). In the latter case, the YLL and mortality rates for men were higher than for women.

Table 2 shows the cardiovascular mortality rates by diagnostic group and sex.
Table 3 shows total hospitalization rates for CVD by diagnostic group and sex.

Table 1. General mortality rate (per 100,000) and estimated YLL (years of life lost) for individual disease groups in Croatia, 2002

Disease group	Total		Males		Females	
	Rate	Years of life	Rate	Years of life	Rate	Years of life
Neoplasms	274,0	105 195	333,2	46 366	219,0	49 214
Cardiovascular diseases	601,6	99 622	560,8	46 224	639,5	43 301
Injury total	61,0	54 557	84,4	37 868	39,3	12 251
Traffic injuries	14,4	20 557	24	15 222	5,5	3 774
Diseases of the digestive system	53,9	25 230	71,7	14 195	37,5	7 904
Diseases of the respiratory system	47,4	9 662	57,7	5 055	37,9	3 611

Source: National Bureau of Statistics; Croatian National Institute of Public Health.
Years of life lost were calculated per anticipated lifespan based on the 2002 overall Croatian mortality rate

Table 2. CVD deaths by diagnostic group and sex, Croatia 2002

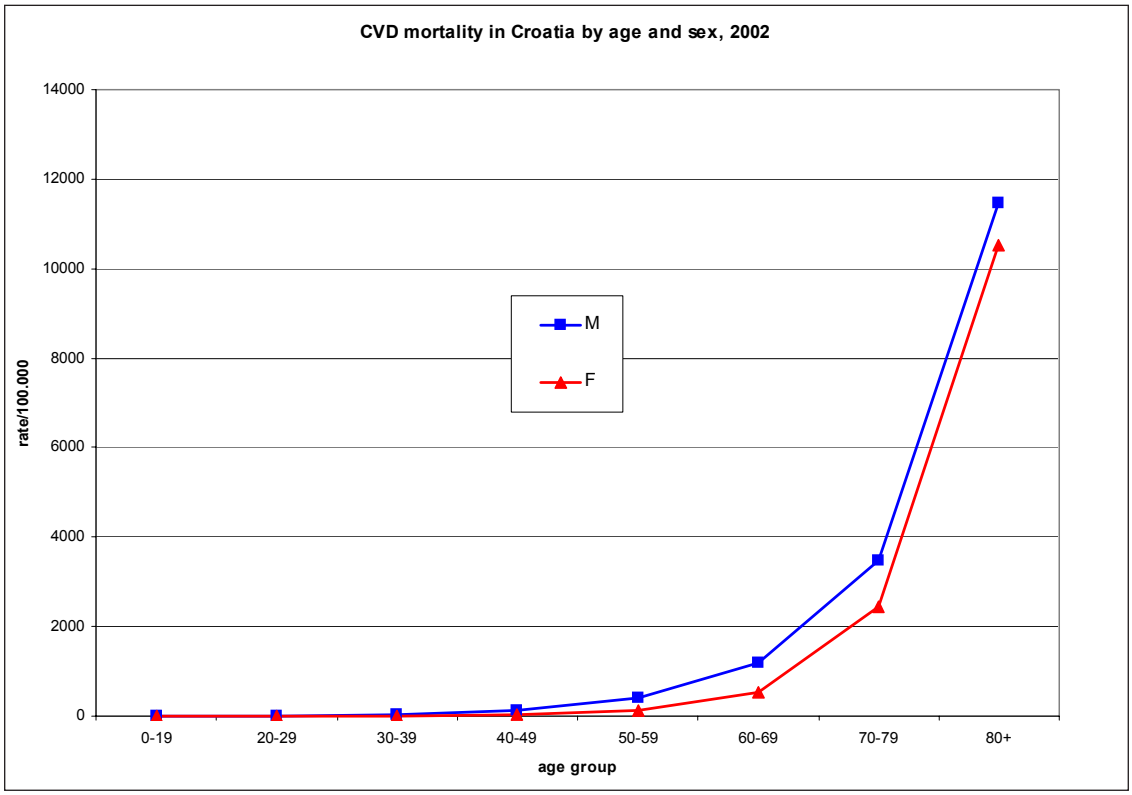
DIAGNOSES	Female		Male	
	Number	Rate/100,000	Number	Rate/100,000
Hypertensive diseases	494	21.46	293	13.72
Ischaemic heart diseases	4402	191.26	4427	207.27
- Acute myocardial infarction	1720	74.73	2603	121.87
- Chronic ischaemic heart dis.	2564	111.40	1576	73.79
Heart failure	2007	87.20	1384	64.80
Cerebrovascular diseases	4753	206.51	3616	169.30
Atherosclerosis	615	26.72	282	13.20
Cardiovascular diseases - total	14719	639.52	11979	560.84

Source: Croatian Central Bureau of Statistics; Croatian National Institute of Public Health

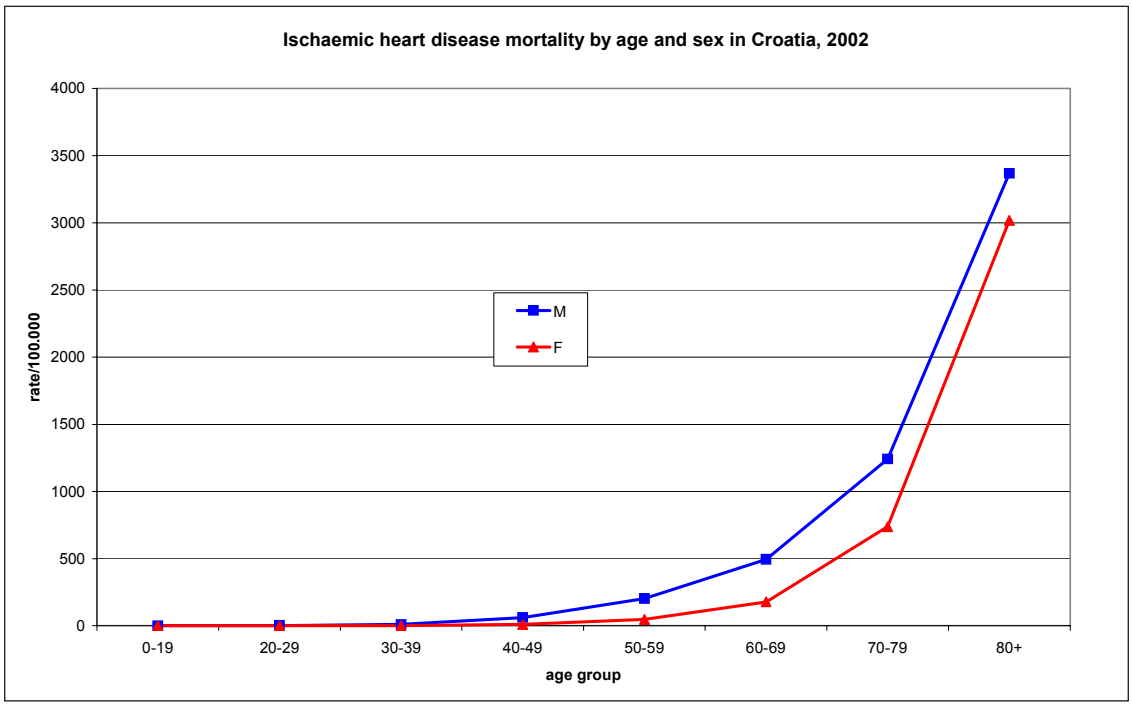
Total mortality rates from cardiovascular diseases are higher for women (639.5/100,000) than for men (560.8).

However (as is shown in pictures 1-3,) for every age group, specific mortality rates are higher for men than for women.

Picture 1



Picture 2



Picture 3

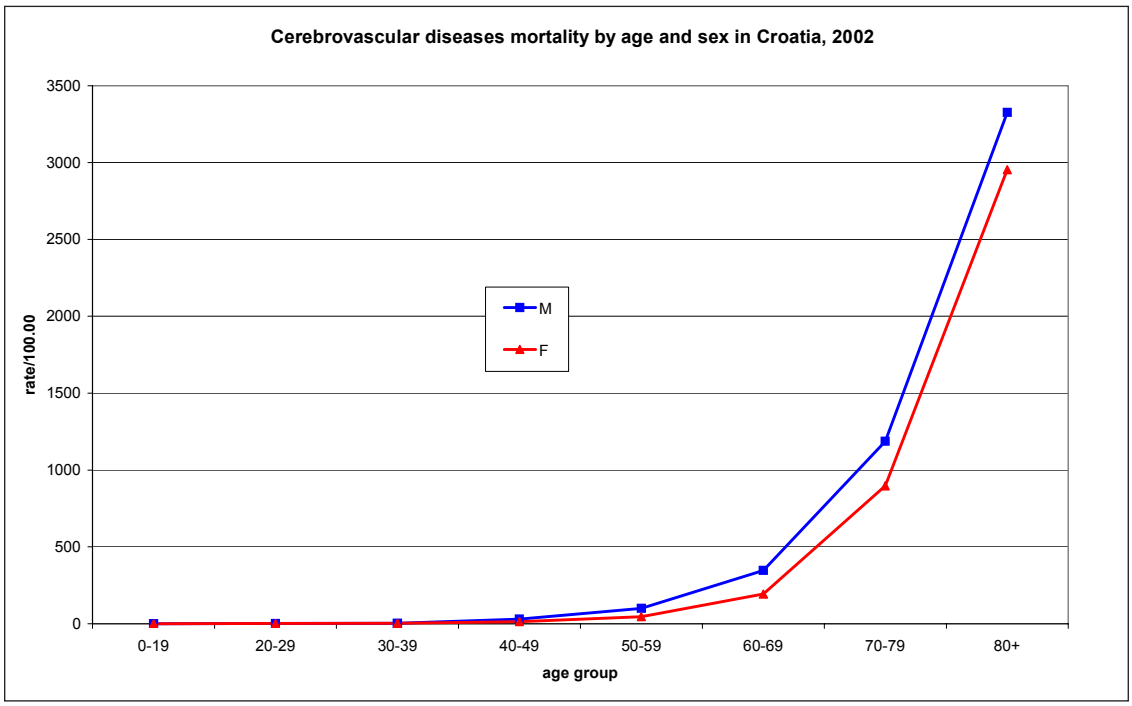


Table 3 CVD hospitalizations by diagnostic group and sex, Croatia 2002

DIAGNOSES	Female		Male	
	Number	Rate/100,000	Number	Rate/100,000
Hypertensive diseases	4261	185.13	2363	110.63
Ischaemic heart diseases	7817	339.63	12536	586.91
- Acute myocardial infarction	2090	90.80	3435	160.82
- Chronic ischaemic heart dis.	2213	96.15	3742	175.19
Heart failure	2970	129.04	2435	114.00
Cerebrovascular diseases	9109	395.77	8494	397.67
Atherosclerosis	918	39.88	1705	79.82
Cardiovascular diseases - total	37213	1616.85	39658	1856.73

Source: Croatian National Institute of Public Health

Although the total cardiovascular mortality rate is higher for women than for men, table 3 shows that the total hospitalization rates are higher for men (1856.7/100.000) than for women (1616.9). This is also true for age specific hospitalization rates (not shown). There is little difference in the average length of hospitalization for men and women by diagnostic group as shown in Table 4.

Table 4. Average length of hospitalization for CVDs by diagnostic group and sex, Croatia 2002

DIAGNOSES	Female	Male
	Length (days)	Length (days)
Hypertensive diseases	12.2	10.0
Ischaemic heart diseases	11.6	9.9
- Acute myocardial infarction	13.3	12.72
- Chronic ischaemic heart dis.	11.1	8.4
Heart failure	12.7	11.7
Cerebrovascular diseases	14.2	13.0
Atherosclerosis	15.0	12.0
Cardiovascular diseases - total	12.3	11.0

Source: Croatian National Institute of Public Health

Data from Croatian registers of family medicine show that cardiovascular diseases comprise 12% of all cases diagnosed in 2002. Unfortunately, these data are not segregated by sex.

Risk factors for cardiovascular disease in Croatia by sex

Data on the prevalence of cardiovascular disease risk factors are based on a survey among a representative sample of the Croatian population conducted in 1995. This study provides information about the prevalence of smoking in adults and schoolchildren, mean values for cholesterol, triglycerides, BMI, hypertension and physical activity. Unfortunately, a more recent survey conducted in 2003 did not include information on biochemical variables such as cholesterol. Table 5 summarizes the results of the 1995 study.

Table 5. Prevalence of Risk factors in Croatia's population aged 18-65 yr

	N = 5840	
	MALE	FEMALE
HYPERTENSION	31,9	23,6
CHOLESTEROL	5,81+/-1,36	5,66+/-1,29
TRIGLYCERIDES	2,13+/-1,69	1,41+/-0,94
BMI – degree I	48,1	34,7
BMI – degrees II and III	31,1	15,2
SMOKING	34,1	26,6
PHYSICAL ACTIVITY		
Work: light work	42,3	66
heavy work	10,1	4,3
Engagement in sport:	17,1	4,3

Source: Turek S et al. A Large Cross-Sectional Study of Health Attitudes, Knowledge, Behaviour and Risks in the Post-War Croatian Population/The First Croatian Health Project. Coll Antropol 2001; 25/1/:77-96

The survey indicates that more men than women smoke and are obese. It also shows that more men engage in sports and heavy work than women. Women are more likely to do light work and only a small percentage do heavy work. While data on dietary habits and alcohol consumption by sex are not available in this survey, more recent surveys do contain such information and the results are currently being analyzed.

In summary

The available data for Croatia show that cardiovascular diseases are the leading cause of death and hospitalization in Croatia and the second cause of years of healthy life lost. The most common causes of death are ischaemic heart disease and cerebrovascular disease.

There is also some specific information available about men and women: The total mortality rates for CVD are higher for women than for men; The age specific mortality rates are higher for men than for women in all age groups; The total as well as the age specific hospitalization rates are higher for men than for women; The available indicators for cardiovascular risk factor show higher prevalence rates for men than for women.

No further analyses of these gender specific data have been conducted. However, in hind sight these data raise certain questions for further analysis:

Are women less sensitive to CVD symptoms than men?
Do they present a different symptomatology than men?
Are women asking for help in more advanced stage? If so, why?
Are GPs and other doctors less sensitive to CVD symptoms in women?
Are they referring women in more advanced stages to specialists or hospitals? If so, why?
Are smaller atheromas fatal for women because of anatomic differences?

Question Two:
How have gender issues been included in current cardiovascular health policies and programmes?

The prevention of cardiovascular disease has become a priority in the *Health System Reform Project* in Croatia and several recent policy documents address this issue.

The Health Care Plan

The Health Care Plan is a four year plan that provides general directions for health care in Croatia. On April 7, 2004, the latest Health Care Plan was signed and enacted by the Croatian government and its prime minister. The plan is valid until the end of 2007 and it addresses the following issues.

- Assignments and goals for the health care sector.
- Priority areas for development.
- Health care of special interests to the Croatian population.
- Specific health care needs in specific areas.
- Institutions charged with implementing the plan and deadlines.
- Basic developmental activities required at each level of the health care sector, including staff and institutions responsible for education, training and health care system development.
- Criteria for establishing a network of health care.

The section of the plan on the health care needs of the population identifies (among others) the prevention, early detection, diagnosis, treatment and rehabilitation of chronic non-communicable diseases as a priority area. Cardiovascular diseases are specifically mentioned along with diabetes, malignant diseases, injuries, mental diseases and addictive diseases.

The section on the developmental activities necessary for executing the plan gives general directions on preventive health care measures and the implementation of health promotion and disease prevention activities. The plan also provides references to the tasks required of health care institutions such as the Institutes of Public Health. They are responsible for planning and programming, for coordination and implementation of health promotion, for the evaluation of programmes, for developing a system for monitoring and for the prevention of wide spread chronic diseases and related risk factors.

The section of the plan that describes the criteria for basic health care activities provides data on the health status of the population for morbidity, mortality, and health risks. These data were provided by Croatian National Institute of Public Health.
As far as morbidity data are concerned, the only data which are divided by gender (aside from reproductive health indicators) describe inpatient morbidity in the elderly (65 years and above). These data contain information on the most common causes of hospitalization (ICD-10 disease groups), displaying within each disease group the most common diagnosis. The data show that CVD is the most common cause of hospitalization for elderly men and women and that cerebrovascular infarction is most common in females while angina pectoris is most common in males.
No sex disaggregated data are given on mortality, except for violent deaths.
Sex disaggregated data are provided on risk factors for cardiovascular disease such as smoking, physical activity, mean values for cholesterol and triglycerides, and for obesity. Data on alcohol consumption, hypertension and diabetes for either sex was not provided.
In the description of the social characteristics of the population, gender specific data were only given for unemployment rates. Social characteristics may play an important role in the prevention of CVD.

The new Health Care Plan identifies the prevention, early detection, diagnosis, treatment and rehabilitation of cardiovascular diseases as a priority for the health care sector between 2004 and 2007. All levels of government (national, regional and local) must be involved in implementing the plan. Funding is guaranteed by the national budget, budgets of the regional and local governments and from compulsory health insurance.
Experts from the Croatian National Institute of Public Health are delegated to study and monitor the population health status, to conduct epidemiological surveys of mass chronic diseases, to programme, implement and monitor population health awareness and health education campaigns, and to promote the Health Care Plan. They have also participated in the development of the Health Care Plan.
The current Health Care Plan provides hardly any information about gender related aspects of cardiovascular health. This is due to a lack of awareness about potential gender differences in cardiovascular health and most importantly a lack of research and available data. It is the task of the Croatian National Institute of Public Health to provide the necessary sex-disaggregated data for gender planning and for the analysis of policies.
Indeed, a debate on how health care planning can include gender issues in cardiovascular health has yet to begin. The Croatian National Institute of Public Health must provide evidence to instigate this debate and to ensure a collaboration of leading cardiologists.

The Croatian Health Care Measure Programme

Along with the four year Health Care Plan adopted by the government, the Health Care Measure Programme plays a guiding role in structuring health care in Croatia. This programme was proposed

by the Croatian National Institute of Public Health and Croatian Health Insurance Institute and accepted by the Minister of Health in 2002.

The programme is based on an analysis of the population health status and has the following objectives:

- To promote the health of the entire population.
- To increase life expectancy and to reduce mortality rates.
- To increase the number of years in a disease- and/or disability-free life.
- To ensure the maximum level of physical and mental health by improving quality of life through the maintenance of health and functional capacities.

One chapter of the programme is dedicated to women's health. It includes a description of health care measures needed in family planning, perinatal care, breast cancer, gynaecological carcinomas, as well as the management of climacteric complaints and side-effects.

The programme also contains a chapter on cardiovascular health care measures written in compliance with the National Cardiovascular Disease Prevention Programme, which was issued in 2001. The chapter focuses on primary, secondary and tertiary prevention of cardiovascular disease and targets the entire population, regardless of sex.

The chapter stresses the importance of primary prevention and describes the relevant measures: educating and encouraging the population to adopt healthier lifestyles, to maintain improved health and to avoid potential risk factors for cardiovascular diseases. It also stresses the necessity of adopting a proper diet which balances energy intake and calorie consumption. Finally, it promotes regular physical activity, non-smoking and combating excessive alcohol consumption.

Secondary prevention of cardiovascular diseases focuses on high risk patients. The chapter includes guidelines on determining risk factors (high blood pressure, excessive body weight, smoking etc.) and on educating subjects about health risks, beneficial health behavior and risk factor control. Again, these measures are aimed at the entire population and not at a particular gender.

Tertiary prevention targets people with arterial hypertension, ischaemic heart disease and cerebrovascular diseases. The chapter describes the necessary measures to be taken, including not only disease detection, diagnosis and treatment according to contemporary medical knowledge, but also patient and convalescent education about healthy lifestyles and compliance with the therapeutic regimen. Household education on cardiovascular disease is also provided for family members such as education on the recognition signs of ischaemic heart diseases and cardiovascular diseases and basic resuscitation methods.

The chapter on Primary Health Care also contains a section on measures for health promotion and disease prevention. Of these measures the following are important to CVD:

1. Health promotion and providing health education to the public.

2. Providing care to high-risk individuals: Implementing preventive health measures for high-risk individuals including medical surveillance, guidance, health information and planned, systematic, preventive work.

3. Prevention: Assessing the risk factors for major chronic diseases (excessive body weight, smoking, high blood pressure, hyperlipidaemia etc.), and initiating activities to reduce these risks; planning measures for disease-prevention.

4. Early detection of chronic patients: Encouraging the population to take self-protective and co-protective measures such as self-examination, self-control, targeted medical surveillance, etc.

The Croatian National Health Measures Programme contains one chapter on measures to be taken in the field of women's health. However, in neither of the two chapters dealing specifically with cardiovascular health is any considerable attention given to gender issues. The measures are directed toward the entire population.

National Prevention Programme for Cardiovascular Diseases
In 2001, the National Cardiovascular Disease Prevention Programme was launched by the Minister of Health. (See annex 2 for a summary of this report)
This programme is based on a situational analysis of cardiovascular disease as a public health problem in Croatia, but the analysis provides little information on gender in cardiovascular health.

The programme focuses not only on individuals with symptoms of cardiovascular disease (tertiary prevention) and high-risk individuals (secondary prevention), but also on promoting healthy living to prevent health hazards such as cardiovascular problems (primary prevention).

The programme defines seven major goals:
1. To decrease by 20% the coronary and myocardial infarction age of mortality to 64 years.
2. To improve the detection and treatment of hypertension.
3. To improve the detection and treatment of hyperlipidaemia.
4. To decrease the number of smokers by 10%, especially among young.
5. To decrease the incidence of obesity by 20%.
6. To promote nutrition.
7. To increase the number of people who engage in physical activity regularly by 20%.

For each target, the programme describes methods and deadlines for implementation.

The programme also states that its success must be monitored by the indicators mentioned.
Though this programme was launched in 2001, its implementation plan has not yet been published.

The National Programme for the Prevention of Cardiovascular Diseases is targeted at the entire population. There is no mention of gender differences in the entire document, including the description of the problem, the proposed goals, the measures to reach these goals and the indicators to monitor the success of the programme.
This may be because while the programme was in development, there were few data available on gender and cardiovascular health. Also, there was a lack of understanding of the relevance of a gender approach to the prevention of cardiovascular diseases.

Matrix 1. Summary of the assessment of gender considerations in the development of the National Programme for the Prevention of Cardiovascular Disease

Title of the policy: National Program for the Prevention of Cardiovascular Disease. Date of issue: 2001				
	Gender considerations included	Enabling Factors	Gender considerations not included	Barriers
Objectives	Not gender specific	NA	Gender was not included	No awareness of the importance of gender in CVD existed at that time
Stages of policy development				
• Problem description	Only analyses of CVD mortality	CVD databases were sex disaggregated	Data on mortality trends and hospitalization rates were not analyzed by sex	No awareness of the importance of gender in CVD existed at that time
• Planning	Not gender specific	NA	The program is aimed at the entire population	No awareness of the importance of gender in CVD existed at that time
• Implementation	Not gender specific	NA	The program is aimed at the entire population	No awareness of the importance of gender in CVD existed at that time
• Monitoring	Not gender specific	NA	The program is aimed at the entire population	No awareness of the importance of gender in CVD existed at that time
Process characteristics • Gender experts included in policy development	No	NA	No such experts	No awareness of the importance of gender in CVD existed at that time

Question Three: What factors either hindered or enabled acknowledging gender?

Based on interviews with experts

Leading experts in the field of cardiovascular health in Croatia were interviewed to gauge their awareness of sex and gender differences in cardiovascular diseases and to asses to what extent they feel that health planning documentation should acknowledge sex and gender differences.
A short questionnaire was developed and sent to experts who create health care measure programmes and other health planning documents. Nine professionals answered the questionnaire, mostly internists and cardiologists.

Their responses were as follows:

All interviewed experts (with the exception of one):

- were participating in the development of a National CVD prevention programme and other health policy documents.
- noticed an increase in CVD among women.

- found that females are asking for help at a more advanced stage of CVD than males.
- noticed a difference in symptoms for the same diagnostic entities in females and in males.
- thought that CVD lethality was roughly equal in both sexes; One thought it was higher in females.
- concluded that planning documents for CVD should define measures for females and males separately.

All interviewed experts (with the exception of two):
- noted that physicians in Croatia devote more attention to males who complain of precordial oppression, dyspnea, vertigo etc. than to females with the same symptoms.
- thought that therapeutic outcomes are not different in females and in males.

More than half thought that co-morbidity was more common in women with CVD than in men.

These interviews show that among experts there is an awareness of the relevance of gender in cardiovascular disease. This may be an important prerequisite for any future planning of cardiovascular health services.

Discussion and conclusions

Based on the information obtained by answering the first three questions, the following conclusions were reached:

- CVD has been recognized as a public health priority for both genders in Croatia.
- The available data indicate that:
  - CVD is the leading cause of death and hospitalization in Croatia and is the second leading cause of years of life lost.
  - The most common diagnostic groups are ischaemic heart disease and cerebrovascular disease.
  - The total mortality rates are higher for women than for men.
  - The age specific mortality rates in all age groups are higher for men than for women.
  - The total and age specific hospitalization rates are higher for men than for women.
- The health policy documents on CVD in Croatia are aimed at the entire population and are not sex/gender sensitive. Although some sex disaggregated data are available, they are only presented exceptionally in cardiovascular policy documents.
- An important policy document on cardiovascular health is the National Programme for the Prevention of Cardiovascular Disease, written in early 2001. However, at that time, there was too little data and too few studies published on indicators to sufficiently describe the needs of men and women in cardiovascular health.

One obstacle to carrying out this study came from the limitations of the Croatian language. Croatian does not have separate and distinct terms for gender and sex and so it was often difficult to understand whether documents were referring to social (gender) or biological (sex) differences in health.

Question Four:
What recommendations can be made to integrate an awareness of gender equity into cardiovascular health policy and practice?

Recommendations for Croatia

- A gender perspective must be used to develop any future public health policies in Croatia.
- In order to develop a gender sensitive cardiovascular health policy, the following measures must be taken:
- The association of cardiologists (the country's leading cardiologists) must use the results of this project to design guidelines for the prevention and care of cardiovascular disease which focus on sex and gender related risk factors and aspects of care.
- These guidelines should be adopted by the Ministry of Health.
- Professional training about potential sex and gender differences in cardiovascular health should be offered to all family physicians.
- An implementation programme for CVD prevention in Croatia should be prepared and enacted by the Ministry of Health.
- Sex and gender specific information should be added to the existing CVD Prevention Programme from 2001.
- The health care programme should include these measures and ensure that they are funded by obligatory health insurances. These measures should also be incorporated into any contracts between the family physician and the Health Insurance Administration.
- Beneficiaries, i.e. the population, should be informed by the media and other promotional materials about the risks of CVD and the differences between men and women.
- Public health institutions in all counties should be involved in health educational activities and in the creation of promotional materials.
- Indicators should be developed so that situations can be monitored along gender lines.
- Monitoring and evaluation should be the responsibility of public health institutes and of the Croatian National Institute of Public Health. The Ministry of Health, professional circles, and the public at large should be informed of all results.
- The Croatian National Institute of Public Health should take the initiative to further assess the data and research materials available on gender and cardiovascular health to enlarge the evidence base on these issues.

Recommendations to WHO

- The results of this multi-country project should be used to prepare common recommendations on how to develop, implement, monitor and evaluate gender sensitive health policies and programmes.
- WHO should develop gender sensitive public health indicators and pilot them in countries.
- The same toolkit or guideline used in this project should be tested in other health policies such as mental health or injury prevention.
- Examples of good practices in gender sensitive policy development should be made available.
- The results of this study should be published.
- The results should be discussed with other relevant WHO units/departments.

Remarks about the method used in this study

- The proposed method was useful for a gender analysis of health policy. It enabled a uniform approach for considering gender in health policy documents. Additional explanations and definitions on the matrix would have been helpful. The guidelines used in this project should be part of a toolkit for policy makers in the gender mainstreaming of health policies.

7

A gender analysis of the national health promotion policy in the Netherlands

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Introduction

In recent years there has been increasing scientific evidence that gender can have an important impact on health behavior and life styles. The Netherlands has made international and national commitments to integrate attention to gender issues in national policy development (gender mainstreaming). Following these commitments a qualitatively sound and effective health promotion policy should address avoidable gender differences. For that reason, the WHO guidelines for evaluating the integration of gender issues into health policies are used in this study as an instrument for the evaluation of the recently published national health promotion policy for 2004-2007 titled *"Towards a longer and healthier life 2004-220: A matter of healthy behavior"*. By evaluating this document, this study aims to provide national policy makers with a number of concrete suggestions improving the effectiveness and the quality of health promotion. The results will also offer WHO some suggestions for the further development of its guidelines for gender sensitive health policy development.

Main questions

The *main questions* of the case study were:

- To what extent, and in what way have women's and men's different biological constitutions, different positions and roles in society and the family, differences in health behaviour, differential health risks and health needs, been considered in the development and implementation of the new Dutch health promotion policy?
- What were facilitating factors and what were obstacles for acknowledging sex and gender differences?
- How can the quality and effectiveness of future health promotion policies be improved by gender mainstreaming?

Methods

To put the findings of this study in context we start with a short description of the Dutch policies regarding gender and health.

To answer the questions of the case study the following methods were used:

The main document describing the new Dutch health promotion policy titled *Langer gezond leven 2004-2007: ook een kwestie van gezond gedrag (towards a longer and healthier life 2004-2007: a matter of healthy behavior)* was analyzed with the main questions in mind. Because it is based on many 'underlying documents' (mostly scientific studies), the document is limited in size (79 pages), but broad in scope.

Three civil servants from the Ministry of Health who participated in the development of the health promotion policy were interviewed: R. Mooij, S. Rutz and L. Singels.

Health statistics were obtained from the report *Volksgezondheid Toekomst Verkenning 2002 (Public Health Forecasting, 2002)*, which was published by the National Institute for Public and Environmental Health (RIVM). The National Institute for Public and Environmental Health publishes these reports to support policy development. This particular report was used as a major source of information for the health promotion policy.

A content analysis of the policy document and interviews with informants were used to determine the extent to which gender considerations have been included in the new health promotion policy (question 1). The interviews were also used to acquire background information about factors hindering or enabling the inclusion of gender in the policy (question 2). The report on health statistics was used to assess what sex and gender specific data were available during policy developement. The questions in the WHO guideline provided a framework for document analysis. A special questionnaire was developed for the interviews. The results of the document analysis and the interviews were catalogued as quotes and subsequently summarized in a matrix (Matrix 1).

Context: The Dutch policy on gender and health

In the Netherlands, gender equity is a cross cutting issue for policy development. Based on its international commitment to the Convention of All Forms of Discrimination Against Women, the Beijing Platform for Action and the Treaty of Amsterdam, the Dutch government adopted a gender mainstreaming policy in 2001. The policy is titled *"Gender Mainstreaming: A strategy for quality improvement"* and was developed by the Ministry of Social Affairs and Employment. The policy aims to provide policy makers in different ministries with a structure, a strategy and a toolkit for the mainstreaming of gender in every phase of policy development.

In response to requirements of the Treaty of Amsterdam and the European Framework on Gender Mainstreaming, in 2003 the Netherlands drafted a plan to monitor advances in the gender mainstreaming. Two mechanisms will be used: First, key indicators for gender equity will be monitored regularly by means of an "emancipation monitoring system" developed by the National Social and Cultural Planning Bureau and the National Bureau of Statistics. Second, the extent to which gender mainstreaming goals are met by national, regional and local government agencies will be evaluated by external visitation committees. Both policies offer a *general* framework for the gender mainstreaming of policy, but they do not include specific guidelines for health policy or any other specific policy area.

Between 1987-2001, the Ministry of Health, Welfare and Sports had a specific programme on women, gender and health that was supervised by a steering committee of experts. This programme was designed to promote women's issues and gender issues in health policy development and health care. With the introduction of the national gender mainstreaming policy in 2001, the Ministry of Health decided to end this programme. At its closure, the steering committee provided the government with some recommendations for future work.
These included:

- Ensuring that future health policies and programmes acknowledge gender equity and ethnic diversity.
- Preserving the results of gender mainstreaming that have already been achieved.
- Ensuring that appropriate instruments will be developed to integrate attention to 'gender and ethnicity' in mainstream health care and health policy.

Based on these recommendations, the Ministry of Health continued to support certain gender related activities in health care and health research. However, no new programme on gender and health was launched. It was assumed that the new national policy on gender mainstreaming provided a sufficient framework for the gender mainstreaming of health policies. This study can be seen as a check.

Results

Attention to gender issue in policy document on health promotion

The new Dutch policy on health promotion is called, *"Towards a longer and healthier life 2004-2007: a matter of healthy behavior"*. The structure of the policy document follows the standard model and it is broken down into the following sections: problem description, objectives, planned actions and monitoring. Therefore, it was relatively easy to perform the content analysis of the document according to the questions suggested in the WHO guidelines. In this section, each part of the policy will be followed by an anlysis of what were facilitating factors or obstacles for acknowledging sex and gender differences. For this analysis information obtained from interviews was integrated.

Section 1: Problem discription

The introductory chapters of the policy document provide an overview of the problems the policy addresses. The following points summarize the main problems:

- Life expectancy in the Netherlands is increasing more slowly than in other European countries.
- Dutch people no longer have the longest life expectancy in Europe.
- The life expectancy of men is increasing relatively slowly. The increase in life expectancy for women has come to a complete standstill. In the worst case scenario, the life expectancy of men and women will decrease by 3 years in the near future.
- The life expectancy and the healthy life expectancy of people in the lowest social strata (SES) is considerably lower than of those in the highest social strata.
- Smoking, excessive alcohol use, overeating, excessive junk food and a lack of physical exercise, are life style patterns that increase the risk of serious health problems such as cardiovascular diseases, cancer or diabetes.
- The prevelance of these life patterns is relatively high in the Netherlands, especially among people with a lower SES.

The problem description also includes more detailed information about the factors which have contributed to the recent stagnating life expectancies and the increase in ill-health (see below). This additional information provides insight into sex and gender differences present in the Netherlands.

Unhealthy behavior
"The stagnation in life expectancy is caused by the increasing prevalence of unhealthy life styles.

- One out of every three people in the Netherlands smokes. This number was decreasing over the past 20 years, but recently it has come to a standstill. Because women began to smoke more frequently in the 70s, the mortality rate for women from lung cancer is rising.
- Nine out of every ten Dutch person eats more than enough full fat.
- 75% of the Dutch eat too few fruits and vegetables.
- More than half of the Dutch do not get enough exercise.
- Half of the Dutch men and more than a third of the Dutch women are overweight. The percentage of severely overweight (obese) people has doubled in a little over 20 years."

"It is mostly young people that live unhealthy lives:

- Almost half of the young people between 15 and 19 are smokers.
- Nine out of every ten youngsters eat too few vegetables and fruits.
- Half of the people between 13 and 17 and almost 60 percent of the population between 18 and 34 do not get enough exercise.
- 14% of boys and 7% of girls drink too much alcohol.
- About one third of people between 15 and 35 with multiple partners do not always use a condom."

Consequences of unhealthy behavior
"Mortality and disease are partly related to – avoidable – health risk. Often, we are dealing with a combination of lifestyle, personal qualities and circumstances. By modifying our behaviour, it is possible to lead healthier lives. According to the calculations of the RIVM, if the Netherlands were to achieve risk factor levels comparable to the most favourable levels for Europe, men would theoretically live 1.4 years longer, and women would live 1.2 years longer. Although such calculations have no actual predictive value, they are important as reflections of the Dutch situation."

Social and economic health differences
The Institute of Public and Environmental Health observed no decrease in social differences for health in the Netherlands:

- People live shorter and less healthy lives in Zuid-Limburg (a province in the South of the Netherlands), the North-East of the Netherlands and in the big cities. The average number of healthy life years of the population can differ as much as 10 years between regions.
- Within the cities, there are large differences in the health situation of people living in upper-class neighbourhoods and those living in lower class neighbourhoods.
- The life expectancy of men with the lowest level of education is five years less than the life expectancy for men with higher professional training or a university degree. For women, the difference is 2.5 years.
- People with a lower education live shorter and less healthy lives. Less educated men and women live ten and eight-and-a-half years less respectively (assuming no other health limitations) than people with higher educations.
  These socio-economic health differences have not decreased over the past ten years."

Attention to gender in problem description
Some sex and gender issues are acknowledged in the problem description of the policy document. Sex differences in life expectancy and the stagnation in life expectancy for women have been identified as problems to be tackled. According to our informants one enabling factor was the availability of sex disaggregated health data in the Netherlands. Additionally, the civil servants who created the problem analysis for the new health promotion policy were supported by a team of consultants, some of which were gender experts.
However, while there is some attention given to gender issues in the problem description section of the health policy document, it is presented and used in an ad hoc manner. According to our informants, there is clear evidence that socio-economic determinants (low SES) and age (young people) are major risks factor for unhealthy life styles. There is less evidence that gender characteristics are a specific risk factor influencing unhealthy life styles. For that reason, it was decided not to include gender issues in the problem description of this policy document, so no systematic attention was given to sex and gender differences within risk groups.

Section 2: Goals and objectives
The main objectives of the health promotion policy are:

- To increase the number of 'healthy years' on the total life expectancy.
- To decrease the differences in health between persons with a high SES and persons with a low SES.

The specific objectives necessary for achieving the main objectives of the policy are:

- To reduce the mortality rates and the number of unhealthy life years that are connected with cardiovascular diseases, cancer, asthma and chronic lung diseases, diabetes mellitus, mental illness and locomotor apparatus problems.
- To reduce the number of people – especially young people – that smoke to a total of 25% by 2007
- To reduce the number of children with obesity and to stabilize the number of adults with obesity
- To reduce the number of people under 55 years of age that suffer from Diabetes mellitus.

In addition, specific measures will be taken to target the two key risk groups: young people and people with a low socio economic status.

Attention to gender in policy goals
These objectives are gender neutral. Sex differences or gender considerations are not mentioned in any of the major objectives of the policy. Only in one minor objective a reference to men's and women's health is made: "If we can achieve the best score in Europe on risk factors, 1, 4 years can be added to the life expectancy for men and 1, 2 years to the life expectancy for women."

Sex and gender differences are also mentioned in some of the texts used as information sources for the objectives. Concern about the developments in life expectancy seems to have enabled the inclusion of gender in the objectives of the policy document. However, none of the gender aspects mentioned in the text were of any consequence to the development of the actual policy.

Section 3: Planning
For implementation, the following strategies were recommended by the policy document:

- To monitor the implementation of the new (2002) anti-smoking measures. These measures include: higher taxes on tobacco, prohibiting smoking in public places like post offices or railway stations, prohibiting tobacco advertisements, and prohibiting the sale of tobacco products to young people
- To facilitate information campaigns on (non-)smoking.
- To facilitate the national implementation of the marketing experiment 'non-smoking for young people'
- To increase the tax on tobacco.
- To facilitate local activities aimed at reducing the number of young people and the number of people with a low SES that smoke
- To facilitate local activities that promote the consumption of healthy food and that advise against the consumption of unhealthy food
- To facilitate local physical fitness programmes.
- To facilitate the screening and prevention of obesity among children by local services
- To facilitate local activities to reduce the number of people with a low SES that are obese.
- To participate in the WHO-strategy 'Global strategy on diet, physical activity and health'.
- To develop a national diabetes programme in 2004-2008 on the prevention, screening and care of diabetes mellitus.

In 2004, 45 million euros were available for health promotion and health care. However, no financial provisions are made for targeting men and women specifically.

Attention to gender in policy planning
All of these planned measures are gender neutral. There are no recommendations targeting men or women specifically or that consider gender. Additionally, no funds have been allocated for gender.

Section 4: Monitoring
The document states that monitoring will take place based on the following four questions:

- Does the national government understand what is to be done?
- Does the national government realize what has been planned?
- Are the policy expenses equal to what they were calculated to be?
- Are the policy goals (still) the right goals?

Attention to gender in policy monitoring
Indicators still must be developed. The need for gender senstive indicators is not noted in the policy document. However, there appears to be ample possibility for modifying the policy goals, targets and indicators.

Policy Implemenation:
The policy was adopted in December 2003 but it has not yet been implemented. However, the national and local government, health services, educational institutions, research institutes, health promotion organizations and health insurance organizations will be responsible for its implementation.

The results of our analyses are summarized in Matrix 1. Column 1 summarizes the references made to sex and gender issues in the policy document. Column 2 indicates which gender or sex disaggregated data were available while the policy was drafted. Column 2 and 3 describe enabling factors and bariers for mainstreaming gender into the policy document. The information in the latter columns is based on the information from the interviews with informants.

What has the Ministry of Health done to facilitate gender mainstreaming?
According to the national gender mainstreaming policy of 2001 (see policy context) each Ministry is responsible for making sure that gender mainstreaming is part of all its activities. However, in the Ministry of Health there is no committee or focal point responsible for ensuring the inclusion of gender concerns in the development and monitoring of this health promotion policy or, similarly, for any other health policy.

Conclusions

Evaluation of document:
The assessment of the Dutch health promotion policy *Towards a longer and healthier life 2004-2007: a matter of healthy behavior* reveals that the Ministry of Health and the policymakers did in fact have information available to them about sex and gender in health, health risks, prevalence of diseases like CVDs, life expectancy, disability adjusted life years, lifestyle and (un)healthy behavior. However, throughout the document male-female differences are presented in an ad hoc way. The sex/gender differences mentioned are not followed by sex or gender-specific policy goals, targets, measures or programmes. The civil servants interviewed point out that one reason for the lack of attention to sex/gender issues in the policy may be that epidemiological studies have not identified men and women as a risk group, in contrast with young people and people with a lower SES.

Although the policy document contains a number of references to sex and gender differences, the policy as a whole must be characterized as ‘sex and gender-neutral’. Indeed, most of the problems, objectives and goals the policy addresses are formulated in a gender neutral way. However, no significant gender-bias exists in favor of the male or the female position, needs or lifestyle.

There was much more information available in the Netherlands on sex and gender prevention and health than the Ministry of Health has used in its health promotion policy. The main data source for the development of this policy - *Public Health Forecasting, 2002* - contains many sex-disaggregated data on life expectancy, health problems and DALY’s. It also contains some gender-disaggregated data on (unhealthy) behavior like smoking, alcohol abuse and eating patterns. Other information on gender (differences) in (un)healthy behavior was available from other national and international sources.

Most of the references to males and females in the policy document are concerned with biological characteristics (sex). References to 'gender' (psycho-social characteristics of men and women) are minimal, although there is ample data available on the impact of gender on (un)healthy behaviour.

Barriers to gender awareness:
The shortcomings of the health promotion policy's gender awareness can be explained by the following factors:

- Unlike people with a lower SES and young people, men, women and ethnic minorities are not viewed as specific target groups in this policy. According to those interviewed, this can be explained by two factors: There are convincing research data available that age and socio-economic factors have an impact on lifestyle. The data about the impact of gender and ethnicity on lifestyle are not convincing enough to warrant attention. Secondly, data on acknowledged risk groups do not provide information (subgroup analyses) about sex, gender or ethnic diversities.
- Sex/gender experts have played a relatively small role in policy development. They had some input in the definition of the problems to address but they had no influence on the objectives, health promotion strategies or the selection of indicators.
- Policy makers are sensitive to public opinion. Many people believe that Dutch men and women are already more or less equal, especially in the younger and more-educated groups. For that reason, the promotion of gender equity has begun to lose relevance in the public opinion and some people even regard it as old fashioned.
- There is not an adequate Dutch word for 'gender mainstreaming' and the use of the English word evokes resistance because many view it as 'snobbish' or "policy speak".
  The concept of sex differences in health are often more understandable for policymakers and the public at large than the concept of gender differences. Information about sex differences is therefore more effective than informations about gender differences in lobbying for gender mainstreaming because it is better understood. This method should be used more consistently.

Evaluation of the methodology:
While useful, the content analysis of policy documents did not give much insight into the underlying processes and the choices made during composition of the document. Interviews with civil servants and others involved in the development and implementation of health policies were more adequate. Due to time limitations, only three policy makers could be interviewed. More interviews would have been useful to better understand the factors which enabled and hindered the decision process on whether or not to take gender considerations into this policy. The interviews did however provide some information about the bariers which hinder putting gender mainstreaming on the agenda of policy makers.

National policy
This analysis is focused on national policy. These policies typically contain a high level of abstraction – they provide a global framework for activities to be carried out by regional or local authorities (the region or the city) and health care institutions. Regional authorities and institutions also have their own policies and strategies by which they implement national policies. For the integration of attention to gender concerns into (public) health care services it is therefore also relevant to assess what regional and local governments and health organizations institution are doing in this area.

Recommendations

To the Dutch national government:

- The Ministry of Health must encourage the National Institute of Public and Environmental Health to reanalyze and break down all relevant health data and indicators by gender (and ethnicity) as a matter of routine. In order to promote healthy living, better sex disaggregated data are needed for life styles (smoking, obesity, physical exercise, alcohol abuse). These sex dissaggregated data should be used in public health campaigns promoting a health life style.
- The national health promotion policy has two special target groups - young people and people with a low SES. We recommend to divide these groups into four target groups – girls and boys, women and men with a low SES – in order to make the organizations that implement the health promotion policy aware of the necessity of gender differentiation, especially in information campaigns.
- A focal point or a committee should be in place at the Ministry of Health to facilitate gender mainstreaming in all aspects of policy development and implementation.
  The Ministry of Health must promote gender mainstreaming at all levels: the national level, the local level, the management of health services, and at the level of health practitioners.
- Any health policy will be more effective if a gender perspective is included in its goals and strategies.

To WHO

WHO EURO is urged:

- To ensure that gender mainstreaming is made a routine part of any policy support work in the Member States, in the Region.
- To commit suffcient finances and staff to the development of support intruments for gender mainstreaming national health policies (lobbying techniques, practicle tools and gender sensitive health indicators).

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Matrix 1. Results of a gender analysis of the Dutch health promotion policy 2004-2007: *Towards a longer and healthier life 2004-2007: a matter of healthy behavior*.

	Which references to sex/gender issues were included in the policy document?	Which available data on sex/gender was not included in the policy document?	What were enabling factors for including sex/gender in the policy document?	What were barriers to including sex/gender considerations?
Problem description	Sex/ gender considerations were included in one of the three main problems the policy addresses. *Langer gezond leven* states as one of three problems to be addressed: • The Netherlands has lost its leading role in Europe for life expectancy and healthy life expectancy. In other European countries, the life expectancy for both women and men is increasing rapidly. In the Netherlands, the life expectancy of men is increasing relatively slowly and the life expectancy of women has come to a complete standstill. In the worst case scenario, the life expectancy of both men and women will decrease by 3 years in the near future. The texts used to illustrate the problem contain several references to sex/gender dimensions: • One out of every three people in The Netherlands smokes. The number of smokers has decreased in the past 20 years, but this decrease has recently reached a standstill. Because women began to smoke more frequently in the seventies, the mortality rate due to lung cancer among women is growing. * Half of men and more than a third of women are overweight; the percentage of severely overweight (obese) people has doubled in a little over 20 years. * 14% of boys and 7%of girls drink too much alcohol. * Men with only a primary school diploma live five years less than men with higher professional training or a university degree. For women, there is a gap of 2.5 years.	Available sex–disaggregated data that were not referenced in the policy document: * data on healthy and unhealthy lifestyles: smoking, excessive use of alcohol, overeating, obesity and physical exercise. (particularly data on young men and women and smoking, alcohol use and obesity.) * Mortality and morbidity data on the health problems the policy seeks to prevent: cardiovascular diseases, cancer and diabetes. *data on sex differences in life expectancy and healthy life expectancy for persons with high SES and low SES.	1. The negative development of life expectancy for Dutch women 2. The availability of many sex-disaggregated facts & figures 3. The availability of experts on gender and health issues.	1. Young people and people with a low SES are viewed as risk groups for unhealthy life styles and therefore are specifically targeted for this policy. Women and/or men are not specific risk groups for healthy life styles and therefore are not target groups for the policy. Within the selected target groups (people with a low SES and young people) no sex or gender differentiation is made. 2. The differences in health and quality of life between men and women are considered to be relatively small in The Netherlands. 3. The idea exists that national policy must not be too specific. Identifying sex/gender differences within the target groups 'young people' and 'people with a low SES' is too specific. 4. The idea exists that (young) men and (young) women are equal. Therefore, policy on health promotion does not require gender-specificity.
Goals and objectives	Sex/gender considerations do not appear in any of the main objectives or goals of the policy: They are gender neutral. Sex and gender differences are only addressed in one minor objective. In the illustrating text, a number of sex considerations (biological male/female differences) are mentioned, but very little reference is given to gender (psycho-social) differences.	The main goals are sex/gender neutral while the main source of information for the policy (*Public Health Forecasting, 2002*) contains data on the 'gendered' character of life expectancy, healthy life expectancy and (un)healthy behaviour patterns.	See above	See above.

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Problem description	Sex/ gender considerations were included in one of the three main problems the policy addresses. *Langer gezond leven* states as one of three problems to be addressed: • The Netherlands has lost its leading role in Europe for life expectancy and healthy life expectancy. In other European countries, the life expectancy for both women and men is increasing rapidly. In the Netherlands, the life expectancy of men is increasing relatively slowly and the life expectancy of women has come to a complete standstill. In the worst case scenario, the life expectancy of both men and women will decrease by 3 years in the near future. The texts used to illustrate the problem contain several references to sex/gender dimensions: • One out of every three people in The Netherlands smokes. The number of smokers has decreased in the past 20 years, but this decrease has recently reached a standstill. Because women began to smoke more frequently in the seventies, the mortality rate due to lung cancer among women is growing. * Half of men and more than a third of women are overweight; the percentage of severely overweight (obese) people has doubled in a little over 20 years. * 14% of boys and 7%of girls drink too much alcohol. * Men with only a primary school diploma live five years less than men with higher professional training or a university degree. For women, there is a gap of 2.5 years.	Available sex–disaggregated data that were not referenced in the policy document: * data on healthy and unhealthy lifestyles: smoking, excessive use of alcohol, overeating, obesity and physical exercise. (particularly data on young men and women and smoking, alcohol use and obesity.) * Mortality and morbidity data on the health problems the policy seeks to prevent: cardiovascular diseases, cancer and diabetes. *data on sex differences in life expectancy and healthy life expectancy for persons with high SES and low SES.	1. The negative development of life expectancy for Dutch women 2. The availability of many sex-disaggregated facts & figures 3. The availability of experts on gender and health issues.	1. Young people and people with a low SES are viewed as risk groups for unhealthy life styles and therefore are specifically targeted for this policy. Women and/or men are not specific risk groups for healthy life styles and therefore are not target groups for the policy. Within the selected target groups (people with a low SES and young people) no sex or gender differentiation is made. 2. The differences in health and quality of life between men and women are considered to be relatively small in The Netherlands. 3. The idea exists that national policy must not be too specific. Identifying sex/gender differences within the target groups 'young people' and 'people with a low SES' is too specific. 4. The idea exists that (young) men and (young) women are equal. Therefore, policy on health promotion does not require gender-specificity.
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8

Integrating gender considerations into health policy development: A UK case study on coronary heart disease

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Introduction

The UK has been surprisingly slow to address sex and gender issues in health care. The NHS has developed sex-specific services for women in the arenas of obstetrics and gynaecology. Sexual and reproductive health services have begun to take a greater interest in the particular needs of men. However, very little attention has been given to the wider issues of gender mainstreaming. No policies have been designed specifically with gender issues in mind. Therefore the proposed WHO guidelines for evaluating gender and health policy were not appropriate for use in this report. Instead, this paper aims to identify some of the reasons for gender blindness in the NHS policy and also to assess its implications for clinical care.

The paper begins with an overview of the national legislative and policy context of gender equality. Following is a review of recent NHS policy documents to assess to what extent these equality concerns are reflected in the health sector. The analysis is illustrated in more detail by a case study of the National Service Framework for coronary heart disease. This case study is reviewed in the context of evidence from a literature search on sex and gender differences in coronary heart disease and its treatment in the UK.[2] The paper concludes with a discussion of the changes that would be necessary if sex and gender issues were to be integrated into the delivery of health services in the UK.

Gender equality in the UK: the broader context

Gender policies in the UK are framed within the international context of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), signed by the government in 1981 and ratified in 1986.[3] The UK government is also committed to the follow up of the Beijing Platform for Action and the Beijing +5 outcome document. Gender equality policies are also shaped considerably by the UK's membership to the European Union. However, some equality issues are addressed slightly differently in England and in the devolved administrations of Northern Ireland, Wales and Scotland than in other member states.[4]

1. This paper is based on a longer document prepared for the Equal Opportunities Commission by Lesley Doyal, Sarah Payne and Ailsa Cameron (Doyal et al 2003). Work on this version was funded by the European Men's Health Development Foundation.
2. The much larger literature from the US and Canada formed the background to this project but is not cited in detail here
3. However it has not yet signed the optional CEDW protocol
4. This case study will concentrate on gender equality in the NHS in England and Wales but many of the issues are very similar in the Northern Irish and Scottish Health Services.

The UK government has committed itself to a policy of gender mainstreaming (Cabinet Office 1998) as well as to introducing a Gender Equality target into the Public Service Agreements with different government departments. The Women and Equality Unit (WEU) based in the Department of Trade and Industry (www.womenandequality.gov.uk) is largely responsible for this work. This agency has the broad remit of developing policy on 'women, gender equality, sexual orientation and the coordination of equality'. However, it has until now been focused on the economic arena with an emphasis on equal pay and work/life balance.

The relatively low priority given by the New Labour Government to gender issues has been widely criticized and reflected in the limited powers of the WEU (Squires & Wickham-Jones 2004). During its short life time, the unit has undergone two name changes and three institutional base changes. It has a low status and relatively few resources and has not been fully integrated into the machinery of government. As a result, departments have been under little pressure to use their tools or to accept their advice.

The main focus of gender equality activity in England has been the work of the Equal Opportunities Commissions (EOC) established under the Sex Discrimination Act of 1975 (www.eoc.org.uk).[5] This is an independent statutory body with government funding set up to promote equal opportunities for women and men and to provide legal advice and assistance to individuals who believe themselves to have been discriminated against. The Government also funds the Women's National Commission (WNC) which is an official, independent advisory body which represents the views of women through consultation with a variety of voluntary bodies (www.thewnc.org.uk).

The mechanisms for promoting gender equality in the UK remain underdeveloped in certain key areas. Progress has been made regarding employment issues and legal remedies against some types of discrimination.[6] However, currently little evidence exists of proactive policies on gender equality and equity in service delivery in the public sector. This is especially evident in the arena of health care.

Men and women: an overview of health status and use of the NHS

When the National Health Service (NHS) was set up in 1948, it received widespread acclaim as a new model for meeting the health care needs of a diverse population. It occupies a highly symbolic position, representing citizenship and social justice. Despite financial constraints, it delivers comprehensive care at relatively low cost and compares well on most criteria to provisions in other countries at similar levels of economic development. Because it is funded from taxation and free at the point of delivery, the creation of the service removed the financial obstacles that formerly prevented people (particularly women) from receiving care (Doyal 1998).

Some information on sex and gender differences in health and on the use of the NHS is available from official statistical sources published by the Department of Health.[7] However this source is

5. Changes are currently being proposed with a unified Equalities and Human Rights Commission under discussion covering gender, race and ethnicity and disability
6. Again this reflects the main focus of EU equality policy
7. For a summary of this information and the relevant sources see Doyal, Payne and Cameron 2003. Available online at www.eoc.org.uk

relatively limited in scope and at times difficult to interpret. These statistics tell us very little about the quality of male and female experiences of health care or about any differences in its effectiveness along gender lines. The available information is also complicated by the inter-relationships between gender and other factors such as age, ethnicity and socio-economic status.

Women in all countries in the UK have a longer life expectancy than men. In England in 1999 average life expectancy at birth for a female child was 80.2 years compared with 75.8 for a male. Life expectancy also varies by social class. In England and Wales, the life expectance of a female born into the highest occupational group in 1992-6 was 83 but only 77 for women in the lowest occupational group.[7]

National data show little difference between women and men, perhaps because ill-health is much more difficult to measure than mortality. In 2001, about three quarters of both genders reported that their health was either good or very good though slightly more women reported acute ill health in the previous fortnight. These patterns vary by age and levels of work commitment, so definite conclusions on gender differences in health are hard to draw from the answers to a simple question. In 2001, 41% of men and 35% of women in England were estimated to have high blood pressure while 68% of men and 56% of women were overweight or obese. In the youngest age group (16 to 24,) male smoking rates were just over 30%. Older age groups had higher rates.[7]

While women are more likely to use GP services than men, the differences are small. In 2000, women made an average of five visits to a GP per year while men made an average of four. Not surprisingly, the gap between women and men widened during reproductive years: women aged 16-44 made an average of five visits while men of the same age made only three. The number of consultations rose with age for both women and men.

Patterns of hospital outpatient attendance also vary between women and men. Though both have roughly the same numbers of visits, men are more likely to visit accident and emergency departments while women are more likely to be referred for general medicine, general surgery and psychiatry. Women are also more likely to be admitted to hospital as in-patients. The only exception occurs among Pakistani and Indian groups where men are more likely to be admitted than women (excluding maternity care).
Despite their limitations, these statistics show that there are differences in the health status of women and men and in the ways they use the NHS. The numbers reflect different health care needs as well as the gendered nature of health and illness behaviour. But these variations have received very little attention in the planning and delivery of services. The government's formal commitment to gender mainstreaming has been given little priority in the management of NHS.

Gender and equality in the NHS

The Department of Health is responsible for policy development in the NHS. It also provides guidance on service developments and it implements and oversees the education of health workers. Recently this policy has been geared towards 'modernization' and overseen by the Modernization Agency. Because the Department of Health determines priorities for the NHS, considerable debate on the impact of certain political agendas on the service has been generated.

Tackling broader social inequalities has been a major theme in the history of the NHS. A number of high profile reports have been followed by policies varying in effectiveness. The focus of these initiatives shifts over time. Social class or socio-economic status has always been a key concern and ethnicity has received considerable attention, especially over the past decade. Sexuality and disability have also recently been highlighted in the inequalities debate. However gender has remained largely ignored except in the context of employment policies.

As the problems of staffing the NHS have increased, the business case for gender mainstreaming in the workforce has been widely recognized (Coyle 2003). Equal opportunities procedures have been put in place to ensure that women can compete on more equal terms with men, especially in medicine and senior management. Policies have also been developed to promote part-time and flexible working hours to facilitate a work/life balance. However this progress in the workplace has not been mirrored in service delivery.

Women's health advocates have a long history of campaigning for greater gender-sensitivity in the delivery of care. Though poor and uninsured women now face fewer obstacles than they did before the NHS, problems of access still exist (Doyal 1998). As pressures on health spending have increased in recent years, there is evidence that women have been disproportionately affected in some areas. Family planning services for example have been significantly reduced in some parts of the country. Women are also more likely than men to find their access to health care limited by domestic responsibilities and by a lack of transport

When women do use the available services, some have reported difficulty in relationships with those who are paid to care for them (Doyal 1998). Older doctors in particular still appear to be reluctant to let women speak for themselves and many women feel unable to assert their own wishes. They too often report being treated as less rational, less capable of complex decision making and simply less valuable than men. There has also been a growing concern that women are less likely than men to be offered some diagnostic and treatment resources (Raine 2000).

In recent years, the impact of gender on men's health care has begun to receive attention (Banks 2001; Cameron & Bernardes 1998 ; Davidson & Lloyd 2001; Doyal 2001; Luck, Bamford & Williamson 2000). Maleness can clearly be an advantage in gaining access to NHS and other health promoting resources. But in order to 'demonstrate' their masculinity, men often have to take greater risks with their health than women do. It is also clear that an unwillingness to admit weakness may prevent men from consulting a doctor when health problems arise. In light of these new insights, some men have followed women in campaigning for services to meet their particular needs more effectively (www.menshealthforum.org.uk; www.emhdf.org)

Despite the government's formal commitment to gender mainstreaming, the NHS does not have a specific policy for women's health, for men's health or for gender and health. While some services are devised to meet the specific biological needs of women and men, gender itself receives little attention and there still appears to be considerable confusion about the underlying conceptual issues. Within the NHS policy framework, the biological implications of sex are rarely distinguished from the social implications of gender, leading to an ad hoc and fragmented approach.

This lack of clarity is evident in several recent responses by the UK government to international monitoring bodies. In its Fifth Report to CEDAW (2000), the main health areas highlighted for comment were improved breast cancer screening and reproductive health services, especially teenage pregnancy. Similarly the official UK Report on the Implementation of the Beijing Platform for Action addressed contraception, sexual health and screening and a reduction in the use of mixed sex wards. This very narrow interpretation of gender issues in the NHS can be illustrated in more depth by looking at current guidelines on coronary heart disease (CHD).

Sex, gender and heart disease: a case study of gender blindness

Coronary heart disease (CDH) is the leading single cause of death in the UK. It claimed the lives of 125,000 people in the year 2000, one in four men and one in six women. It causes 24% of all premature deaths in men and 14% in women, making it the leading cause of premature mortality among males in the UK. In England and Wales, the rate of premature death from CHD is 50% higher among male manual workers than among their non manual compatriots. Similar social inequalities are found among women. These very high rates have received considerable attention within the broader context of NHS modernization policies.

The National Service Framework for Coronary Heart Disease (NSF) is a ten year plan to reduce mortality from heart disease (Department of Health 2000). Twelve standards are proposed to improve prevention, treatment and rehabilitation strategies both within the NHS itself and in related agencies. The NSF has the additional role of tackling inequalities related to ethnicity, social class, sexuality, disability and gender. However no mention is made in the guidelines of specific differences between women and men and no incentives are given for the development of gender sensitive services (White & Lockyer 2001). Of particular concern is the lack of attention given to gender as a causal factor in the large numbers of men dying prematurely from heart disease.

Standards one and two of the NSF are concerned with *reducing heart disease in the population*. The NHS is told to develop policies that reduce coronary risk factors, but no information is provided on gender differences in risk factor prevalence. The need to reduce smoking rates in the UK is given particular attention but no reference is made to the marked differences in male and female smoking patterns (Bostock 2003). A number of studies indicate that different cessation strategies may work best for male and female smokers, but this is never discussed (Perkins 2001). The guidelines also fail to reference the emerging literature on the links between gender and other aspects of health related behaviour. For example, different concepts of masculinity accompany different ages, ethnicities and classes and shape a man's participation in heart health promoting activities or the more self destructive alternatives (Connell 1997 & 2000; Luck et al 2000).

Standards three and four are designed to *prevent chd in high risk patients*. Primary care teams are encouraged to identify everyone with established chd as well as those at significant risk, but no discussion is included on sex and gender differences in the characteristics of the disease (Sharp 1998). Women with CHD who experience symptoms which are uncommon in men (and therefore less well-known) may be less visible to primary care teams. They are also more likely than men to suffer 'silent' myocardial infarction. Similarly, men who are at risk may be missed because fear of

appearing weak can prevent them from bringing their symptoms to a doctor's attention.

Standards five to eleven are concerned with *the diagnosis and treatment of people with the symptoms of a possible heart attack or other heart problem*. They call for protocols to ensure that all those showing signs of a possible heart attack are given the appropriate assessment and emergency treatment in good time. However, these goals are likely to be constrained by a failure to discuss the ways in which chd may manifest itself differently in women and in men.

Women often visit a doctor for the first time with atypical forms of angina. This may not be as easily recognized as the classic male symptoms (Philpott et al 2001). Confusion may also ensue because younger women are more likely to report non-coronary-related chest pain sometimes leading to false positive diagnoses. Men are more likely to delay seeking help even when in extreme pain and may underplay their symptoms (White & Johnson 2000). If these differences are not properly recognised they may lead to less than optimal treatment.

Standard twelve focuses on the development of *strategies for rehabilitation and secondary prevention*. Protocols are required to ensure that all chd patients are invited to participate in a rehabilitation programme. No attention is given to possible differences between women and men. The greater average age of female cardiac patients will influence the factors to be considered when developing appropriate services. Studies have also shown gender differences in attitudes towards physical exercise: Women often feel less able than men to participate in organized exercise in a mixed setting.

In recent years, some researchers in the UK have begun to evaluate local cardiac services from a gender perspective (Petticrew et al 1993). This literature remains small in comparison with the burgeoning volume of evidence in the US and some of the studies report conflicting results. But the existing evidence does offer important insight into the effects of the gender blindness in the NHS guidelines.

A recent study on general practice in the Trent region showed that men were more likely than women to have cardiovascular risk factors recorded on a computer (Hippisley-Cox et al 2001). The women were more likely to have an abnormal reading, but the men were more likely to receive lipid lowering treatment. Another study in general practices in England and Wales also found that men were significantly more likely than women to be prescribed statins (Majeed, Moser & Maxwell 2000). Researchers in primary care practices in Ireland found that female patients were significantly less likely than their male counterparts to receive prescriptions for aspirin, beta blockers or ACR inhibitors but were more likely to receive benzodiazepine. (Williams, Bennett & Feely 2003)

There is also evidence of gender differences in coronary care in hospital settings. A recent study found that women with myocardial infarction were less likely to be admitted to intensive care than men with the same condition (Raine 2002b). Another study done by the same author found no gender differences in the use of revascularisation procedures overall but men were more likely to undergo a coronary artery bypass grafting (Raine et al 2002a).

A number of studies have examined gender differences in the use of cardiac rehabilitation services in the UK. In a recent national study, hypertensive men were found to be nearly twice as likely to undergo a rehabilitation programme as hypertensive women (Raine, Hutchings & Black 2004).

These illustrative examples demonstrate the differences in the way women and men with heart disease are treated within the NHS. Of course such findings are not always easy to interpret. They could simply reflect differing needs along sex and gender lines and therefore represent good medical practice. However, the evidence suggests at least a lack of knowledge among practitioners and a general belief that heart disease is predominantly 'male.' This can lead to gender biases with women usually coming out as the losers.

Failure to take sex and gender seriously in health care may also harm male patients. In the case of heart disease, the psychological consequences of illness may be especially profound, posing threats to sexuality and masculinity which many men may find difficult to handle. Similarly, the concentration of research on the experience of young white males ignores to the experiences of older and/or non-white men. Appropriate attention must be given not only to differences between male and female patients but also to variations within these groups in order to maximize the sensitivity and effectiveness of services.

Mainstreaming gender: recommendations for the NHS

Little attention is currently given to sex and gender issues in the NHS. The reasons are clearly complex but some of the key factors can be identified. Many people in the UK view the NHS as a moral 'gift' to be accepted with gratitude. However, the power of biomedicine and of those who practice it remains very strong, so the differences between women and men are framed largely within the biological sphere of reproduction. This trend is reinforced because women have not been a powerful constituency in the post war period either in medicine or in wider society. Other social inequalities such as class or ethnicity have been assumed to have greater urgency by successive governments.

The NHS does not have an overall gender policy, nor are gender issues commonly integrated into its specific policies. As a result, gender issues receive a low priority in the design and delivery of services. Despite a rhetoric of decentralization, the government continues to exert strong pressure on methods of delivering health services in the UK. It uses a range of strategies to ensure that its political priorities are placed high on the agenda of managers and health care workers. For example, the government sets targets and then imposes penalties on organizations and individuals who fail to meet them. Under these circumstances, there is little incentive to focus more closely on sex and gender concerns.

This situation is unlikely to change without a marked increase in political commitment from the government and from senior policymakers in the NHS. New policy initiatives would be necessary not just in the context of coronary care, but across the entire range of health care provisions including disease prevention, health promotion and interventions that address the wider determinants of health. In other words, sex and gender mainstreaming are necessary in all the activities of the NHS and its associated agencies.

For health care within the NHS to meet the needs of both women and men, new policy initiatives are necessary not just in the context of coronary care but across all health care provisions that address the

wider determinants of health, including disease prevention, health promotion and interventions. In other words, sex and gender mainstreaming is necessary in all the activities of the NHS and associated agencies.

The collection of data on health status and health care must be sensitive to both sex and gender differences. A recent review of official statistics in the UK included a consultation with a wide range of users and providers. It revealed considerable dissatisfaction, with two thirds of respondents reporting a lack of separate data for males and females and also a lack of data disaggregated by sex according to age, ethnicity and region (Dench et al, 2002). While some improvements have already been made, more work is necessary in the health sector, particularly where the gender disaggregation of routine statistics is essential for all aspects of planning.

More information is needed on health problems disproportionately affecting one group (Murgatroyd, 2000). For example, gender violence affects women more than men while criminal violence is more likely to affect men. However, little information has been collected on the health implications of these issues. Similarly, surveys on workplace health issues focus mainly on male experiences of occupational mortality and morbidity. More studies are needed of both male and female work hazards from a gendered perspective as part of a broader strategy for preventing disability and premature mortality.

With these changes in the collection of routine data on health and health care, *greater sensitivity to sex and gender issues is also needed in medical research*. There is now a strong emphasis in the NHS on 'evidence based medicine'. However, much of the evidence used in everyday clinical practice has been generated by studies based on the experiences of young white men (Bandyopadhya et al 2001; Lee et al 2001).This is true of both epidemiological studies and of clinical trials. The full extent of this bias has been demonstrated with particular clarity in research on coronary heart disease. It is also evident in a number of other settings (Sharp1998)

In the US this bias has been treated as an equity issue and has received a great deal of attention (Mastroianni et al 1994). In the late 1980's, some women began to claim their right to involvement in clinical trials in the same numbers as men. They made the case that when studies did not include appropriate numbers of women and men, the universality of their results would be indeterminate and hence they would be unscientific. Drugs that were tested on men but then used on both women and men ran the risk of being less effective or more hazardous in one sex than in the other.

In response to these arguments, the US government passed a law in 1993, requiring all applications for federal funding to show that women and men (and ethnic minority groups) were represented in appropriate numbers in the proposed research design. Similar initiatives have been implemented in a number of other countries including Canada, Australia and South Africa. But these arguments have received little attention in the UK.

Guidelines for the implementation of clinical trials show almost no awareness of the ethical and the scientific relevance of gender issues. The current guidelines for research ethics committees are also lacking. The new Research Governance Framework for the UK does mention the need for a body of research evidence that 'reflects the diversity of the population,' but it offers no practical guidance for achieving this.

For the evidence base of clinical medicine in the UK to optimally meet the clinical needs of both women and men, policies which are similar to those adopted in other countries must be developed. This will require the inclusion of sex and gender sensitivity in the criteria for peer reviews of funding applications, appropriate training for researchers, and the addition of gender (and other diversity issues) to the agendas of ethics committees.

For the NHS to deliver health care which is equally sensitive to the needs of the whole population, a workforce will be necessary which is both individually and collectively capable of recognizing these needs and meeting them in appropriate ways. This will require *training initiatives on the delivery of gender sensitive services for individuals and for teams*.

Health care workers must learn about gender issues as they apply to both women and men as part of their initial training. In a number of countries, these issues are becoming incorporated into medical, nursing and other curricula but such initiatives are scarce in the UK. A recent survey of British medical schools revealed very few examples of systematic innovation in the area of gender (Doyal 2003). A similar gap exists in the education of nurses (and other health related professionals).

Aside from mainstreaming gender issues into the undergraduate curriculum, those already working in the NHS require training. Those involved in the delivery of coronary care services should recognize the different symptoms and illness behaviors of male and female patients and to respond appropriately to their needs. This is equally important for those working in areas such as accident and emergency, mental health and primary care.

In recent years, a number of innovative services have been set up to meet the particular needs of women and men. Some hospitals are now offering one-stop clinics to support women in danger of miscarrying, while specialist cessation clinics have been developed to support women in disadvantaged areas who wish to give up smoking. Similarly, a range of health promotion initiatives have been designed to meet the gender-specific needs of some men. Services are being offered through local football clubs for example, or in a barbers shop or a Harley Davidson show room. Male drop- in centres have also been set up to target gay men.

These specialist projects are often developed in conjunction with agencies outside the NHS but their lessons are too rarely transferred into the mainstream. Gender sensitive care of this kind should be available for all patients in all services. This means that *sex and gender issues must be integrated not only into planning, but also into monitoring and evaluation*. Researchers have shown that women and men often differ in their perceptions of health and disease, in their illness behaviour and in their judgments about the care they receive. These differences should be at the heart of quality assurance mechanisms.

Traditionally, women have been the major providers of health care both inside and outside the NHS. Yet they have always had less control over decision making. Men have always held the majority of high status positions in the medical profession and in the management system. They are also a majority in the public bodies which run the services: In 2002, women made up just over a third of appointees to these positions. *Mechanisms are needed to ensure a more active involvement of women in NHS leadership*.

Despite the predominance of some men in positions of power, there is little evidence that researchers consult men as a group on their health and health care. This is especially true of those groups that are hardest to reach. Hence *gendered consultation processes are necessary to ensure that the needs and desires of both male and female service users are adequately represented*.

Conclusion

The elements of a gender mainstreaming strategy for policy and practice in the NHS have been outlined. The foundations of an evidence base have been provided in order to show why such changes would be beneficial to both users and providers of gender services. From the perspective of equity, it is clear that if policymakers and service providers understand the impact of gender on the daily lives of all patients, they will offer a better quality of care. From the perspective of efficiency and effectiveness, sex and gender are major determinants of health and health care needs. Failure to recognize this will lead to inefficient science and the already scarce resources will be wasted on interventions that are not effective in addressing both individual and population health problems. Both equity and efficiency arguments are necessary for generating a political will that takes sex and gender seriously in health care.

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9

A case study on the integration of a gender perspective into reproductive health policy in Turkey

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Introduction

Ensuring that men and women are given equal opportunities to realize their potential for health is an important goal of the UN. A crucial strategy to achieve this goal is the gender mainstreaming of national health policies. This entails integrating attention to sex and gender differences in all stages of policy development: problem definition and agenda setting; policy design; decision-making; policy implementation and monitoring.

As a member state of the WHO in the European Region, Turkey participated in and signed all the recommendations of The International Conference on Population and Development (ICPD) and the Beijing Platform for Action. Although gender mainstreaming theoretically is an accepted strategy for promoting gender equality in Turkey, so far the issue has not been studied in detail, particularly regarding health policy development. Because reproductive health is an area for concern in Turkey, "Gender & Health Policy Development in the area of Reproductive Health (RH)" has been selected as a topic for this case study. A comprehensive approach to reproductive health necessitates analysis and then response to the needs of women and men in their sexual relationships and reproduction. This demands that reproductive health care policy not only be based on the biomedical model as this tends to look at individuals out of context, and is often insufficient in its analysis of the causes of ill-health. Instead it must take into account and respond to the many faceted life-cycle needs of women and men (WHO, 1998; WHO, 1999). A crucial strategy to achieve this holistic view is the gender mainstreaming of national health policies.

In Turkey, programmes have been initiated to improve the status of women, which is a crucial determinant of their reproductive and sexual health. The General Directorate on the Status and Problems of Women (GDSPW) established in 1990 has collaborated with relevant government agencies and NGOs to carry out advocacy activities and to modify the existing legislation which lead to discriminatory practices against women. Similarly, the Social Structure and Women Statistics Department of the State Statistical Institute, established in 1993, makes gender specific statistics available in the country. In 1996 the General Directorate of MCH/FP of the Ministry of Health prepared "A National Strategic Plan on Women's Health". Nonetheless, gender inequalities continue to be apparent in reproduction and sexual issues in Turkish society.

With this in mind, the objectives of this study were;

- To analyze health policies on Reproductive Health (in particular, Family Planning and Unwanted Pregnancies) from a gender perspective.

- To provide recommendations on future work or policy options for Turkey as well as for the WHO.
- To evaluate the method used in the study.

Methodology

The case study aims to provide baseline information for the formal adoption of a national gender sensitive policy and to assess the extent to which gender specific considerations play a role in specific health policies. The study was conducted by a team of six people; four with medical/public health backgrounds, and two social scientists (See Annex 2). Weekly meetings with team members were organized to discuss the collected data and its interpretation, procedures and progresses. The study team formulated the results and a preliminary report was drawn up. This was initially prepared in Turkish and then translated into English.

The main questions for the analysis were:
- How have women's and men's needs been considered in development, implementation and monitoring of the family planning and unwanted pregnancies policy?
- What were obstacles for paying attention to men and women's needs?
- What were possibilities for paying attention to women and men's needs?

To address the objectives of the study, the main health policy documents and five pieces of legislation were examined for gender mainstreaming in *family planning* and *unwanted pregnancy*. Key policy documents related to Reproductive Health in Turkey were:
- Main Constitution of Turkey.
- Health Law on Socialization of the Health Care Services (# 224).
- First Population Planning Law (# 557).
- Second Population Planning Law (# 2827).
- Last Five Year Development Plan.

The study consisted of a content analysis on the selected policy documents using the guidelines set out by the WHO to examine the gender sensitivity of all stages of policy development. The guidelines were modified slightly to suit the purposes of the research team. Each piece of legislation was examined according to the guideline questions, namely problem analysis, policy formulation, implementation, monitoring, and evaluation.

After completion of the document analysis, interviews with key informants were also carried out to get information about unanswered questions and some other details for the study. Interviews were conducted by a social scientist from the team who is skilled in interview procedures, using the original WHO-guideline for the interviews. Because of the deadline for the project, it was only possible to carry out two interviews with the key informants. The team also wished to interview service providers and service recipients at the periphery but due to time constraints, this was not possible. The team hopes to expand the study, however, and may thus carry out such interviews at a later date.

Sources of epidemiological data were also used to inform the results of the study. These included data from the DHS of Turkey, Population Census data, statistics made available by the State Institute of

Statistics (SIS) and the Ministry of Health, information from the 'Five Year Development Plans' of the State Planning Organization (SPO), and the results of relevant research carried out by the universities. These sources provided information on the use of contraception and induced abortion by married couples in Turkey, maternal mortality rates, crude birth rates, unwanted pregnancy rates and infant mortality rates. Full details are provided in Annex 1.

A matrix was formed to summarize the document analysis based on the following questions:

- What gender considerations are included in the policy?
- What were the enabling factors to do this?
- What available information about gender was not included in the policy?
- What were the barriers to including this information?

A detailed report on the analyses is attached as Annex 2.

Results

The first piece of legislation analyzed, *The Main Constitution of the Republic of Turkey* (1982) includes references to gender issues in relation to both gender equity and gender equality perspectives. The term gender appears first in "General Principles" (Chapter I) when Article 10, on "Equality Before Law" states that:

> *"All are equal before law regardless of language, race, color,* ***gender****, political ideas, philosophical commitment, religion, sect, etc."*

Equality is defined as one of the three indispensable principles of democracy. It is further stated that discrimination based on any qualification or criterion is strictly prohibited and that state bodies and administrative authorities are obliged to observe this principle of equality and non-discrimination. The document frequently uses terms such as "all" and "no one" which may indicate some kind of equality, but not specifically gender equality. It is non-discriminatory as regards socio-economic status, gender, age etc. However gender as a term does appear in some of the articles, with references to both gender equity and gender equality. Further amendments to the Constitution made progress towards creating gender sensitive legislation. In conclusion, The Main Constitution was concerned with gender equality and gender equity in its overall approach. Its later alterations include positive discriminative items for women. (See Matrix 1 and Annex 2)

The second law analyzed was *The Law on General Hygiene* (1930) which focuses on general health issues, including the obligation to educate people on health issues and to incorporate health courses into schools. Some of its articles are sensitive to gender equality while others have gender discriminative profiles. Some of the articles include traditional female gender roles in society, for example, Article 169 provides for the incorporation of childcare courses in curricula for schoolgirls to prepare them for future motherhood, which is seen as the principal duty of women. Nevertheless, the recognition of women's presence in the public sphere and entitlements for paid leave before and after delivery can be seen as significant steps forward (Article 155). The era in which this law was created should be considered, however - following the devastating effects of the First World War and War of Liberation, population growth was supported through pronatalist policies which are likely to

have had a significant impact on legislation. (See Matrix 2 and Annex 2)

The goal of the third law analyzed, *The Law on Socialized Health Care Services* (1961), is to ensure social justice in access to and delivery of health services. It seeks to create gender equality by eliminating discrimination between men and women and to provide all citizens with equal rights regardless of their gender, age, religion, etc. In general, articles in the original law were found to reinforce patriarchal norms emphasizing the traditional gender roles of women, especially their reproductive roles. The document does contain some articles on gender equality, however, for example Article 64 which states that:

> *"training in family planning should cover not only to women but also to husbands and other household members like in-laws and close relatives who may be influential on fertility behavior" (Paragraph d).*

Under the new regulations, equity became the focus rather than equality and the importance of providing services according to people's needs. Later amendments targeted all women (not just mothers) which led to women being seen as a 'special risk group' due to their fertility rather than merely as instruments for raising healthy generations. In spite of this new perspective, the law limits the role of a woman to that of a mother and a housewife who is responsible for childcare and family health, especially problems with fertility. (See Matrix 3 and Annex 2)
The fourth piece of legislation examined was *The First Population Planning Law* (1965) which has been implemented at national level. This law specifically addresses maternal mortality caused by induced abortions and unwanted pregnancies, and stresses the adverse effects of population growth on the national economy. Although this law allowed for the use of contraception (except for surgical sterilization), pregnancy termination was still forbidden if not performed for medical reasons. The law was deemed insufficient as regards satisfying gender related targets. In preparing this policy, the results of Turkey's first survey on fertility and health, conducted by the Ministry of Health in 1963, were considered.

The policy aimed to promote education on contraception, to provide people with contraceptives and to train health service providers. The monitoring mechanism for this law established by the reporting system of the Ministry of Health is a five-year development plan from the SPO and statistics published periodically by the SIS. The statistics show that the crude birth rate decreased by 12 % between the years 1960 and 1978. Maternal mortality rate decreased from 208 in 100.000 live births to 132 from 1974 to 1981. The records of the Ministry of Health and the Population Censuses as well as the Population and Health Surveys contain sex disaggregated data for married women only. This data acts as a guide for some authorities and decision makers. (See Matrix 4 and Annex 2)

The fifth law examined was *The Second Population Planning Law* (1983), also implemented at the national level. The Ministry of Health has the responsibility of implementation, but it cooperates with universities, social insurance institutions, Radio and Television Corporation, other relevant governmental agencies, professional organizations and nongovernmental organizations. The law addresses population planning including fertility regulation, providing and producing contraceptives, and surgical sterilization. It allows for the termination of pregnancies, where it is carried out under the supervision of physicians and in safe conditions. The law partially satisfies the goals of gender and health. While under earlier policies, women were regarded as instruments of birth and were associated mainly with

their biological reproduction, under this policy the decision on whether or not to have an abortion rests primarily with women. The law does not allow discrimination by marital status in terminating pregnancies. Surgical sterilization is permitted for both men and women over 18 years of age.

The policy aims to decrease the ratio of high risk pregnancies, the maternal mortality rate and to educate at least 5 % of couples each year on effective methods of contraception. The parties responsible for following-up on this policy are the Advisory Boards of Family Planning and Women's Health of the Maternal Child Health – Family Planning General Directorate of the Ministry of Health, Population and Health Surveys, Population Censuses and Five-Year Development Plans arranged by the State Planning Organization. The General Directorate of Women's Status and Problems, a standing commission of the Turkish Parliament, The State Planning Organization, The Women's Health Commission (KASAKOM) and Women Research and Implementation Centers in 14 universities (including Hacettepe University Research and Implementation Center on Women's Issues – HUWRIC) will ensure that gender issues are incorporated into health policy. For selected policy, the data on gender distribution comes from The State Institute of Statistics, the universities that conduct research on this issue and the Ministry of Health. In this policy, data from the DHS of 1978, from SIS and MoH and research conducted by the universities [1] were used. (See Matrix 5 and Annex 2)

Conclusions and discussion

Five major laws were examined in the Turkish study for gender mainstreaming in reproductive health and its specific sub topics of unplanned / unwanted pregnancies and family planning. The study showed that limited attention has been given to sex differences in problem definition, agenda setting, and policy design. However, further investigations are necessary to define the extent to which current legislation affects decision making and policy implementation. An examination of the legislation only is not enough to determine whether or not a gender perspective is integrated into real life. Information must be collected from the peripheral levels to monitor the implementation of gender sensitive policy on RH.

Observations from the current study:

- Because concepts of gender equality and gender equity were not clearly defined in the past, gender perspectives and gender specific considerations either received little emphasis or were missing from old legislation.
- Differences between sexes and the disadvantages of one sex were emphasized. Some preventive measures were taken.
- The reproductive role of women was overemphasized in past laws because women were characterized as a necessity for demographic purposes: a woman's fertility was pushed without her consent. However, in the recent laws she is given the right to decide about her fertility regulation.
- Male involvement in reproductive health has been neglected in all stages of policy development. However, reproductive health can be improved by involving men in family planning and by equally and equitably meeting the reproductive health needs of both men and women.

1. The results from the "Operation Research" jointly carried out by the Public Health Department of Hacettepe University and the WHO were used to formulate 3 important articles of Law no. 2827 on induced abortion, authorization of trained nurses-midwives for the provision of IUD services and authorization of trained general practitioners for the termination of pregnancies.

Limitations of the study:

- The language of the old/new legislation was difficult to interpret and understand even in Turkish (1930). In addition, the background information for the legislation was not easily accessible or at times even missing.
- An extensive number of policy documents on the topics of the study are available, however the time constraints allowed the team to examine only 5 legislations.
- Because the time allocated to the study was rather short, extensions and continuations require consideration. There are plans to continue the Turkish study into its next phase with the support of the UNFPA to see to what extent gender equality and equity has been implemented in practice. Because the work was first prepared in Turkish and then translated into English, it required more time. As a result, only a few key experts were interviewed. With more time, more core persons will be interviewed to fill in missing information.

Recommendations

For Turkey:

- Advocacy activities that promote the consideration of gender issues among policy makers, related sectors who design and develop the policies on reproductive health and especially the jurists / law faculties should be continued.
- Because democratic parliamentary system MPs prepare the legislation, they should be educated and sensitized to gender perspectives and the consideration of gender issues. Also, the proportion of female MPs with sufficient knowledge on gender perspectives in parliament should be increased.
- In order to integrate a gender perspective into the development of health policy, accurate data on gender issues is necessary.
- Sex disaggregated data is at times confused with gender. The distinction between “sex” and “gender” should be clearly defined.
- A 2nd phase of the study is necessary because gender mainstreaming is based on the theory that its implementation requires examination.
- In order to create policy dialogues, information should be disseminated to the relevant stakeholders, such as policy makers (including MPs), health personnel, NGOs, women/men in the community and the media.
- Both gender equality and gender equity should be considered in analysis and policy formulation.
- The existing laws should be screened for gender blindness and gender sensitivity. Gender issues must be incorporated into any new legislation.
- Male involvement should be considered in all stages of reproductive health policy.

For the WHO:

- Some time extensions/ continuations of this project should be considered. The next phase of the current Turkish study will be completed with the support of the UNFPA.
- Dissemination meetings should be organized because getting information to member states, international organizations and other relevant stakeholders including NGOs is extremely important.
- Standard definitions of gender issues are not clear. Terminology should first be standardized, then adapted to the local / country / region specific terminology. The criterion used to determine whether a specific health policy is gender sensitive should be clearly defined. Another proposed

WHO project: "The development of gender sensitive indicators for public health policy" should be carried out.
- The WHO should communicate the results of this study with other UN health agencies including the World Bank and the European Union.
- Methodology for the "integration of a gender perspective" into health policy should be simplified/ standardized with clear indicators.
- The report should be sent officially by the WHO to the Member States.
- An assessment of the gender sensitivity of WHO policies and programmes should also be made. through case studies.
- Every effort should be made to integrate "gender issues" into all WHO programmes.
- The WHO should organize at least 2 inter-country dissemination meetings to publicize the results of the 7 country case studies.
- WHO should allocate a budget for gender analysis.
- Regional activities should communicate and collaborate closely with the WHO / HQ based on the principles of "One WHO" and "One UN".

Comments on WHO – Guidelines
- The guidelines were well-developed and well-prepared which enabled and facilitated the gender analysis analysis much more effective. It is recommended to include them in a gender mainstreaming tool kit.
- The matrix was helpful for summarizing the results, but further explanation should have been provided, as it was not easy to fill in.
- Indicators should be developed to assess gender issues.

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MATRIX 1. Title of the policy: Constitution of the Republic of Turkey, 1982				
	Gender considerations included	**Enabling factors**	**Gender considerations not included**	**Barriers**
Objectives	1980 Constitution considers the reassurance of individuals' rights and freedom. Article 10– "All are equal before law regardless of language, race, color, **gender,** political ideas, philosophical commitment, religion, sect, etc" Article 42– "Primary education is compulsory for **all male and female citizens** and is provided free by the State" Article 41– "Family is the basis of Turkish society…and family itself is based on the equal status of spouses"	The development level of the state. Equality is defined as one of the three indispensable principles of democracy; state bodies and administrative authorities are obliged to observe this principle of equality and non-discrimination	No specific gender approach Article 50- "no one can be employed in work unfit to his/her age and **sex;** minors, **women** and persons with physical and mental disabilities shall be accorded special protection in terms of working conditions"	'Gender' not taken into account at that time. Positive discrimination / lowering the status of women?
Stages of policy development • **Problem Description**	1961 Constitution had some gaps with regard to its items about individuals' rights and freedom. In addition, realizing and practicing all the requirements that parliamentarian regimen necessitates in terms of execution and legislation should be met. Execution should be strengthened and the control of justice should be done legally."	Again, there is a general consideration including men and women..	No specific consideration of gender	As above – gender not taken into account
• **Planning**	Equality is the guiding principle (Article 10) Women, more specifically mothers, said to enjoy special protection in terms of working conditions. Further amendments and provisions removed some gender discriminative expressions from the law, e.g., re. the citizenship status of a child born to a Turkish mother and a foreign father; political parties' rights to organize units as female branches.	Equality is defined as one of the three indispensable principles of democracy. Later amendments to the Constitution were influenced by the adoption of CEDAW and 4th World Women Conference (Beijing).	Women are classified under "Persons Requiring Special Protection in the Field of Security" Targets female widows of martyrs, married women and mothers - not all women.	Lower status of women Gender was not a term that was addressed and stressed in the 1980's in Turkey.
• **Implementation**	To be investigated and examined further at a later date.	--	--	--
• **Monitoring**	To be investigated and examined further at a later date.	--	--	--
Process Characteristics • Gender experts included	Not available	NA	NA	NA

MATRIX 2. Title of the policy: Law on General Hygiene, #1593, 1930				
	Gender considerations included	**Enabling factors**	**Gender considerations not included**	**Barriers**
Objectives	Defines the duties and responsibilities of all institutions in the field of health; aims to introduce up-to-date provisions and arrangements to respond to current health needs. No specific consideration of gender	General poor health and needs of population Pro-natalist policy of Turkey at the time	No specific consideration of gender	No gender perception at that time
Stages of policy development • **Problem Description**	Women's health was considered mainly for their fertility Article 155- paid leave to working women before and after childbirth Article 169- incorporation of childcare courses in curricula for schoolgirls to prepare them for future motherhood, which is seen as the principal duty of women	Exclusively focuses on health issues, many articles pertaining to both male and female health equally.	Some articles reflect gender discrimination. Some articles favor motherhood but not women in general. Some articles view women's body and fertility as an instrument	No gender perception at that time Culture and traditional view of gender roles
• **Planning**	No information	No information	No information	No information
• **Implementation**	An equitable approach prioritizing needs of 'risk' groups	General attitude of the policy makers	Any positive discrimination favors motherhood rather than women, which further consolidates women's traditional gender role in society.	No gender perception at that time Culture and traditional view of gender roles
• **Monitoring**	Establishes a reporting system whereby health facilities and health workers are obliged to report on certain issues. Compulsory to incorporate health courses to school curricula and to launch programs for training public at large on health issues. Fines and/or imprisonment for acts of breach. Items encouraging excessive fertility changed later.	The new legislation come into force (224, 557)		There was no gender perception at that time
Process Characteristics • Gender experts included	No	NA	No such experts	There was no gender perception at that time

MATRIX 3. Title of the policy: Law on the Socialization of the Health Care Services in Turkey, #224, 1961 & later Regulations				
	Gender considerations included	**Enabling factors**	**Gender considerations not included**	**Barriers**
Objectives	To provide unpaid/free and equal health services to **all** citizens (men and women accepted as equal citizens by the state). Article 2- "Socialization of health services envisages **equal** access to and use of available health services by all citizens either totally free or by partially sharing the cost of these services." Reg. No. 6/3470 Article 3 (d)- "especially uneducated women in urban and rural areas will be trained in childcare, household affairs, personal hygiene and nutrition of children and adults to enable them to raise well cared and healthier generations." Reg. (2002), Article 64 (d)- "training in family planning should cover not only to women but also to husbands and other household members like in-laws and close relatives who may be influential on fertility behavior"	Health indicators of the country led to this law. New, comprehensive and inclusive health services were necessary to improve health situation of men and women.	Equality between sexes was only included because of absence of current understanding of "gender" concept at that time. Reinforces traditional role of women – few references to the role of men	Lack of understanding of gender issues Cultural barriers like education, working status and gender roles in the family and in the society
Stages of policy development • **Problem Description**	Regional disparities were considered important priority by the state. Women were seen as the first agent for improving family health, especially children's health.	Level of social status of women and their poor reproductive health was recognized.	Policy makers protected traditional female roles - improve women's health knowledge and attitudes to develop healthy & happy family life.	As above. Women seen only in terms of their roles as "mother", "wife" and "housewife".
• **Planning**	Women were accepted as health care provider in solving family's (husband, children and close environment of family) health problems.	Low participation rates of women in the paid labour force.	As above, women's primary role was defined by the traditional/patriarchal values	As above
• **Implementation**	As above	As above	As above	As above
• **Monitoring**	Less developed region of country was selected for implementation. The Ministry of Health monitored Mother and child health steadily.	Established mechanisms for data collection on level of women's education and MCH.	Not included	Infrastructure,; patriarchal values, partial implementation of the law.
Process Characteristics • Gender experts included	There was no gender perception at that time. However, health care professionals emphasized disadvantages of women and their poor reproductive health.	NA	Only RH of disadvantaged women was included; RH of other groups (incl. men) not seen as important	Unavailability of such experts.

MATRIX 4. Title of the policy: Population Planning Law No: 557, 1965				
	Gender considerations included	**Enabling factors**	**Gender considerations not included**	**Barriers**
Objectives	Partially Preamble stresses the negative effects of rapid population growth on national economy and points out the need to prevent unacceptable rates of maternal mortality (often from abortions attempted as a result of unwanted pregnancies). Stated that it is the duty of the State to help women who want to avoid pregnancy and husbands who don't want their wives to get pregnant.	After previous pro-natalist law, the state adopted an anti-natalist population policy and promulgated the first population planning law Effects of excessive fertility on women's health	Non-married couples not catered for	Gender issue was not recognized in the country at that time
Stages of policy development • **Problem Description**	Partially Unfavorable outcomes of unwanted pregnancies have been mentioned in the statement of law Different needs of men and women are taken into consideration	Increased maternal death due to induced abortion High prevalence of unwanted pregnancies Advocacy activities by the NGOs	Partially	Conservative and traditional approach on abortion Lack of information on surgical contraception Demographic concerns were more influential
• **Planning**	Resource allocation Government support	Negative economic impacts of over-population	-	-
• **Implementation**	Resource allocation Government support	Importation and selling the contraceptives were legalized Government support all contraceptives as free of charge	Difficulties in implementation of the gender consideration	Personal acceptance Insufficient health education on contraceptives Lack of trained staff Social constraints
• **Monitoring**	Partially Sex specific qualitative data was collected but issues related to gender issues were not specified	Results of Turkish Population and Health Surveys Results of MOH records State Planning Org. Reports	Difficulties in monitoring	Lack of routine periodic and gender specific data, because gender issue was not recognized in the country at that time Also poor recording and reporting system
Process Characteristics • Gender experts included	No	-	-	Conservative and traditional approach on women participation to policy making

MATRIX 5. Title of the policy: Population Planning Law No: 557, 1965				
	Gender considerations included	**Enabling factors**	**Gender considerations not included**	**Barriers**
Objectives	Article 1: "The principal objective of this legislation is to lay down the principles of population planning and arrange for such relevant issues as termination pregnancies, surgical sterilization, cases of urgent intervention and identification, procurement and manufacturing of contraceptive methods." Abortion and Family Planning method choice is up to woman	Results of the scientific studies, which guided the objectives of law	Concentrates on the needs of women re. maternal mortality, not much reference made to men's needs	Gender issue was not recognized in the country at that time
Stages of policy development • **Problem Description**	Maternal deaths remained high Unwanted pregnancies continued to be a problem Target group for the policy: Males & females aged 15-49	Results of the scientific studies on maternal mortality related to unsafe abortion Advocacy activities by the university	-	-
• **Planning**	Partially - Special resource allocation for contraceptive methods (Article 3- "…free or at low cost to **all those** who are in need")	Resource allocation Government support	-	-
• **Implementation**	Partially - Abortion and Family Planning method choice is up to woman	Resource allocation Government support	Difficulties in implementation	Personal acceptance Insufficient health education on contraceptives
• **Monitoring**	Partially; Sex specific qualitative data was collected but not issues related to gender issues were specified	Results of Turkish Population and Health Surveys Results of MOH records State Planning Org. Reports	Partially ; Last two- DHS take gender consideration into account (unmarried women & men were included into the survey)	Lack of systematic and gender specific data Conservative and traditional approach on woman's health
Process Characteristics • **Gender experts included**	Partially; only gender sensitive scientists included in policy development	Dept. of Maternal & Child Heath and Family Planning Women's heath commission and study groups CEDAW University Research Centers on Women's Issues	-	-

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Gender analysis of health policies in family planning services at the National Center of Reproductive Health in the Republic of Tajikistan

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Introduction and background

The Beijing Declaration and Platform for Action both proclaim that a woman's right to control her sexual behavior is one of her basic human rights. This includes sexual and reproductive health and the right for both men and women to have access to information on "safe, effective and appropriate family planning methods."
The law of the Republic of Tajikistan on population health protection states that a woman has the right to decide about motherhood and to voluntarily obtain contraceptive services. Discussions are underway on the right of the family to plan its number of children and to undertake the responsibility for their health and education. The government must guarantee conditions supportive to reproductive rights for women, men and children.

During Soviet times, the high birth rate was the result of a number of factors, including limited access to contraceptives, a lack of information on contraception methods, abortion bans from 1935 to 1955, and different parental incentives and benefits.

On February 20, 2002 the President of the Republic of Tajikistan made a speech at the nationwide meeting on the problems of demographic development and family planning, stressing the relationship between family planning issues and poverty. More than 70% of Tajikistan's population lives in rural areas where the birth rate exceeds the capacity of the land resources. Mr. Emomali Rahmonov underlined that if the population growth continues to escalate under these conditions, the rural inhabitants will soon represent the poorest and most uneducated group in society.

In a country where 83% of the population live below the national standards of poverty, (source: the Government and international organizations) family planning must have priority. The Millennium Development Goals National Report states as its first objective "to reduce the population living under the poverty standard twofold by 2015".

This report analyzes Tajikistan's gender policy in the health sector with a focuses on family planning. The National Reproductive Health Center and the Reproductive Health Center in Vahdat city provided most of the information.

Goals of the report:
- To describe the governmental policy for gender mainstreaming,
- To describe results of a survey of how gender considerations are taken into account in

reproductive health services;
- To develop recommendations for the incorporation of gender issues into health care policy in Tajikistan;
- To make recommendations to the World Health Organization (WHO) for further policy development;

Methods

To conduct the policy analysis, a number of regulations, legislation and strategic plans were analyzed as well as the Reproductive Health Centre's (RHC) reports and statistical data (including health information.) A survey was conducted through interviews with health personnel from the National RHC and the RHC in Vahdat city. Visitors of these centers were also interviewed.

Men and women who were not clients of the centers were also questioned by the quota method as described below:

Age	Men	Women
15-19	**3**	**3**
20-24	**3**	**3**
25-29	**3**	**3**
30-34	**2**	**2**
35-39	**2**	**2**
40-44	**1**	**1**
45-49	**1**	**1**
Total:	**15**	**15**

The questionnaires were designed by specialists and then approved by the Ministry of Health of the Republic of Tajikistan.

For two weeks, the interviewers observed the work of the National RHC and RHC in Vahdat city and interviewed visitors. In most cases, the interview followed the *question-answer* method and the answers were filled into questionnaires. In some cases, the responses were recorded by a voice-recorder and then transcribed by the special expert onto questionnaires.

The interview analysis was carried out by trained specialists.

Purpose of the survey:
- To analyze gender policy in Tajikistan.
- To analyze gender policy in the health sector with a focus on family planning.
- To analyze the work of the Reproductive Health Center for the potential inclusion of a gender perspective in the family planning services.
- To monitor the local success of gender policy.
- To develop a country report on the incorporation of gender issues into health care policy with a focus on family planning.

Results

Gender policies in place in the Republic of Tajikistan

Equal rights and equal opportunities for men and women
The development of a gender policy began in the mid-90s. Legally, Tajikistan has a significant amount of non-discriminatory legislation for women in place. The government ratified a number of international conventions and agreements on human rights and Tajikistan is a country-member of the Convention on the Abolition of All Forms of Discrimination Regarding Women (CEDAW). The legal, social and economic guarantees on the protection of women's rights are described in the constitution and are regulated by several legislative documents.

The republic adopted laws to defend women's rights in matrimonial relationships, labor, criminal code and reproduction. The President of the Republic of Tajikistan issued a decree for the democratization of society, including an "Increase in the role of women in society" (December 3, 1999). Its purpose was to ensure the extended involvement of women in public life and governance, to increase the social status of women, to enhance the national gene pool, and to activate the role of women in protecting moral standards, peace and unity of the country. In response, the government of Tajikistan and a number of public authorities and departments committed themselves to developing the national policy: "The place and role of a woman in society". This policy interprets the presidential decree as recognizing the competence, professionalism and business skills that women have and that are necessary to fill managerial positions in ministries, national committees, prosecutor and court offices, facilities that offer higher and lower education, and in a number of other departments and organizations. Additionally, law enforcement agencies were given orders to tighten control on cases of violence against women, polygamy and the discrimination of women.

Currently, a draft of the law "on governmental guarantees to ensure equal rights and opportunities to men and women" is under discussion.

Gender and health
The government of the Republic of Tajikistan has approved the National Action Plan to increase the status and role of women from 1998 to 2005 (Regulation #363, September 10, 1998), and the national programme "basic guidelines from national policy to ensure equal rights and opportunities to men and women from 2001 to 2010" (Regulation #391, August 8, 2001). Both of these documents aim to create health protection for both men and women, and to enhance the quality of services available in Tajikistan.

The documents "The Poverty Reduction Strategy Paper" (2002) and "Achieving Millenium Development Goals" (2003), clearly define the current problems in Mother and Child Health (MCH.) These reports stipulate specific goals for the elimination of gender inequity in primary and secondary education, for the reduction of mortality rates in children under 5 by 2/3, by 3/4 in new mothers, and by 2/3 in all children, for the extension of access to reproductive health services, and for the prevention of HIV/AIDS risks.
National concept #201 on demographic policy in the Republic of Tajikistan was adopted on May 6, 2002 for 2003-2015. This concept focuses on protecting maternity rights. Child and reproductive rights are already in place.

In 1997, the government of the Republic of Tajikistan approved a national programme entitled "The Strategy of the Republic of Tajikistan on Population Health Protection until 2010." This programme includes 29 global objectives for improving the health sector and population health status, including the reorganization and development of primary health care, the introduction of family medicine, a transition towards the health insurance system, etc. This strategy was created within the framework of the WHO European Office's Health For All 21 strategy.
The parliament of Tajikistan also approved the law "On Population Health Protection" which grants a population the right to choose its services from the multiple-level health system. For example, a population may choose private or government-controlled health care.

The Republic of Tajikistan has adopted national programmes such as "Reproductive Health and Reproductive Rights for 2000-2003" and "The Strategy for Tajikistan on Health Protection until 2005."Since 1999, UNFPA and the government have been implementing a collaborative programme to improve reproductive health and to enhance access to family planning. A sectoral programme on reproductive health, family planning and other initiatives is also in development.

The law on "Reproductive Health and Reproductive Rights" has been approved. All of its documents are based on principles from the Cairo Conference on Population and Development and from the Beijing Declaration and Platform for Action. The existing programmes promote health, illnesses prevention and a more efficient use of resources. Its goals correspond to international practices and are supported by a number of international organizations, including the World Health Organization (WHO), the UN Child Fund (UNICEF), the UN Population Fund (UNFPA) and the UN Development Programme (UNDP).

Non-governmental organizations (particularly organizations for women) are beginning to lobby for new laws. For example, the public organization "Gender & Development" (an executing agency for four years for the project "Promotion of population density, reproductive rights, family planning, gender and the environment,") has delivered expertise on the draft law "On Reproductive Rights and Reproductive Health" and has made recommendations to the government to include amendments and changes. This was achieved through the support of local NGOs with small grants. The majority of amendments and changes were incorporated into the final draft law.

The Ministry of Health initiative and the Draft Strategy Plan of the Republic of Tajikistan, both address reproductive health until the year 2014. The government's concern about the continuing consequences of gender inequity on women's health and about the social and economic inequalities between men and women – all have encouraged the development of the above mentioned plan. The draft Strategic Plan addresses problems in reproductive choice, safe motherhood, the control of STIs and HIV/AIDS, sexual violence and trafficking, sexual and reproductive health among adolescence, and a number of other issues.

From 1996 to 2003, pioneer institutions were established to address population development and demography. Some of these institutions include the Commission on Population and Development under the government of Tajikistan, the Institute of Demography (affiliated with the Academy of Science of Tajikistan,) the Reproductive Health department within the Ministry of Health, and the national, regional (oblast) and district centers of reproductive health.

Current situation

A decrease in health sector budgeting from the government equally affects both men's and women's health. Before 1991, the government budgeted $25 USD per person for health care. In 1999, it budgeted only $10 USD per person. Various epidemics, poor nutrition and poverty provoked the emergence of a large and vulnerable population group, consisting mainly of women and children without adequate health care or proper nutrition.

Tajikistan currently has high rates of maternity and infant mortality and is experiencing a decrease in the average life expectancy. Frequent labors and abortions, a reduction in contraceptives coverage and a heightened tendency towards early marriages and pregnancies among adolescent girls has negatively influenced the reproductive health of the population (Report "Tajikistan: On the Way to Gender Equality", 2003, p.9).

Interview results: the situation of gender in the National Reproductive Health Centre

According to the interviewers, a total of 843 clients visited the National Reproductive Health Centre (RHC)from March 23 to April 6, 2004, (the time period of the survey). The majority of these visitors refused to talk to the interviewers.

Selection of participants
Both in the National RHC (Dushanbe) and Reproductive Health Centre (RHC) in Vahdat city, a total of 418 visitors were questioned. Of these, 93.5% (390) were women and 6.5% (27) were men. The interviewed visitors fit the following criteria: they were 30 men and 30 women in the 15-49 age group living in either Dushanbe (the Giprozemgorodok area), in three villages (Jomry 1,2,3), or in *kolkhoz Lenin* in Vahdat city.
Household interview were also held. In Dushanbe the sample consisted of people in specific age groups on every other floor and in every door located on the left in multi-story buildings. In the villages, the survey was conducted in every second household.

The respondents were selected as follows:

In RH Centers	**In randomly selected households (quota)**
18-24 – 26.1%	15-19 – 20.0%
25-34 – 44.5%	20-24 – 20.0%
35-44 – 26.8%	25-29 – 20%
45-54 – 2.6%	30-34 – 13.3%
	35-39 – 13.3%
	40-44 – 6.6%
	45-49 – 6.7%

Demography: family status and social status

In both RHCs, the majority of respondents were married (91.9% and 68.9% respectively). Of the respondents at the RHCs, 1.7% of men/women were identified as the second spouse or as engaging in a polygamous marriage.

However, in the random survey this percentage was 9.85%, in spite of the smaller number of respondents. These figures suggest that a second wife in a polygamous marriage often does not apply to an RHC for consultancies or other services. 74.9% of respondents at the RHCs are unemployed. This number was 43.3% in the random survey.

Respondents were asked about the visits made by their spouses to the RHCs. It was found that only 15.4% of the respondents' spouses applied for health services and that 81.6% did not. Seventy-six percent of men said that their wives had applied for health care while only 11.3% of women said the same about their husbands. This confirms that women are the major clientele of RHCs. Young married couples aged 18-24 are frequent visitors. The older the respondents get, the less their spouses apply to RHCs.

The majority of RHC clients were students and professionals with a higher education.

In the RHCs, the breakdown of children in each family was as follows: 1 child – 13.4%, 2-3 children – 42.3%, 4-5 children – 20.6%, 6 and 6 or more children – 4.5%, no children – 19.1%.
The respondents from the randomly selected households gave the following information: 1 child – 15.5%, 2-3 children – 38.3%, 4-5 children – 11.7%, 6 or more children – 3.3%, no children – 31.7%.

Preferred health care institutions/services
When asked the questions "Which institution do you consider for reproductive health care?" the respondents answered as follows: RHCs – 9.1%, women consultancy offices – 10.5%, policlinic – 12.4%, other medical facility – 6%. Of the women who consulted RHCs, 14.6% went to detect a pregnancy, 9.6% went in the case of an illness, and 2.4% went because of infertility.

The RHCs provide various reproductive health services. The household survey showed that 65.9% of respondents (particularly those aged 18-24) had an ultra-sound examination while visiting the RHC, and 55.6% respondents got consultancies on a variety of subjects. In the RHC in Vahdat city, a double amount of respondents (59.7%) received consultations compared with the 26.1% of respondents in the national RHC.

Reproductive awareness; Services sought/available
Information on contraception was given to 15.4% of interviewees in the RHCs, especially students, civil employees, housewives and unemployed visitors.
Only 3.1% of respondents received handouts and other printed materials.
In comparing the work of the national RHC and the RHC in Vahdat city, one can see a difference in the list of frequently demanded services. In the national RHC, there were more consultative services, treatments, and contraceptive distributions. The RHC in Vahdat city never distributed printed handouts.

A function of the RHCs is to provide information and to raise awareness on reproductive health among the population. One method for achieving this is by designing and printing informational brochures and facilitating discussions. The survey shows that there is a shortage of printed materials being distributed to visitors in the RHCs. Also, only women receive brochures and verbal information.

82.7% of respondents are aware of pregnancy prevention methods. Remarkably, more men that women answered positively to the question "Do you know pregnancy prevention methods?" Of the 17.3% of interviewees answering negatively, most were housewives, unemployed visitors or workers. The highest rate of awareness was observed in men and in older respondents.

There is a minor difference in the responses from randomly selected households and in those collected from the RHCs: From the randomly selected households, 86.7% of interviewees were aware of contraceptive methods, while 13.3% were not aware. According to age groups, there was a contrary tendency in respondents below 30: the younger the respondents, the more they knew about pregnancy prevention methods and the issues involved. These trends indicate that the young generation has a greater interest in this subject and has better access to new information and technology through the internet and television.
Regardless of sex, age and education, more respondents in the RHCs (51.0%) knew about IUDs, condoms, pills and injections than those from the randomly selected households.

When asked where they had received their information on contraception, they responded that they had learned about contraception from their doctors (71.3%), mother (3.8%), spouse (6.5%), at the National RHC (3.3%), teachers (1.7%), friends (24.2%) and others (8.6%).

The majority of respondents had received information on reproductive health from policlinics (52.6%), RHCs (40.2%), mahalla meetings/community-level (0.5%), affiliated family doctors (40.0%), the media (37.1%) and other sources (1.0%).

Contraceptive methods: preferences, availability and attitudes towards
IUDs remain the preferred contraceptive method. 57.5% of respondents, regardless age and a RHC location use them. Professionals with higher education degrees gave the highest priority to condoms (47.4%), and then to IUDs (36.8%). Students favor condoms (50.0%) and the pill (50.0%) equally.

Of the respondents from the randomly selected households, only 38.5% used IUDs. More residents use condoms (30.8%), the pill (19.2%) and injections (11.5%).

The survey results show that 23% of respondents get contraceptives from the RHCs, 15.3% purchase them from women consultancy offices, and 8.1% get them from pharmacies. However, there are difficulties in purchasing contraceptives. The most critical problem is the cost (88.9% of answers) and a shortage of contraceptives (11.1%). These difficulties were highlighted by respondents regardless age, occupation and sex. 50.0% of the respondents from the randomly selected households did not know where to purchase contraceptives (including all the respondents who were aged 15-19, a housewife or unemployed), and 50.0% of respondents thought that contraceptives were very expensive (including all of the housewives and unemployed respondents). 100% of the respondents interviewed at the RHC in Vahdat city did not know where to purchase contraceptives, and 100% of those interviewed at the national RHC stressed that they were too expensive.

Because Tajikistan tends to be religious, the survey tried to identify the degree to which respondents consider the attitude of Islamic towards contraception. The household survey showed that the majority do not have a clear ideology. 44.8% answered that Islam has a positive attitude towards

contraceptives and 55.2% responded that its attitude is negative. Men were more likely to view the attitude as positive (72.2%) while more than half of the women answered that it is negative (57.1%). The majority of positive responses come from professionals with a higher education (63.9%) and from workers (61.5%). Housewives, unemployed visitors (40.7%) and civil employees (41.9%) showed a lower level of awareness. There was also a difference between the answers collected at the National RHC in Dushanbe and the RHC in Vahdat. Most of the respondents in Vahdat (73.1%) believed that Islam forbids the use of contraceptives. But half of the respondents from Dushanbe (50.9%) believed that Islam does not ban the use of contraceptives.

Gender roles in the family
Some questions asked were meant to provide a picture of gender relationships in families. One question was, "In your family who decides to use contraceptives?" Less than half said that the decision was mutual– 43.3%. The rest of interviewees replied as follows: independently – 23.2%, a husband/wife – 9.1%, mother/mother-in-law – 1.2%.

Another question was how the husband/wife reacts to contraceptives. Only 17.8% of respondents used contraceptives: these were mainly the professionals with a higher education. 48.6% of respondents did not wish to use them and 8.3% were forbidden to use them by their spouse.

42.1% of interviewees never discussed contraception with a husband/wife. More men said that they did not discuss this issue with their spouse. Remarkably, more than half of these men were professionals with a secondary technical education. Looking at the breakdown of responses by age, the older respondents were more likely to discuss contraception with a spouse and the younger the respondents were less likely.

The visitors at the national RHC were twice as likely to discuss contraception with a spouse as the interviewees from the RHC in Vahdat city.

In the randomly selected households, only 36.2% of respondents discussed the subject. This is much lower than the responses from the National RHC in Dushanbe.

The question "Who decides in your family how many children to have and when?" is also critical to understanding gender roles. The survey showed that 50.2% of respondents decide together, 26.3% decide with a spouse, 15.1% decide independently, 4.8% leave the decision to the mother or the mother-in-law, and 1.7% decide either by God's blessing or by none of thee above.

Birth and follow-up
73.8% of respondents gave birth in a maternity hospital. However, the number of women who deliver at home is also significant: 26.2%. More than half of respondents had more than one delivery at home. The responses to the question "How many deliveries at home have you had?" were as follows: one – 49.5%, two-three – 44.3%, four or more– 6.2%. The majority of such responses were from housewives and the unemployed (76% and 97% respectively).

The answers from the selected households were distributed differently: one delivery at home – 50.0% (regardless of occupation), two-three – 50% (75% were housewives whose husbands had no job). No

one marked that they had 4 or more deliveries at home.

The majority of the respondents from the National RHC in Dushanbe had only one delivery at home (75.0%) and only 25.0% had two-three deliveries at home. However, more respondents from Vahdat had two-three deliveries at home (62.5%) than single case deliveries (37.5%).

The health of the mother and child is dependent on continuous medical follow-up. When women were asked if they had been registered at the health facility while pregnant, 89.0% of respondents said they were and 11.0% said they were not. Most of the unregistered respondents were either women aged 18-24 classified as professionals with secondary technical educations, housewives, the unemployed or workers.

The answers of respondents from the RHCs and of the respondents from the randomly selected households were significantly different. For the household residents, there was a slightly lower proportion of registered pregnancies (68.0%) and a higher proportion of unregistered pregnancies (32.0%). The unregistered category consisted mainly of housewives, the unemployed and professionals with secondary technical educations.

Abortions

To understand their attitudes towards family planning, the respondents were asked how many children they desired. 51.7% of respondents wanted to have 4-5 children, 40.6% wanted 2-3, 6.3% wanted 6 or more, and only 1.4% wanted only one child. These respondents were mainly students and civil employees.

About 40.0% of respondents had undergone abortions. The majority of these were professionals with secondary technical educations (64.3%) and civil employees (57.1%). Most of them were aged 45-54. Their reasons for having abortions were: the previous baby was still too little – 15.1%, sickness – 9.3%, want no baby – 1.7%, unstable financial status – 7.4%, husband's desire – 1.7%, other reasons – 0.7%. Frequent abortions negatively affect the woman's health. To get the opinions of the women, the respondents were asked how many of abortions they had had. 39.9% of respondents had had one abortion, 37.2%- – 2 abortions, 20.9% – 3-4 abortions, 2.0% – 5 or more abortions. 47.6% of housewives and the unemployed, and 37.5% of specialists with higher educations said that they had had a single abortion. Abortions performed without medical assistance present a high risk to a woman's life. Fortunately, most women understand this. 96.0% of women who had had abortions had them in hospitals and only 4.0% had them at home or in other places. The critical group consists of women aged 25-44, housewives and unemployed civil servants. More women from the randomly selected households (9.1%) mentioned abortions at home then respondents from the RHCs.

Analysis of survey

In observing the RHCs and their staff, a low level of gender awareness and an absence of gender sensitive policy was noted. An insufficient infrastructure limits the number of visitors accepted daily because there are not enough resources to provide visitors with the required quantity of contraceptives and informative leaflets. In addition, the RHCs' personnel are poorly involved in training programmes on gender issues.

Conclusions and recommendations

The government of the Republic of Tajikistan deserves credit for attempting to align its legislation with international standards. Nevertheless, none of the adopted reproductive health laws have included a gender perspective. Also, the system for monitoring legislation and programme success is weak and fails to consider gender.

The population has received inadequate information on the adopted laws and programmes. Due to a lack of knowledge and training, the personnel in the RHCs does not provide gender–sensitive services. The infrastructure of the RHCs is underdeveloped and therefore does not provide men and women with the necessary contraceptives, informative materials and services.

Recommendations to the government:

The government of the Republic of Tajikistan is encouraged to:

- Include gender issues in strategic planning programmes. It is necessary to include a gender perspective in draft laws, draft regulations, etc. by involving gender specialists.
- Take measures to fulfill the goals of the state programme "Basic guidelines from the national policy on ensuring equal rights and opportunities to men and women in the Republic of Tajikistan in 2001-2010", especially the design and implementation of gender statistics.
- Urge the Coordinating Council under the Ministry of Health to include a gender perspective in decision making for the health sector, focused especially on family planning.
- Unite the RHCs, women consultative offices and women's policlinics, and create Human Reproduction Centers in addition to them.
- Train health personnel on the fundamentals of family planning consultancy and on considering the demands of both men and women.
- Continue to survey men's participation in family planning and reproductive health protection in order to extent the information database and to increase the efficiency of managerial decisions.

Recommendations to WHO:

WHO is encouraged to:

- Provide technical assistance to the Ministry of Health and to the newly established Human Reproduction Centers in gender sensitivity trainings for the managerial staff and health personnel.
- Support the design and publication of informational and educational materials on family planning.
- Support and equip Human Reproduction Centers with the necessary resources.

Barriers to fulfilling recommendations:

- The low economic level of the population hinders access to expensive contraceptives.
- The available contraceptives do not meet the needs of the population.
- There is a lack of awareness of the quality and types of contraceptives available.
- The mass media is not being used to educate the populations on contraception.
- Contraceptives are brought in without any preliminary investigation of needs.
- Possibilities for involving state budget resources in purchasing contraceptives for vulnerable populations need identifying.
- Communities require mobilization so that they will promote gender policy in the health sector.

- The infrastructure of the RHCs is lacking in strength.
- Professional qualifications and attitude of the staff to patients are not always adequate.
- Services are expensive.

11.1

A gender analysis of health care policy in primary care family planning services: Summary

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Introduction

The welfare of any country depends on the status of women in its society and on solving gender equality problems. Since the first days of independence, Kyrgyzstan determined gender equality as a priority. In 1995, Kyrgyzstan joined the Beijing Platform for Action, which was recognized by the world as a programme for the female human rights. On the basis of this programme, Kyrgyzstan began to draft a national strategy for developing and utilizing female potential in the republic and for providing gender equality. As early as 1996, the Parliament of Kyrgyzstan ratified a series of basic International UN Conventions on the status of women. Ratification of the UN Convention on the "liquidation of all forms of discrimination against women" is of special significance, because it facilitates concrete changes for granting women equal rights.

From 1996 to 2000, the National Programme "Ayalzat" was approved and began to function. The principles of this programme were to decrease the problems that women face in the field of health care, education, culture, poverty reduction and employment. In 2001, the results of "Ayalzat" were reviewed at the National Conference "Women of Kyrgyzstan on the frontier of centuries". A decision was made to develop a new action plan on improving female status, but now the emphasis was to shift from solving only female problems towards solving gender problems.

Taking into account the abovementioned factors, the achievements, obstacles and problems within Kyrgyzstan, the National Action Plan (NAP) on gender equality in the Kyrgyz Republic for 2002-2006 was developed and adopted. This was a new stage in solving gender problems. The strategic objectives of the NAP are:

- To optimalize the institutional mechanism for reaching gender equality.
- To maintain a gender balance on all levels of decision-making.
- To include a gender component in economic development in labour, employment and social protection.
- To include gender in health care policy.
- To maintain gender parity in education and culture.
- To decrease of all forms of violence against women.

1. This paper is an short summary of the study. The full description of the study in Russian and in an unauthorized English translation is available from the author. Address: National Council of Women, Family Affairs and Gender Issues, Government House, 205 Chairprosya, 720003 Bishkek, Kyrgyzstan. gender@mail.gov.kg

The main goal of a gender policy in health care is to eliminate all forms of gender discrimination. It aims to provide equal access for both men and women to medical services, including those involving family planning. The potential of both sexes to have good health is one of the fundamental principles of equality. Traditionally in Kyrgyzstan, medical and health care services are directed at the reproductive health of women.The gender aspects of health care seek to increase access of the entire population to quality medical services, prevention programmes and information. This includes the following aspects:

- Increasing funding to female and child health protection and using allocated resources more efficiently.
- Implementing the preventive programmes in women's health.
- Increasing family planning measures and reducing the number of abortions.
- Increasing measures on the reduction of infant and maternal mortality.
- Increasing measures on the reduction of STIs among women.
- Encouraging the prevention of HIV-infection among population, especially intrauterine HIV transmission.

Currently within the frame of NAP for gender equality, the programme "Jan-Ene" is set to run from 2003-2006. The WHO strategy on promoting effective perinatal care (PEPC) is the basis of this programme. The goal of the programme is to provide protection to womens' health during pregnancy, delivery and the post-delivery period. It also implements modern methods to minimize health risks for the woman, the fetus and the newborn in the early neonatal period. It improves the status of population health at the expense of safety and family planning efficiency, it perfects the legislative base of maternal and child health protection, and it elevates the role of society and the family in caring for a pregnant woman.

The current changes in the health care system indicate the necessity of a focus on the social aspects of health, a change in life-style, and a more active community in the formation of health care policy. In this context, the gender approach becomes important, because it is one the most important social components of a person's health.Primary health care plays a key role in population health protection. It creates an integral and complex approach and aims to:

- Strengthen communicable and noncommunicable disease prevention.
- Increase the volume of quality of medical care.
- Decrease the expenses of health care.
- Provide access to and guarantees of medical care.

Today, primary health care level is provided by eighty-seven Family Medicine Centres (FMCs) and 700 FGPs (according to data from the Republican Medical-Information Center and the Ministry of Health).
In August 2000, a new programme for mandatory health insurance for drug supply on the primary level was implemented. Reimbursements for medicine on the primary level not only promote the accessibility of medicine for the population, but also provide a market mechanism for lowering the price of medicines.

However, there are currently problems in the primary health care system for both men and women.

During the time after the adoption of the NAP, much attention was given to gender research in economics, policy and education. But special research has not yet been conducted on the gender aspects of health care, especially in reproductive health.
In the conclusion comments and recommendations of the UN Committee on liquidation of discrimination against women, (given in the second national report on the Convention by Kyrgyzstan in January 2004,) the Committee expressed its concern about the insufficient attention given to the negative consequences of medical system reforms on women.

Aims and objectives
The aim of this study was to conduct a gender analysis of health care policy in family planning services on the primary health care level.Its objectives were to answer the following questions:

- What are, from a gender perspective, key problems for improving access to and quality of primary care family planning services in medical facilities (MFs)?
- What could be recommended to the government to improve access to primary care family planning services and the quality of care for both men and women.

Subject and goals of the study:
We conducted interviews among a leading group of health care providers who worked on national and regional levels. In addition the study also focused also on health care providers in primary health care centres in three villages of Chui oblast: Sokuluk and Novo-Pavlovka, and Shopokov Town.

A questionnaire was developed to attain knowledge about attitudes, opinions and experiences of the above mentioned health care providers from different sectors on attention to gender issues in family planning and STI prevention. A full description of the study in Russian is available from the author.

Conclusions

Based on the results of the study, the following *conclusions* were made:
1. Kyrgyzstan demonstrates gender inequality and discrimination on all levels its of health care system, including:
   - health status.
   - access to medical care and in the quality of services provided .
   - preventive medicine.
2. The health care statistical data currently used do not always adequately reflect gender related problems.
3. With regard to reproductive health, the major emphasis gender focus is on supporting female fertility. The “health of women” has become synonymous with reproductive health. The consequences become strikingly obvious in policy and scientific research. Outside reproductive health, other initiatives regarding women’s health are predominantly focused on married women of a child bearing age. They mostly ignore the health status of adolescent girls and unmarried and/or childless and older women.
4. With regard to reproductive health, differences between males and females are ignored, including differences in life cycle.

5. Vertical segregation and a gender imbalance exists in the health care system among professional workers who provide services to the population. Fewer women work in the (reproductive) health care particularly in higher positions.
6. The programme for broadening the male involvement is impeded by a lack of current information on the positions, knowledge and habits of men towards family planning and reproductive health.

Recommendations to the Ministry of Health:

- A gender approach should be applied to the assessment of political directions, legislation, reform strategies, and health care projects in at all of the following stages: The problem definition of policy, strategy or project, its development, realization, and the assessment of its results
- It is necessary to include gender-disaggregated statistics in the health care system.
- Medical workers should be trained on family planning consultation, including the needs of men, adolescents, women and men of a late fertility age.
- The differing needs of men and women in various periods of their lives should be included in the development of methodical recommendations, guidelines and clinical protocols.
- Research should be continued on the involvement of men in family planning and reproductive health aimed at broadening and deepening the information base for increasing the effectiveness of managerial decisions.

Recommendations to the World Health Organization:

WHO should:

- Support countries in the development and implementation of indicators for integration of a gender approach into the health care system.
- Provide gender expertise to the legislative base, especially for programme documents in the projecting phase and at completion.
- Provide assistance in the development of textbooks, guidelines, methodical recommendations which include a gender approach.

11.2

Male Involvement in Family Planning and Reproductive Health Protection in Kyrgyzstan

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The aim of this study was to identify current gender stereotypes and males attitudes toward family planning and reproductive health protection

Objectives

- To determine the extent to which men are informed of reproductive and sexual health, family planning, contraception, and prevention of sexually transmitted infections and how often they ask for medical care and consult doctors for advice on these subjects.
- To analyze male behavior in order to preserve reproductive and sexual health and male involvement in family planning.
- To reveal the attitude of the rural population from the pilot territories towards reproductive health and family planning questions; To determine the priority of the above-mentioned questions within various needs of the local communities; and to analyze the suggestions on how to improve the availability and quality of primary medical care services in reproductive and sexual health.

Subjects of the study:
A population of young and middle aged men and middle aged women in rural areas of the Narynsk and Chouysk regions – of Kyrgyz nationality. In all 548 respeondents.

Methods

Pilot territory selection criteria
The following criteria were used to select the study population

Table 1.1 Pilot territory selection criteria

#	*Name*	*Description*
1	Country representation	▪ Selected territories which most accurately represent the specific geographical and climatic conditions of the country. ▪ Selected the ethnic group in the majority, whose culture most strongly reflects the lifestyles and behavior of the larger population.
2	Remoteness of pilot territories from each other and from the capital	Closely located territories may give single-type results. To prevent such results, it was decided to select 3-4 rural councils at a distance of 380 km, 60-62 km from the capital, and no less than 120 km from each other.
3	Vulnerable population	A pilot study cannot pretend to be the country's national study; Therefore, it must concentrate on those sections of the population, who face difficulties caused for local reasons, in addition to objective common difficulties. According to vulnerability criterion, the following were selected as important obstacles to accessing public health services: ▪ Poverty: the main obstacle; ▪ Gender – gender-related restriction; ▪ Migrant status and status-related restriction; ▪ Lacking or poor cultural integration in mini poly-ethnic communities.

The pilot territories satisfying the above criteria are given in Table 1.2.

Table 1.2 General information on the pilot territories

No	*Name of village*	*Distance from the capital*	*Height above sea-level*	*Population (people)*	*Ethnic composition*
1	Zhany-Zher rural council - Verkhnevostochnoe - Nizhnevostochnoe - Zhany-Zher - Zapadnoe - Zelenoe	62 km	600 m	7,250	Polyethnic Kyrghyzs Tajiks
2	Tosh-Boulak rural council - Tosh-Boulak - Boruluu - Chetindi	60 km	1,700 m	2,715	Monoethnic Kyrghyzs
3	At-Bashy rural council -	380 km	2,700 m	2,862	Monoethnic Kyrghyzs
4	Dyubelin rural council -	350 km	2,600 m	492	Monoethnic Kyrghyzs

As can be seen from Table 1.2, each rural council covers 3-4 villages. However, for simplicity's sake, only the key villages At-Bashy, Zhany-Zher, and Tosh-Bulak shall be further referred to. Such reference should be taken to mean all the villages under jurisdiction of a single rural council.

Methods of study

The purpose of the study was to determine the extent to which the population is informed of reproductive and sexual health, family planning, and contraception. In order to fulfill the purpose, qualitative methods were used in the study under field conditions.

Table 1.3 contains the general characteristic of the methods of study.

Table 1.3 Methods used in the study

No	*Methods of study*	*Description*	*Period of study*	*Unit of measure*
		Individual level		
1	**Interview –** direct inquiry of a respondent ▪ unstructured ▪ informal	- the extent to which an individual is informed of a certain question - cultural stereotypes *existing* - gender stereotypes *obstacles* - individual expectations	40-45 min	1 person
2	**Case-work –** direct examination of a particular case	- cultural stereotypes *existing* - gender stereotypes *obstacles* - individual expectations - **individual experience in** the success of solving problems and overcoming obstacles - individual opinion	25-30 min	1 person
		Community level		
3	**PRA** – Participatory Rural Appraisal - determining collective needs and priorities	- the extent to which a community is informed, - collective expectations - priority needs of community - ways of solving the priority problems - public opinion - common understanding and concentration on mutual problem solving	45-60 min	10-15 persons at once

Project partners at the sites

Table 1.4 shows data on project partners in the provinces.

#	*Name*	*Status*	*Contribution to the project*	*Contact phone*
1	Birimkulov	Head of the	1. Organizational resources	*Office phone.:*
	Temirlan Birimkulovich	Sokuluk district state administration, Chouyskaya oblast	2. Help in choosing rural councils accessible to project criteria. 3. Establishment of contacts with the heads of ayyl oukmotu	+996 (3134) 4-29-09 *Fax:* +996 (3134) 4-25-72
2	Koulov Batyrlan	Head of the Zhany-Zhersk rural council (ayyl oukmotu)	1. Organizational resources – support in carrying out studies 2. Provision of information on population structure 3. Cartographic data on the settlements 4. Accommodation of members of the study group in the villages	*Office phone.:* +996 (3134) 2-41-09; 2-45-41
3	Degenbayev Kenzhebek	Head of the Tosh-Boulak rural council (ayyl oukmotu)	1. Organizational resources – mobilization of people for carrying out the study 2. Provision of information on population structure 3. Cartographic data on the settlements 4. Accommodation of members of the study group in the villages	*Office phone.:* +996 (3134) 2-81-19; 2-81-39
4	Alikeyev Kydyrma Tourganbayevich	Deputy head og At-Bashinsky rural council (ayyl oukmotu)	5. Organizational resources – mobilization of people for carrying out the study 6. Provision of information on population structure 7. Cartographic data on the settlements 1. Accommodation of members of the study group in the villages	*Office phone.:* +996 (3534) 2-11-66 2-23-95 2-17-84

Male involvement in family planning

242 Male respondents living in the three pilot territories were questioned: At-Bashi village - 92, Zhavy-Zher village - 80, Tosh-Boulak - 70. Method of testing: informal interviews.

First sexual contact and marriage

Male respondents tended to make a clear distinction between two concepts– first sexual contact and marriage.

In all pilot villages cumulatively, sexual activity of 40.5% of boys began when they were 15-17 years of age, or prior to the full legal age of 18. The differences revealed between the regions were insignificant. By the age of 18-20 years, more than 70.6% of respondents were sexually active.

Table 2.1 First sexual contact

Age	*Zhany-Zher*	*Tosh-Boulak*	*At-Bashy*	*Average %*
15-17 years	41.3%	35.7%	40.0%	40.5%
18-20 years	41.3%	28.6%	21.7%	30.1%

Table 2.2 Marriage age

Age	*Zhany-Zher*	*Tosh-Boulak*	*At-Bashy*	*Average %*
15-17 years	7.5%	1.4%	4.3%	4.6%
18-24 years	41.3%	42.9%	25.0%	35.6%

By the age of 24 years, about 35.6% of respondents were married. Differences between regions were found: male respondents living in the mountain areas married at a later age. Marriages at the age of 18-24 years accounts for only 25.0%, half as many as those in the plain and middle mountain area. (See Table 2.2.)

Use of condoms

A total of 64.0% of 242 respondents used no condoms. The differences between the regions were insignificant. (Se table 2.3.).

Table 2.3 Condom use

Purpose	*Zhany-Zher*	*Tosh-Boulak*	*At-Bashy*	*Average %*
Do not use	60.0%	62.9%	69.3%	64.0%
Prevention of infections	7.5%	12.9%	12.0%	10.8%
Prevention of pregnancy	32.5%	24.3%	26.7%	27.8%

Many men (27.7 % of respondents) considered the *prevention of unwanted pregnancy* as the main purpose for using condoms. Only 10.8 % of the questioned men thought that condoms should be used to avoid sexually transmitted diseases.

Discussion of contraception with the partner

From the total number of male respondents using condoms, 58.7 % discussed these questions with their sexual partners. Some regional differences were noted: Spouses tended to discuss these issues more frequently in areas where earlier marriages are registered (Zhany-Zher village).

Urogenital diseases

The question “Have you had any urinary diseases?” was ignored by most respondents; they were unwilling to answer this question or even to discuss it. Only *41 of 242* male respondents answered that they had had urogenital diseases. No significant differences between regions were found.

Questions about urogenital diseases were usually countered by the question of whether a real man

could have such diseases at all. Other respondents insisted that they were really tough men and proud of themselves. Questions about such diseases injured their pride. The contents of cases No. 2, 3, and 5 are show that male pride resides in the men's minds.

The analysis of the respondents' answers shows that most men (82.0%) still have an idea of male pride that forces them to conceal disease. Male respondents considered the matter of urogenital diseases to be closed to public discussion. In this case, the clinical outcome is fully dependent on the extent to which the individual is informed and aware of the disease.

How often do men ask for medical care?

Table 2.4 Sources of medical information

Medical workers	*At-Bashi*		*Zhany-Zher*		*Tosh-Boulak*		*Total*	
	Total number of cases - 92	*%*	*Total number of cases - 80*	*%*	*Total number of cases - 70*	*%*	*Total number of cases - 242*	*%*
Doctor	12	11.8	11	14.7	11	15.8	34	14.0
Nurce	-	-	-	-	1	1.4	1	0.4
Urologist	2	2	1	1.2	3	4.4	6	2.4

All male respondents were asked the question: "Do you ask for medical care if you have urogenital problems? If so, who do you ask?" The results are given in Table 2.4. Thirty-four (14.0%) of 242 respondents asked for medical care from primary medical care services (PMCS). The male respondents from three pilot territories consider the FDG doctor a key figure. However, it is rare that men ask for medical care and consult the FDG doctor (only in 14.0% of cases).

Male respondents gave several reasons for rarely seeking medical care from FDG. The first reason is that the majority of *doctors and nurses are women*. The second reason is the idea of the *low functional competence* of a man if he is unable to solve his health problems through the benefits of the primary medical care services. Thus, he might receive the FDG doctor's appointment card and undergo a standard examination.

Case No 7 is evidence of the assumption that male respondents' functional competences are low. In the described case, a man ignored a doctor of the local outpatient department and consulted the doctors in the capital. He paid a lot of money for consultations with 6-8 doctors and ended up consulting an urologist to get relevant treatment. In case-work No. 5, a male respondent asked a veterinarian for medical care. In case-work No. 1, a man asked a friend with experience in treating urogenital diseases, rather than the FDG doctors.

Most male respondents prefer to address familiar doctors. Only 2.4 % of men had the opportunity to receive specialized medical assistance from an urologist.

Another important reason for men to avoid FDG doctors is *the time restrictions* caused by high employment at seasonal field works (case No. 7) and the low priority given to protecting reproductive and sexual health. More attention is given to the family's financial problems.

The small number of visits made by male respondents with urogenital diseases at the primary medical sanitary level (14.0 %) is a cause for concern. This study shows that men with reproductive health problems face obstacles in accessing primary medical sanitary services. These obstacles are caused by cultural and gender restrictions, which manifest themselves by:

- a male unwillingness to consult female medical workers.
- the idea of "a man's pride" and a fear of showing weakness.

Other reasons why men with sexual and reproductive health problems not often ask for help at the primary level of the medical sanitary aid are:

- The low level of male functional literacy on solving reproductive health problems and family planning problems.
- The low priority given by men to health questions compared to their financial problems.

Male sources of information on family planning

Table 2.5 Family planning information sources

Source	*At-Bashy village*		*Zhany-Zer village*		*Tosh-Boulak village*		*Total*	
	Total number of cases	*%*	*Total number of cases*	*%*	*Total number of cases*	*%*	*Total number of cases*	*%*
Doctor	4	4.3	7	8.7	11	15.7	22	9.0
Nurse	-	-	-	-	1	1.4	1	0.4
Relatives	1	1	3	3.75	3	4.2	7	2.8
Acquaintances, friends	15	16.32	17	17.5	6	8.5	38	15.7
Mass media	16	17.3	7	8.75	11	15.7	34	14.0
Unreliable sources	56	60	46	57.5	38	54.2	14	57.8

To the question "Who taught you about family planning methods?", respondents answered as follows *(See table 5.5.)*: Of the 242 men questioned, 140 (57.8 % of the respondents) pointed to the absence of reliable sources of information. Men regarded doctors, nurses, relatives, acquaintances and mass media as sources of information. *(see. diagram 2.1. from table 2.5.)*

In 32.5 % of cases, men had received data on contraceptive methods from non-professional sources: 15.7 % from acquaintances and friends; 14.0 % from mass-media and 2.8 % from relatives. And only 9.4 % of the respondents had received the information from medical workers.

Regional differences were exposed. Information from doctors on family planning and protection of reproductive and sexual health was the lowest in the At-Bashy village (4.3 %).

Men do not receive information on family planning methods from members of their family and close relatives because of cultural traditions other than those resulting from the Kirghiz ethnicity. In Zhany-Zher village, additional obstacles were detected within the Dargin ethnic group. In this ethnic group, even viewing television programmes is strictly forbidden. This interdiction applies to the whole community and is strictly supervised by senior men - the elders (case No. 4).

Another obstacle to information is the absence of television sets among migrant social groups, especially migrants from Tajikistan.
The poorest part of the population has no means of buying printed mass-media (newspapers, magazines, brochures). This was emphasized by respondents from At-Bashy and Zhany-Zher villages.

Along with a lack of information on reproductive and sexual health, men tend to engage in highly hazardous sexual relations. All cases mention casual sexual relations which are perceived by men as normal behavior. This results from the absence of any moral condemnation of men in the family as well as in society. Furthermore, men are often allowed to ignore existing general prohibitions.

Male respondents were asked: "Who would you like to give you information on family planning and reproductive and sexual health?" 78,3 % of the men wanted to receive the information from a doctor, and preferably from a male doctor.

An additional obstacle for men to get information and services on reproductive and sexual health can be attributed to the gender misbalance: There is an insufficient number of male doctors within the primary medical sanitary aid system.

Although a doctor is a key figure for male respondents, a very small number of men received information on family planning and reproductive and sexual health from a doctor. This indicates a lack of qualitative information on family planning and reproductive and sexual health at the primary level of medical sanitary aid.

The facts exposed regarding the low number of male visits to the primary medical sanitary aid system for reproductive health and family planning also indicates missed opportunities for increasing the availability and quality of services at the primary level.

Female involvement in family planning

The informal interview method was used to question 254 female respondents from the following pilot territories: At-Bashy – 54, Zhany-Zher – 120, and Tosh-Boulak – 80.

First sexual contact and marriage
The question "At what age did you have your first sexual contact?' is associated by the female respondents with the time of their marriage (several specific questions were asked). As was indicated earlier, male respondents make a clear distinction between the beginning of sexual activity and marriage.

This is the evidence for gender differences in the attitude towards the onset of sexual activity. The male sexual life is under less voluntary control, so the onset of sexual activity and marriage can occur at different ages. Women make no distinction between these two notions.

Table 3.1 The age structure of the onset of female sexual activity

Age	At-Bashi village		Zhany-Zher village		Tosh-Boulak village		In all from total	
	Total number of cases	*%*	*Total number of cases*	*%*	*Total number of cases*	*%*	*Total number of cases*	*%*
15-17years	3	5.5	21	17.5	12	15.0	36	14.1
18-20 years	33	61.1	48	40.0	29	36.2	110	43.3
21-24 years	11	20.3	28	23.3	15	18.7	54	21.2
25 years and older	1	1.8	7	5.8	6	7.5	14	5.5

Data in table 3.1 show that almost half of female respondents were married in the age of 18-20 years (43.3 %).

Regional differences were detected for the age at which girls got married. Zhany-Zher village has the highest percentage of girls who marry before they reach full age.

Table 3.1 shows that for women from At-Bashi village, most marriages take place at the age of 18-20 years, representing 61.1 % of all marriages.

Pregnancy prevention

Pregnancy is considered an important event in a woman's life. However, only half of the interviewed women answered the question "Do you protect yourself from pregnancy?" in the affirmative (49.7 %). Regional differences were noted. 67.5 % of female respondents in the Tosh-Boulak village use a contraceptive method for protection from pregnancy, which is 17.8 % higher than the average in the pilot territories.

Women in the studied villages use the following methods of the prevention of unwanted pregnancy *(See table 3.2)*:

Table 3.2 Female prevention of pregnancy

Question: *"What method do you use for pregnancy prevention?"*	*At-Bashy village*		*Zhany-Zher v.*		*Tosh-Boulak v.*		*In all from the total number*	
	Number of answers	*%*	*Number of answers*	*%*	*Number of answers*	*%*	*Number of answers*	*%*
Contraceptive pills	3	5.5	5	4.1	5	6.2	13	5.1
Intrauterine means (loop)	17	34.4	33	27.5	20	25.0	70	27.5
Injections	1	1.8	1	0.8	1	1.2	3	1.2
Condom	2	37.0	4	3.3	---	---	6	2.3
Sterilization	---	---	2	1.6	1	1.2	3	1.2
Interrupted coitus	3	5.5	1	0.8	2	2.5	6	2.3

The most frequently used method among the interviewed women for preventing unwanted pregnancy was intrauterine means (27.5 %). This tendency was the same in all pilot territories.

Only 2.3 % of the female respondents considered *male condom use* as a possible method of preventing pregnancy. As specified earlier, 27.7 % of male respondents considered condoms to be an effective method of pregnancy prevention. This difference in percentages indicates that women do not rely on their sexual partners for pregnancy prevention, but rather take the responsibility into their own hands.

STD Prevention

Female respondents were asked: "How do you protect yourself from sexually transmitted diseases?" Table 3.3 shows their answers to this question.

Table 3.3 Female protection against sexually transmitted diseases

Question *"How do you protect yourself from sexually transmitted diseases?"*	*At-Bashi v.*		*Zheny-Zhar v.*		*Tosh-Boulak v.*		*In all from the total number*	
	Number of answers	*%*	*Number of answers*	*%*	*Number of answers*	*%*	*Number of answers*	*%*
Hygiene	9	16.7	23	19.2	13	16.3	45	17.8
Condoms	9	16.7	2633	21.7	11	13.8	46	18.1
Permanent sexual partner	16	29.6	34	28.3	23	28.8	73	28.8
Tablets	3	5.6	2	2.5	-	-	6	2.3
Do not know	17	31.5	34	28.3	33	41.3	84	33.0

As many as 84 out of 254 female respondents, or 33.0 %, replied that they did not know how to protect themselves from sexually transmitted diseases.

28.8 % thought that the only way to protect themselves against sexually transmitted diseases was to have only one partner. But the women did not take into consideration the male inclination to hazardous sexual behavior. Therefore, they did not understand that having a single permanent sexual partner does not insure protection against sexually transmitted diseases.

The women thought they could prevent sexually transmitted diseases through mere hygienic practice. However, they were unaware of this being only a partial protection. Only 18.1 % of the female respondents knew condoms to be a reliable way of protecting themselves against sexually transmitted diseases.

These facts directly display the limited knowledge on sexual and reproductive health among women in the pilot villages.

It is necessary to emphasize that male knowledge on the same issue is even smaller: Only 10.8 % of the male respondents thought that condoms protect against sexually transmitted infections. No regional differences in answers to this question were detected.

Discussion of contraception

Answers to the question "Who do you talk to about contraception matters?" given by the female respondents are shown in table 3.4.

Table 3.4 Female discussion of contraception

Question: *« With whom you discuss contraception matters? »*	*At-Bashi v.*		*Zhany-Zher v.*		*Tosh-Boulak v.*		*In all from the total number*	
	Number of answers	*%*	*Number of answers*	*%*	*Number of answers*	*%*	*Number of answers*	*%*
Husband	30	55.6	46	38.3	30	37.5	106	41.9
Relatives	5	9.3	8	6.7	10	12.	23	9.0
Girlfriends	7	13.0	5	4.2	1	1.3	13	5.1
Doctor	2	3.7	4	3.3	3	3.8	9	3.5
with nobody	10	18.5	57	47.5	36	45.0	103	40.5

40.5 % of the female respondents did not discuss these issues with anybody, i.e. they rely solely on their own judgment. 41.9 % discuss contraception matters with their husbands. Very few discussed these matters with relatives (9.0 %) or girlfriends (5.1 %), and only 3.5 % discussed contraception issues with medical workers at the primary level. This question addresses individual selection of contraception (specifying question).

Family planning information sources

One of the objectives of this study was to identify sources of information on family planning. This question was posed to both men and women. The various answers are shown in table 3.5.

Table 3.5 Women's sources of information on family planning

Question: *"Who told you about contraceptive methods?"*	*At-Bashi v.*		*Zhany-Zher v.*		*Tosh-Boulak v.*		*In all from the total number*	
	Number of answers	*%*	*Number of answers*	*%*	*Number of answers*	*%*	*Number of answers*	*%*
Doctor	13	24.1	30	25.0	24	30.0	67	26.3
nurse / midwife	9	16.7	18	15.0	11	13.8	38	15.0
Relatives	3	5.6	9	7.5	2	2.5	14	5.5
acquaintance	16	29.6	16	13.3	13	16.3	45	17.8
Radio, magazines, TV	11	20.4	10	8.3	10	12.5	31	12.2
Do not know	2	3.7	37	30.8	20	25.0	59	23.2

From table 3.5 it becomes clear that for most female respondents (26.3 %), doctors were the primary source of information on family planning methods. For men, acquaintances and friends come first (15.7 %). For women, acquaintances came in second as a source of information (17.8) and nurses and midwifes came third.

The main source of information on family planning for women was the medical staff which provides primary medical care services (41.3%). For male respondents, this source accounts for only 9.4%. The primary medical care unit is the source of information for women in half of the cases, while it is of no value as a source of information for men. These differing attitudes towards the same source of information can probably be explained by gender differences.

These differences may also result from the gender-neutral medical care policy of the Ministry of Health for primary medical care. In theory, the primary medical care units are designed for the entire population. But because of a failure to consider the specific needs of men and women, the services available to women are more extensive than those available to men. In other words, the gender-neutral policy of the Ministry of Health causes a gender asymmetry. This asymmetry impacts the availability of information for both genders in the primary medical care unit: services are more oriented towards women, especially in reproductive and sexual health.

Work on family planning and reproductive health protection in pilot territories

The total number of people involved in PRA (Participatory Rural Appraisal) in all the pilot villages was 265, and the total number of the opinions expressed was 359.

The community members involved in PRA knew that the interview was medically oriented, so they discussed problems of vital importance to the health of the population.
The analysis of their opinions made it possible to establish a scale of priorities for preserving reproductive health.

Economic questions are the primary concern of the population in the pilot territories (31.2%); second was social problems (24.3%) including water supply and sewage; then health problems (20.0%); then the education of children (14.4%); and finally family planning and reproductive health protection (only 10.2%). No significant differences existed between the pilot territories.

These results indicate that health problems and family planning are of little or no importance to the population of the reviewed villages. The distribution of priorities represents the current public opinion on the preservation of health and reproductive health, including family planning. Health questions, including reproductive health and family planning, are the third and fifth priority, respectively.

To the question "What is family planning?" several opinions were expressed. Of these opinions, only some correspond with the WHO definition. Table 4.1. shows the opinions of PRA participants.

Table 4.1 PRA participants opinion on the concept of family planning

participants' opinion	*The total number of opinions*	*%*
planning the number of children	12	17.3
planning the intervals between births	3	4.4
establishing of a family after reaching nubility	11	27.5

In these communities, "Family planning" is popularly regarded not only a medical problem, but also includes the financial, social and educational aspects of the family. Only 16.4% of PRA participants considered family planning to include the establishment of a family after reaching nubility; 17.3% associated it with planning the number of children, and 4.4% included planning the interval between births. None of the PRA participants considered "Family planning" to include all three aspects.

The low level of understanding of "family planning" can be explained by a lack of education, as well as by the low priority given to health and family planning matters compared with other needs of the rural communities.

In all PRA groups, participants discussed methods of contraception which prevent against unplanned pregnancies. Participants were well-informed on methods of contraception, both popular and those recommended by patient-care and prophylactic institutions. The participants not only discussed methods of contraception, but also made assumptions on how much their communities use these methods. The assumptions were used to ascertain the preferred method within each community. About 10% of the population use folk medicine methods of contraception. Most women (70.0 – 80.0%) prefer intrauterine contraception. The men agree with the female preference. A man uses a condom only if intrauterine contraception is impossible because of a woman's health. The questions on contraceptive methods inevitable touched on another aspect of family planning – the availability of

contraceptives. In the opinion of people involved in PRA, contraceptives are available in every inhabited locality that has a primary medical care unit.

The PRA method allowed participants to reveal the problems of greatest concern to themselves and to recommend methods of solving these problems. The participants were offered many ways to meet the priorities discussed earlier. Table 4.2 contains the reproductive health protection and family planning variants. It should be noted that the variants contained in the table are worded by people involved in PRA. The percentages indicated were proposed by the participants according to the importance of each suggestion to the community.

Table 4.2 Ways of solving the problems concerning reproductive health and family planning as suggested by those involved in PRA

#	*Suggestion*	*%*
1	Furnish schools with information on reproductive and sexual health	20.0
2	Show videos during education; make information available on TV and radio.	46.0
3	Make this information available to all population	30.0
4	Organize trainings (done by doctors), provide medical consultations	60.0
5	Regulate the work of FDG doctors	10.0
6	Free intrauterine contraceptives, injections, pills, and condoms for poor people and families	40.0
7	Reduce the cost of drugs and medical services	10.0
8	Organize local Research and Production Organizations to deal with public health	25.0
9	Make information available to men and from men	65.0
10	Follow personal hygiene rules and require that children observe them	85.0
11	Establish medical stations in primary school in the Zelenoe settlement	10.0
12	Organize trainings with young families	50.0
13	Publish booklets for distribution in several languages	55.0

While discussing methods of solving these problems, the PRA participants sought mutual understanding. An initially amorphous crowd changed into a single thinking body. People learned not only to listen, but also to understand one another. Finally, they began to suggest ways of solving problems so that they were acceptable to most people. Such suggestions were thoroughly scrutinized and new solutions were proposed so that they could be implemented in all communities.

The following are aspects of the participants' suggestions:

- The participants suggested that they should be better informed of health questions and family planning issues. They discussed focus groups which should be furnished with information on age, gender, and interests. The participants suggested that information should be available to the following groups: children in schools, men, young families, and the whole population.
- The participants indicated their preferences for information sources. They are the following:
  - doctors from local medical care settings.
  - male doctors for the male part of population, perhaps as the members of the field consulting teams.
  - mass media, including illustrative material such as video films.
  - local RPO who are involved in public health protection and family planning.

The PRA participants in all pilot territories were disturbed that personal hygiene, health and family planning were taught poorly in school programmes.

These suggestions can be implemented without explicit costs. In the reviewed communities, attitudes

towards health and family planning changed to a certain degree. Key community figures who took the initiative appeared during the PRA and were approved by the community to engage in health and family planning activities.

More steps are necessary: knowledge and management skills require investment in order to increase the community's potential and to facilitate stable development.

The suggestions made show what organizational measures are necessary and the investments that should be made by the Ministry of Health in order to improve the availability and quality of gender services at the level of primary medical care.

Recommendations

Recommendations to the Ministry of Health of the Kyrgyz Republic

- Develop mechanisms to record the incidence of disease in reproductive and sexual health; this should include cases of anonymous treatment provided by both state and private institutions.
- Implement gender-differentiated analyses, regular reports on population morbidity and primary medical care for the entire registered population.
- Implement fixed-address contraceptive distribution at the level of primary medical care and according to the needs of the vulnerable population.
- Implement an annual preventive examination for the registered population in order to ensure early detection of diseases.
- Implement screening examination of males of a reproductive age (18-50 years); If possible, screenings should be carried out by andrologists and urologists.
- Provide training to specialists (doctors and paramedical personnel) in andrology and urology.
- Improve gender training for specialists and make them responsible for implementing the gender-balanced policy prescribed by the Ministry of Health at the level of primary medical care.

Recommendations to WHO

- Help pilot countries to overcome any gender and age asymmetries by distributing information on reproductive and sexual health, and family planning.
- Support the development and replication of printed materials on reproductive and sexual health and family planning while taking into account language, cultural features and variations within rural populations.
- Introduce gender-based examination of the results of programmes on reproductive and sexual health and family planning.
- Support pilot countries in their efforts to train social workers on how to distribute information about reproductive and sexual health and family planning to men according to the principle "equal to equal".
- Introduce and develop courses in the pilot countries for educating FDG doctors and medical staff on the rights of citizens in reproductive and sexual health and family planning.
- Introduce and develop postgraduate courses in the pilot countries on public health management at the primary level of the medical sanitary service.

Annex Kyrgyzstan:

Case studies: 8 representative stories

CASE 1. Akyl (27 y.o.)

...I had my first sexual contact when I was 19 y.o. and I married at 20 y.o. Now I have three children. I had no health problems, but two years ago I had intercourse with another woman. Two weeks later I felt ill. I did not know who I could ask. There is a nurse in our village, but I felt shy before her and, moreover, I was afraid that she would tell everybody about my problems. I have a friend who formerly had similar problems, and he sent me to his doctor who lives in Bishkek. I am so grateful to my friend for this information and the doctor. Our women can ask for and receive medical care without leaving the village. However, the men must go somewhere else. The medical personnel consist mainly of women, and the men feel awkward with them, especially when asking intimate questions. I guess that regular examinations are necessary to protect reproductive health.

CASE 2. Suiunbek (45 y.o.)

...My sex life began when I was 16 y.o. I married later, when I was already 28 y.o. I have no children now. When I was 23 y.o., I got an infection in Turkey, where I bought goods. I never knew that I was ill and believed it only after the analyses revealed a disease. An urologist told me that the disease had become chronic. I underwent a long-term cure, but in vain. I lived 9 years with my wife, and still we had no children. I could not tell her that I was ill because of my pride and shame. I was afraid I could loose my wife. And my wife blamed herself and believed that she was infertile. Now I have lost my wife. She has children and another family. And now I live only because of my work, trying to think only of that. I believe that condoms should be used only by those who have intercourses outside their families; because otherwise they risk getting a sexually transmitted infection.

CASE 3. Ruslan (27 y.o.)

...I got married and went to Russia to work as a salesman. It is natural that far from family, the living conditions are unusual. My friends and I rented a flat. There I got acquainted with a girl, who also worked as a saleswoman. We saw each other a lot. After several commercial failures, I returned to my family in my village. We did alright. I was paid for doing odd jobs. My wife complained of an unusual discharge and pain during intercourse; so she saw a doctor. Then they asked me to come. It appeared that she had gotten infected by me and had health problems. I denied my guilt and blamed her. We divorced, but both she and I underwent treatment. My wife soon became healthy, while I had a long treatment period because of the untimely call for medical care and complications. I married for the second time. After two years of treatment I was told that I had become infertile in spite of the doctors' efforts. I never thought I could get syphilis and lost the possibility to be cured in time. I again divorced my wife. Then I wanted to become reconciled with my second wife, but it was too late. She had married another man. Now she has two nice children, and I have none. My life stopped. I hate myself and that girl that I met who gave me the infection. Unfortunately, nobody told me that I could loose my male health much earlier than the end of my life and that I had to preserve it. I exist rather than live now. Once I tried to hang myself, but my neighbors saved me by bringing me out of the noose. Now I believe nobody and have no friends. I drink.

CASE 4. Anuar (25 y.o.)

...I am not going to speak about it and I'm even afraid. It is prohibited to speak about sex in our community (dargintsy). Most of the members of the community have no TVs, because watching TV is prohibited by the patriarchs. They believe that people get corrupted by television. We never discuss these issues within my family either. The only way of knowing anything is to get information from Kyrgyz or Russians. It is natural that when boys grow older, they want to gain sexual experience outside of the community, with women of other nations. You know, I must show my wife that I am experienced enough. Thanks to Allah, I got no infection. But I know those who were unlucky. They had to look for the doctors in Bishkek so that, God Forbid, nobody in the community would know about their diseases.

CASE 5. Altynbek (17 y.o.)

...My friends and I had a party and invited some girls. I met one of these girls, a really pretty one with long legs. But I am also not the least. We drank a little and then had intercourse. I did not use a condom. After some time I started feeling pain during urination. I did not know what to do. I was ashamed of speaking about it to anybody. I did not want to go to the hospital, because only women work there. I felt awkward and ashamed. What if my fellow-villagers found out? I went to a veterinarian I knew. You know, he is a man, a doctor, although he treats animals. I was given several injections of bicillin and felt better. If anything happens to me, I shall ask him for help. He is a good man, he will never tell anybody about my problems. He is a man and he understands me...

CASE 6. Zhyrgal (25 y.o.)

...I had my first sexual contact when I was 16 y.o. I chased all the girls. I was proud of myself because I had so many girls and women. Then there came an end to my Don Juan's style of life. At the age of 19 years, I had health problems, pains, fatigue, and weakness. I went to a family doctor from our FDG. She referred me to a urologist in the city, whom she knew well. When I knew my diagnosis, I was frightened. All my pride was broken in a minute. However, I underwent a cure, which gave a positive result in 3 months. I was healthy and became reasonable. Recently I married, and my wife is a nice woman. We plan to have children. We like children and want to have no less than five kids. I managed to overcome my prejudice against female doctors and saved my male dignity.

CASE 7. Khamid (36 y.o.)

...As a real man, I am married and from time to time have girls. I cannot even imagine who infected me. I suffered a long time and then, when I had time, I decided to consult the doctors in the city. I visited 5 or 6 doctors and paid for their services. I would like to note that I had to pay more than other persons, because I was a "Person of Caucasian Nationality". Probably, each doctor referred me to another doctor so that all of them could make a profit out of me. Finally, I came to a urologist. The urologist told me that first I had to visit a local medical care facility, where I could have my analyses made, take a referral and then come to him. That was how I learned from my own mistakes.

CASE 8. Bakhtiyar (42 y.o.)

Usually, migrants have many problems in a new country, even though I am also Kyrgyz, only from Tajikistan. My wife, parents, and brothers and I can receive no medical care whatsoever in our village, since we are not registered there. Yes, Tajik Kyrgyz have many children, but nobody tell us that it is possible to regulate the number of children. Islam prohibits abortion; the children God gives to you must be accepted as your due. Of course, children give us pleasure, but we must provide them with food, clothes, and education. And it costs a lot of money. We work hard without a break, but live in poverty. Family planning is a good thing. But where can we get money for it, if we have no money for bread?

Glossary of terms

Gender refers to women's and men's roles and responsibilities that are socially determined. Gender is related to how we are perceived and expected to think and act as women and men because of the way society is organised, not because of our biological differences.
Gender and Health: Technical Paper. WHO/FHR/WHD/98.16. Geneva: WHO, 1998.

Gender refers to the socially constructed distinctions between women and men based on differences in access to resources and knowledge, social roles, division 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 G, George A, Östlin P, 2002. Engendering health equity: a review of research and policy. In: Sen G, George A, ÖstlinP (eds). Engendering international health: the challenge of equity. Cambridge: MIT Press

Sex refers to genetic/physiological or biological characteristics of a person, which indicate whether a person is male or female.

Gender equality refers to the equal rights, responsibilities and opportunities of women and men, girls and boys. Equality does not mean that women and men will become the same but that women's and men's rights, responsibilities and opportunities will not depend on whether they are born female or male. Gender equality implies that the interests, needs and priorities of both women and men are taken into consideration – recognising the diversity of different groups of women and men. Gender equality is not a 'women's issue' but should concern and fully engage men as well as women. Equality between women and men is seen both as a human rights issue and as a predictor for, and an indicator of sustainable people-centred development.
Sen G, George A, Östlin P, 2002. As above

Gender equality is the absence of discrimination on the basis of a person's sex, in opportunities and the allocation of resources or benefits or in access to services.
Gender and Health: technical Paper. WHO/FHR/WHD/98.16. Geneva: WHO, 1998.

Gender equity is fairness and justice in the distribution of benefits and responsibilities between women and men. The concept recognises that women and men have different needs and power and that these differences should be identified and addressed in a manner that rectifies the imbalance between the sexes.
Gender and Health: technical Paper. WHO/FHR/WHD/98.16. Geneva: WHO, 1998.

Gender mainstreaming is 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. It 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.
UN Economic and Social Council. E/L.30 Para Adopted by ECOSOC 14.7.97.

Gender roles are those particular economic and social roles, which a society considers appropriate for women and men. Men are mainly identified with productive roles, which tends to be sequential, while women have a triple role: domestic responsibilities, productive work and community activities, which often have to be carried out simultaneously. Gender roles and responsibilities vary between cultures and change over time.
Gender and Health: technical Paper. WHO/FHR/WHD/98.16. Geneva: WHO, 1998.

Gender sensitivity refers to the ability to perceive existing gender differences, issues and inequalities and incorporate these into strategies and actions
Gender and Health: technical Paper. WHO/FHR/WHD/98.16. Geneva: WHO, 1998.

Gender Analysis examines the differences and disparities in the roles that women and men play, the power imbalances in their relations, their needs, constraints and opportunities and the impact of these on their lives. In health, a gender analysis examines how these differences determine differential exposure to risk, access to the benefits of technology, information, resources and health care, and the realisation of rights.
Gender and Health: technical Paper. WHO/FHR/WHD/98.16. Geneva: WHO, 1998

Gender Planning means using the information gathered in the gender analysis to further analyse and inform the development of health policies, services and research with the aim to develop equitable health care systems and health research, which are sensitive to the ways in which gender has an impact on health.
Liverpool School of Tropical Medicine, the Gender and Health Group. Guidelines for the analysis of gender and health, 1998.

Gender statistics refer to data that are produced and presented to reflect women and men's conditions and contributions in society, their needs and their specific problems. Gender Statistics are statistics on women and men on all spheres of society (power and decision-making, work and economy, social factors including health) for all policy makers, planners and ordinary people to use for gender analysis and planning
Landuyt K, 2001. Gender mainstreaming: a how-to manual. Gender Analysis and Planning. ILO: South East Asia and the Pacific Multidisciplinary Advisory Team (SEAPAT).

Gender Indicators reflect the situation for women and men in all spheres of life (see Gender statistics) and are used to compare outcomes for women and men of policies and programmes.

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Annex 3

Health data from the participating countries in the case study project

1. Ireland

Table 1: Demographic data Ireland

	Since 1990	Ireland	EU Average	WHO European Region Average
Mid Year Population Total (2003)	↑	3956000	n/a	n/a
Male	↑	1967000	n/a	n/a
Female	↑	1989000	n/a	n/a
Age structure				
%Population aged:				
0-14 years (2001)	↓	21.51	16.83	18.57
Male	↓	22.21	17.71	19.69
Female	↓	20.82	15.98	17.53
65+ Years (2001)	↓	11.17	16.03	14.18
Male	↓	9.72	13.3	11.28
Female	↓	12.6	18.63	16.84
Live births (per 1000 population) (2002)	↓	14.24	10.43	10.8
Male infants	↓	14.73	10.99	11.13
Female infants	↓	13.76	9.89	10.04
Crude Death Rate				
(per 1000 population) (2002)	↓	11.38	9.79	11.24
Male	↓	12.03	10	12.04
Female	↓	10.78	9.59	10.53
Probability of dying before age 5				
(per 1000 population) (2002)	↓	7.46	6.06	12.19
Male	↓	7.91	6.69	13.55
Female	↓	6.98	5.39	10.75
Life expectancy at birth in years (2001)	↑	77.21	78.19	74.01
Male	↑	74.56	74.9	70.01
Female	↑	79.92	81.37	78.1

	Since 1990	Ireland	EU Average	WHO European Region Average
Male/Female difference in life expectancy at birth in years	↓	5.36	6.47	8.09
Healthy life expectancy [1] at birth in years (2002)	n/a	69.8	70.74	66.1
Male	n/a	68.1	n/a	n/a
Female	n/a	71.5	n/a	n/a

1. Note: Healthy life expectancy takes into account not only basic mortality rates, but also the years lost to poor health.

Table 2: Main causes of death Ireland

Male

1. Ischaemic heart diseases
2. Cerebrovascular diseases
3. Cancer of the trachea/bronchus/lung
4. Suicide
5. Motor vehicle accidents

Female

1. Ischaemic heart diseases
2. Cerebrovascular diseases
3. Breast cancer
4. Cancer of the trachea/bronchus/lung
5. Suicide

Source: Health & Children's Health Statistics 2002

Table 3: Mortality rates related to cardiovascular diseases Ireland

	Since 1990	Ireland	EU Average	WHO European Region Average
Ischaemic heart disease, per 100000, aged 0-64 (2002)	↓	31.86	25.79	61.9
Male	↓	52.95	42.69	100.84
Female	↓	10.54	9.83	28.18
Ischaemic heart disease, per 100000, aged 0-64 (2001)	↓	1123.95	762.02	1332.44
Male	↓	1506.37	1012.69	1627.46
Female	↓	841.67	598.68	1151.33
Cerebrovascular disease, per 100000, aged 0-64 (2001)	↓	8.43	10.73	30.61
Male	↓	9.76	13.85	40.22
Female	↓	7.1	7.87	22.52
Cerebrovascular disease, per 100000, aged 65+ (2001)	↓	489.7	529.12	926.94
Male	↓	529.08	575.25	954.43
Female	↓	456.8	495.05	900.9

Table 4: Somatic Risk Factors for cardiovascular diseases Ireland

	Since 1990	Ireland	EU Average	WHO European Region Average
% Regular smokers in population, aged 15+ (1998)	↑	31	29.79	n/a
Male	↑	32	n/a	n/a
Female	↑	31	n/a	n/a
Annual pure alcohol consumed, per capita (in litres) (2001)	↑	11.36	9.1	8.89
% total energy available from fat (2001)	↓	32.34	38.06	32.07

Table 5: Male: Female ratio for cardiovascular mortality and smoking rates Ireland

	1990	Latest available year (2001)
Ischaemic heart disease per 100000, aged 0-64		
Ireland	3.78	5.02
EU	4.26	4.34
Europe	3.85	3.58
Ischaemic heart disease per 100000, aged 65+		
Ireland	1.86	1.79
EU	1.75	1.68
Europe	1.44	1.41
Cerebrovascular disease per 100000, aged 0-64		
Ireland	1.39	1.37
EU	1.75	1.76
Europe	1.68	1.79
Cerebrovascular disease per 100000, aged 65+		
Ireland	1.11	1.16
EU	1.17	1.16
Europe	1.07	1.06
% Regular smokers in population, aged 15+		
Ireland	1.07	1.03 (1998)
EU	n/a	n/a
Europe	n/a	n/a

2. Croatia

Table 1: Demographic data Croatia

	Since 1990	Croatia	EU Average	WHO European Region Average
Mid Year Population Total (2003)	↓	4427000	n/a	n/a
Male	↓	2129000	n/a	n/a
Female	↓	2298000	n/a	n/a
Age structure %Population aged:				
0-14 years (2002)	↓	16.72	16.7	18.23
Male	↓	17.79	17.58	19.34
Female	↓	15.74	15.87	17.21
65+ Years (2002)	↑	16.1	16.08	14.33
Male	↑	12.85	13.34	11.43
Female	↑	19.12	18.67	17
Live births (per 1000 population) (2002)	↓	9.02	10.4	10.98
Male	↓	9.63	10.97	11.1
Female	↓	8.47	9.86	10.01
Crude Death Rate (per 1000 population) (2002)	↓	11.38	9.79	11.24
Male	↓	12.03	10	12.04
Female	↓	10.78	9.59	10.53
Probability of dying before age 5 (per 1000 population) (2002)	↓	8.19	5.97	11.58
Male	↓	9.1	6.59	12.86
Female	↓	7.23	5.32	10.22
Life expectancy at birth (years) (2002)	↑	78.4	78.24	73.97
Male	↑	71.21	74.96	69.98
Female	↑	76.4	81.41	78.05
Male/Female difference in life expectancy at birth in years	↓	5.19	6.45	7.07
Healthy life expectancy [1] in years (2002)	n/a	66.6	71.69	66.1
Male	n/a	63.8	n/a	n/a
Female	n/a	69.3	n/a	n/a

1. Note: Healthy life expectancy takes into account not only basic mortality rates, but also the years lost to poor health.

Table 2: Main causes of death Croatia

Male

1. Ischaemic heart diseases
2. Cerebrovascular diseases
3. Malignant neoplasms of trachea, bronchus and lungs
4. Heart failure
5. Chronic liver diseases, fibrosis and cirrhosis
6. Malignant neoplasms of colon, rectum and anus
7. Malignant neoplasms of stomach
8. Bronchitis, emphysema, asthma
9. Malignant neoplasms of prostate
10. Complications and ill-defined descriptions of heart disease

Female

1. Cerebrovascular diseases
2. Ischaemic heart diseases
3. Heart failure
4. Complications and ill-defined descriptions of heart disease
5. Malignant neoplasm of breast
6. Malignant neoplasms of colon, rectum and anus
7. Atherosclerosis
8. Diabetes mellitus
9. Malignant neoplasms of trachea, bronchus and lung
10. Hypertentive diseases

Source: Croatian Central Bureau of Statistics; Croatian National Institute of Public Health

Table 3: Mortality rates related to cardiovascular diseases Croatia

	Since 1990	Croatia	EU Average	WHO European Region Average
Ischaemic heart disease per 100000, aged 0-64 (2002)	↓	37.58	25	63.1
Male	↓	62.41	41.5	102.7
Female	↓	14.7	9.4	28.92
Ischaemic heart disease per 100000, aged 65+	↑	1145.72	754.25	1354.6
Male	↑	1408.3	1001.22	1661.75
Female	↑	983.94	593.52	1166.84
Cerebrovascular disease per 100000, aged 0-64 (2002)	↓	24.53	10.55	30.23
Male	↓	33.79	13.59	40.16
Female	↓	16.12	7.74	21.9
Cerebrovascular disease per 100000, aged 65+	↓	1122.12	525.25	927.79
Male	↓	1302.3	571.46	959.06
Female	↓	1018.51	490.90	898.65

Table 4: Somatic risk factors for cardiovascular diseases Croatia

	Since 1990	Croatia	EU Average	WHO European Region Average
% Regular smokers in population, aged 15+ (2000)	n/a	30.3	29.65	29.66
Male	n/a	34.1	n/a	n/a
Female	n/a	26.6	n/a	n/a
Annual pure alcohol consumed, per capita (in litres) (2001)	↑	10.54	9.1	8.89
% total energy available from fat (2001)	↓	29.74	n/a	32.07

Table 5: Male: Female ratio for cardiovascular diseases and smoking rates Croatia

	1990	Latest available year (2002)
Ischaemic heart disease per 100000, aged 0-64		
Croatia	4.3	4.25
EU	4.26	4.61
Europe	3.85	3.55
Ischaemic heart disease per 100000, aged 65+		
Croatia	1.25	1.43
EU	1.75	1.69
Europe	1.44	1.42
Cerebrovascular disease per 100000, aged 0-64		
Croatia	1.86	2.1
EU	1.75	1.76
Europe	1.68	1.83
Cerebrovascular disease per 100000, aged 65+		
Croatia	1.19	1.28
EU	1.17	1.16
Europe	1.07	1.07
% Regular smokers in population, aged 15+		
Croatia	1.08 (1995)	1.28 (2000)
EU	n/a	n/a
Europe	n/a	n/a

3. The Netherlands

Table 1: Demographic data Netherlands

	Since 1990	Netherlands	EU Average	WHO European Region Average
Mid Year Population Total (2003)	↑	16149000	n/a	n/a
Male	↑	8012000	n/a	n/a
Female	↑	8137000	n/a	n/a
Age structure %Population aged:				
0-14 years (2000)	↑	18.6	17.05	9.6
Male	↑	19.23	17.93	20.09
Female	↑	17.98	16.22	17.92
65+ Years (2000)	↑	13.58	15.79	13.96
Male	↑	11.25	12.99	11.02
Female	↑	15.87	18.45	16.67
Live births (per 1000 population) (2000)	↓	12.97	10.57	10.88
Male	↓	13.41	11.13	11.3
Female	↓	12.55	10.03	10.2
Crude death rate (per 1000 population) (2000)	↑	8.82	9.84	11.06
Male	↑	8.73	10.04	11.76
Female	↑	8.92	9.66	10.43
Probability of dying before age 5 per 1000 population (2000)	↓	6.24	6.21	12.54
Male	↓	6.7	6.82	13.9
Female	↓	5.76	5.56	11.1
Life expectancy at birth in years (2002)	↑	78.29	77.94	73.82
Male	↑	75.65	74.61	69.78
Female	↑	80.76	81.15	77.93
Male/Female difference in life expectancy at birth in years	↓	5.11	6.54	8.15
Healthy life expectancy [1] at birth in years	n/a	71.2	71.69	66.1
Male	n/a	69.7	n/a	n/a
Female	n/a	72.6	n/a	n/a

1. Note: Healthy life expectancy takes into account not only basic mortality rates, but also the years lost to poor health.

Table 2: Main causes of death Netherlands

Male

1. Cardiovascular diseases
2. Cancers
3. Respiratory diseases
4. Symptoms and incomplete descriptions of diseases
5. External causes of injury and poisoning
6. Diseases of the digestive system
7. Endocrine, foods and digestion diseases
8. Mental disorders
9. Diseases of the nervous system and senses
10. Diseases of the ureter and genitourinary system
11. Infectious and parasitic diseases
12. Prenatal disorders
13. Birth defects
14. Muscle, bone and connective tissue diseases
15. Blood diseases and diseases of blood organs and immunity disorders
16. Skin diseases and diseases of connective tissue under the skin

Female

1. Cardiovascular diseases
2. Cancers
3. Respiratory diseases
4. Mental disorders
5. Symptoms and incomplete descriptions of diseases
6. Diseases of the digestive system
7. Endocrine, food and digestion diseases
8. External causes of injury and poison
9. Diseases of the nervous system and senses
10. Diseases of the ureter and genitourinary system
11. Infectious and parasitic diseases
12. Muscle, bone and connective tissue diseases
13. Blood diseased and diseases of blood organs and immunity disorders
14. Birth defects
15. Prenatal disorders
16. Skin diseases and diseases of connective tissue under the skin
17. Complications during pregnancy, birth and maternity period

Source: Central Bureau of Statistics 2003-2004; statistics on sex/gender and health

Table 3: Mortality rates related to cardiovascular diseases Netherlands

	Since 1990	Netherlands	EU Average	WHO European Region Average
Ischaemic heart disease per 100000, aged 0-64 (2000)	↓	21.53	22.84	62.14
Male	↓	33.79	44.42	101.27
Female	↓	9.1	10.22	28.04
Ischaemic heart disease per 100000, aged 65+ (2000)	↓	604.31	783.17	1355.95
Male	↓	866.95	1044.08	1659.75
Female	↓	434.08	614.75	1172.85
Cerebrovascular disease per 100000, aged 0-64 (2000)	↓	8.21	10.96	30.79
Male	↓	9.01	14.11	40.47
Female	↓	7.43	8.05	22.6
Cerebrovascular disease per 100000, aged 65+ (2000)	↓	443.67	539.38	935.32
Male	↓	477.39	590.93	967.1
Female	↓	415.47	502.27	908.08

Table 4: Somatic risk factors for cardiovascular diseases Netherlands

	Since 1990	Netherlands	EU Average	WHO European Region Average
% Regular smokers in population, aged 15+ (2002)	↓	33.5	29.65 (2000)	29.66 (2000)
Male	↓	37.9	n/a	n/a
Female	↑	29.2	n/a	n/a
Annual pure alcohol consumed, per capita (in litres) (2001)	↓	7.99	9.1	8.89
% total energy available from fat (2001)	↑	38.69	38.06	32.07

Table 5: Male: Female ratio for cardiovascular diseases and smoking rates Netherlands

	1990	Latest available year (2000)
Ischaemic heart disease per 100000, aged 0-64		
Netherlands	4.36	3.71
EU	4.26	4.35
Europe	3.85	3.61
Ischaemic heart disease per 100000, aged 65+		
Netherlands	2.02	2
EU	1.75	1.7
Europe	1.44	1.42
Cerebrovascular disease per 100000, aged 0-64		
Netherlands	1.39	1.37
EU	1.75	1.75
Europe	1.68	1.79
Cerebrovascular disease per 100000, aged 65+		
Netherlands	1.11	1.16
EU	1.17	1.17
Europe	1.07	1.06
% Regular smokers in population, aged 15+		
Netherlands	1.35	1.30
EU	n/a	n/a
Europe	n/a	n/a

4. United Kingdom

Table 1: Demographic data United Kingdom

	Since 1990	United Kingdom	EU Average	WHO European Region Average
Mid Year Population Total (2003)	↑	59251000	n/a	n/a
Male	↑	28863000	n/a	n/a
Female	↑	30388000	n/a	n/a
Age structure %Population aged:				
0-14 years (2002)	↓	18.56	16.7	18.23
Male	↓	19.48	17.58	19.34
Female	↑	17.68	15.87	17.21
65+ Years (2002)	↓	15.92	16.08	14.33
Male	↑	13.75	13.34	11.43
Female	↓	17.99	18.67	17
Live births (per 1000 population) (2002)	↓	11.29	10.4	10.98
Male	↓	11.87	10.97	11.1
Female	↓	10.74	9.86	10.01
Crude death rate (per 1000 population) (2002)	↓	10.24	9.97	11.24
Male	↓	9.96	10	12.04
Female	↓	10.5	9.59	10.53
Probability of dying before age 5 (per 1000 population) (2000)	↓	6.16	5.97	11.58
Male	↓	6.96	6.59	12.86
Female	↓	5.32	5.32	10.22
Life expectancy at birth in years (2002)	↑	78.43	78.24	73.97
Male	↑	76.06	74.96	69.98
Female	↑	80.69	81.41	78.05
Male/Female difference in life expectancy at birth in years	↓	4.63	6.45	8.07
Healthy life expectancy [1] (years) (2002)	n/a	70.6	70.74	66.1
Male	n/a	69.1	n/a	n/a
Female	n/a	72.1	n/a	n/a

1. Note: Healthy life expectancy takes into account not only basic mortality rates, but also the years lost to poor health.

Table 2: Main causes of death United Kingdom

Male

1. Ischaemic heart disease
2. Cerebrovascular disease
3. Lung cancer
4. Bronchitis and allied conditions
5. Pneumonia
6. Prostrate cancer
7. Colon, rectum, rectosigmoid junction and anus cancer
8. All accidents and adverse effects
9. Stomach cancer
10. Chronic liver disease and cirrosis
11. Pancreas cancer
12. Diabetes mellitus
13. Suicide

Female

1. Ischaemic heart disease
2. Cerebrovascular disease
3. Pneumonia
4. Breast cancer
5. Lung cancer
6. Bronchitis and allied conditions
7. Colon, rectum, rectosigmoid junctions and anus cancer
8. All accidents and adverse effects
9. Diabetes mellitus
10. Pancreas cancer
11. Stomach cancer
12. Chronic liver disease and cirrhosis
13. Uterine cancer
14. Suicide

Source: Database of health, UK

Table 3: Mortality rates related to cardiovascular diseases United Kingdom

	Since 1990	United Kingdom	EU Average	WHO European Region Average
Ischaemic heart disease per 100000, aged 0-64 (2002)	↓	30.79	25	63.1
Male	↓	49.14	41.5	102.7
Female	↓	12.93	9.4	28.92
Ischaemic heart disease per 100000, aged 65+ (2002)	↓	919.42	754.25	1354.6
Male	↓	1255.2	1001.22	1661.75
Female	↓	686.43	593.52	1166.84
Cerebrovascular disease per 100000, aged 0-64	↓	9.23	10.55	30.23
Male	↓	10.39	13.59	40.16
Female	↓	8.1	7.74	22.9
Cerebrovascular disease per 100000, aged 65+ (2002)	↓	533.12	525.25	927.79
Male	↓	555.4	571.46	959.06
Female	↓	510.21	490.92	898.65

Table 4: Somatic risk factors for cardiovascular diseases United Kingdom

	Since 1990	United Kingdom	EU Average	WHO European Region Average
% Regular smokers in population, aged 15+ (2000)	↓	27	29.65	29.66
Male	↓	28	n/a	n/a
Female	↓	26	n/a	n/a
Annual pure alcohol consumed, per capita (in litres) (2001)	↓	8.46	9.1	8.89
% total energy available from fat (2001)	↓	37.81	38.06	32.07
% Females with high blood pressure (2001)	n/a	41	n/a	n/a
% Males with high blood pressure (2001)	n/a	35	n/a	n/a
% Females overweight (2001)	n/a	68	n/a	n/a
% Males overweight (2001)	n/a	56	n/a	n/a

Table 5: Male: Female ratio for cardiovascular diseases and smoking rates United Kingdom (x:1)

	1990	Latest available year (2002)
Ischaemic heart disease per 100000, aged 0-64		
United Kingdom	3.49	3.8
EU	4.26	4.61
Europe	3.85	3.55
Ischaemic heart disease per 100000, aged 65+		
United Kingdom	1.82	1.83
EU	1.75	1.69
Europe	1.44	1.42
Cerebrovascular disease per 100000, aged 0-64		
United Kingdom	1.43	1.4
EU	1.75	1.76
Europe	1.68	1.83
Cerebrovascular disease per 100000, aged 65+		
United Kingdom	1.3	1.31
EU	1.17	1.16
Europe	1.07	1.07
% Regular smokers in population, aged 15+		
United Kingdom	1.07	1.08
EU	n/a	n/a
Europe	n/a	n/a

5. Turkey

Table 1: Demographic data Turkey

	Since 1990	Turkey	EU Average	WHO European Region Average
Mid Year Population Total (2003)	↑	71325000	n/a	n/a
Male	↑	35929000	n/a	n/a
Female	↑	35396000	n/a	n/a
Age structure %Population aged:				
0-14 years (2002)	n/a	n/a	16.7	18.23
Male	n/a	n/a	17.58	19.34
Female	n/a	n/a	15.87	17.21
65+ Years (2002)	n/a	n/a	16.08	14.33
Male	n/a	n/a	13.34	11.43
Female	n/a	n/a9	18.67	17
Live births (per 1000 population) (2000)	↓	21.53	10.57	10.88
Male	n/a	n/a	11.13	11.3
Female	n/a	n/a	10.03	10.2
Crude death rate (per 1000 population) (1998)	↓	6.25	10.04	10.85
Male	n/a	n/a	10.28	11.4
Female	n/a	n/a	9.82	10.34
Probability of dying before age 5 (per 1000 population) (2002)	n/a	n/a	5.97	11.58
Male	n/a	n/a	6.59	12.86
Female	n/a	n/a	5.32	10.22
Life expectancy at birth in years (2001)	↑	70.1	78.19	74.01
Male (1999)	↑	67	74.13	69.63
Female (1999)	↑	72.1	80.75	77.69
Male/Female difference in life expectancy at birth in years	↑	5.1	6.45	8.07
Healthy life expectancy [1] (years) (2002)	n/a	62	70.74	66.1
Male	n/a	61.2	n/a	n/a
Female	n/a	62.8	n/a	n/a

1. Note: Healthy life expectancy takes into account not only basic mortality rates, but also the years lost to poor health.

Table 2: Main causes of death Turkey

Male

1. Cardiovascular disease
2. Other diseases and accidents
3. Cancers
4. Undefined causes
5. Cerebrovascular diseases
6. Other perinatal causes
7. Pneumonia
8. Enteritis

Female

1. Cardiovascular diseases
2. Other diseases and accidents
3. Cancers
4. Undefined causes
5. Cerebrovascular diseases
6. Other perinatal causes
7. Pneumonia
8. Enteritis

Table 3: Family Planning Turkey

	Since 1990	Turkey	EU Average	WHO European Region Average
Infant deaths				
(per 1000 live births) (2001)	↓	36	5.03	9.64
Male (2002)	↓	n/a	5.56	10.58
Female (2002)	↓	n/a	4.47	8.23
Maternal deaths				
(per 1000 live births) (1998)	↓	130	6.95	20.59
Abortions				
(per 1000 live births) (1998)	↓	181	249.73	582.16
Age of mother:				
Under 20	n/a	n/a	n/a	n/a
35+	n/a	n/a	n/a	n/a
Fertility Rate [2] (2002)	↓	2.46	1.44	1.46

2. Note: The fertility rate is the average number of children that would be born per woman if all women lived to the end of their childbearing years and bore children according to a given set of age- specific fertility rates.

6. Kyrgyzstan

Table 1: Demographic data Kyrgyzstan

	Since 1990	Kyrgyzstan	EU Average	WHO European Region Average
Mid Year Population Total (2003)	↑	5138000	n/a	n/a
Male	↑	2520000	n/a	n/a
Female	↑	2618000	n/a	n/a
Age structure %Population aged:				
0-14 years (2002)	↓	33.2	16.7	18.23
Male	↓	34.13	17.58	19.34
Female	↓	32.3	15.87	17.21
65+ Years (2002)	↑	5.53	16.08	14.33
Male	↑	4.45	13.34	11.43
Female	-	6.59	18.67	17
Live births (per 1000 population) (2002)	↓	20.34	10.4	10.98
Male	↓	20.99	10.97	11.1
Female	↓	19.71	9.86	10.01
Crude death rate (per 1000 population) (2002)	↓	7.1	9.97	11.24
Male	↑	7.85	10	12.04
Female	↓	6.36	9.59	10.53
Probability of dying before age 5 (per 1000 population) (2002)	↓	21.91	5.97	11.58
Male	↓	25.03	6.59	12.86
Female	↓	18.63	5.32	10.22
Life expectancy at birth in years (2002)	↑	66.15	78.24	73.97
Male	↑	60.92	74.96	69.98
Female	↑	71.62	81.41	78.05
Male/Female difference in life expectancy at birth in years	↑	10.7	6.45	8.07
Healthy life expectancy [1] (years) (2002)	n/a	55.9	70.74	66.1
Male	n/a	52.6	n/a	n/a
Female	n/a	59.3	n/a	n/a

1. Note: Healthy life expectancy takes into account not only basic mortality rates, but also the years lost to poor health.

Table 2: Family Planning Kyrgyzstan

	Since 1990	Kyrgyzstan	EU Average	WHO European Region Average
Infant deaths				
(per 1000 live births) (2002)	↓	21.07	4.94	9.15
Male (2002)	↓	25.01	5.45	9.99
Female (2002)	↓	16.97	4.41	7.79
Maternal deaths				
(per 1000 live births) (2002)	↓	58.41	5.36	17.4 (2001)
Abortions				
(per 1000 live births) (2002)	↓	144.11	246.44 (2001)	508.01
Age of mother:				
Under 20	n/a	142.29	n/a	n/a
35+	n/a	263.45	n/a	n/a
Fertility Rate [2] (2002)	↓	2.5	1.44	1.46

2. Note: The fertility rate is the average number of children that would be born per woman if all women lived to the end of their childbearing years and bore children according to a given set of age- specific fertility rates.

7. Tajikistan

Table 1: Demographic data Tajikistan

	Since 1990	Tajikistan	EU Average	WHO European Region Average
Mid Year Population Total (2003)	↑	6245000	n/a	n/a
Male	↑	3112000	n/a	n/a
Female	↑	3133000	n/a	n/a
Age structure %Population aged:				
0-14 years (2002)	↓	40.3	16.7	18.23
Male	↓	40.89	17.58	19.34
Female	↓	39.7	15.87	17.21
65+ Years (2002)	↑	3.9	16.08	14.33
Male	↑	3.56	13.34	11.43
Female	↓	4.24	18.67	17
Live births (per 1000 population) (2002)	↓	27.26	10.4	10.98
Male	↓	28.01	10.97	11.1
Female	↓	26.51	9.86	10.01
Crude death rate (per 1000 population) (2001)	↓	4.24	9.78	11.05
Male	↑	4.51	9.99	11.8
Female	↓	3.96	9.59	10.38
Probability of dying before age 5 (per 1000 population) (2001)	↓	21.03	6.06	12.19
Male	↓	21.43	6.69	13.55
Female	↓	20.6	5.39	10.75
Life expectancy at birth in years (2001)	↑	72.01	78.19	74.01
Male (1999)	↑	70.24	74.9	70.01
Female (1999)	↑	73.85	81.37	78.1
Male/Female difference in life expectancy at birth in years	↓	3.61	6.47	8.09
Healthy life expectancy [1] (years) (2002)	n/a	54.7	70.74	66.1
Male	n/a	53.1	n/a	n/a
Female	n/a	56.6	n/a	n/a

1. Note: Healthy life expectancy takes into account not only basic mortality rates, but also the years lost to poor health.

Table 2: Family Planning Tajikistan

	Since 1990	Tajikistan	EU Average	WHO European Region Average
Infant deaths				
(per 1000 live births) (2001)	↓	27.9	5.03	9.64
Male (1993)	↑	51.5	8.47	16.64
Female (1993)	↑	41.23	6.61	12.73
Maternal deaths				
(per 1000 live births) (2002)	↑	44.99	5.36	17.4 (2001)
Abortions				
(per 1000 live births) (2002)	↓	62.54	246.44 (2001)	508.01
Age of mother:				
Under 20	n/a	21.28	n/a	n/a
35+	n/a	215.81	n/a	n/a
Fertility Rate[2] **(2001)**	↓	3.1	1.44	1.45

2. Note: The fertility rate is the average number of children that would be born per woman if all women lived to the end of their childbearing years and bore children according to a given set of age- specific fertility rates.