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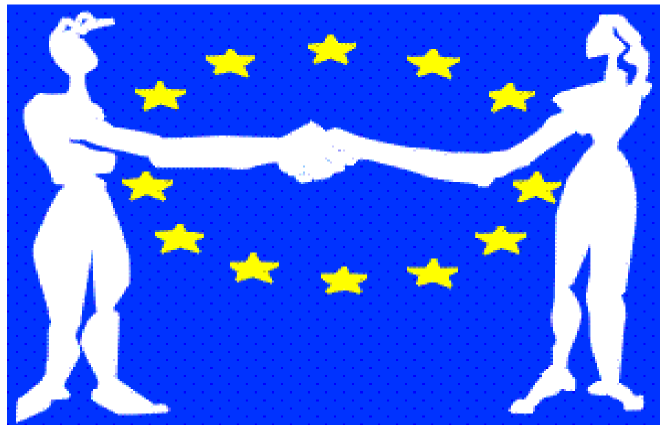

Women`s Health Network:

State of Affairs, Concepts, Approaches, Organizations in the Health Movement

Country Report
The Netherlands

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1. Introduction

Some twenty years ago the Dutch women's health movement developed. It started with critical reflection on health care and its approach towards women as patients and clients. The right of women to decide on their own lives and bodies was claimed, which was expressed in actions such as the campaign for free abortion.

At present, the women's health movement is still alive and in motion. The views, methods, and organizations have evaluated but the critical glance at health care has remained the essence of the movement and a source of inspiration for those who wish to raise the quality of health care.

In this report, the actual situation of the Dutch women's health movement will be described. However it is important to show how the movement is embedded in the Dutch health care system as well as to give an impression of which developments and changes the movement went through.

The first section of the report therefore will give an overview of the Dutch health care system and it's characteristics. Structure and organization of the system will be described and specific features of the system as far as women are concerned illuminated.

The women's health movement will be central in the second section. Attention will be paid to the history of the movement, current policy discussions and the state of the art in different working fields and for certain specific target groups.

2. Characteristics of the Dutch health care system

2.1 Structure and organization

2.1.1 Organization

The Dutch medical care system is a two-step system. Seeking medical help starts with the family doctor. Each Dutch inhabitant appears on the list of his/her own family doctor. Patient records are maintained by the family doctor for each such person, including medical history, risk factors, chronic diseases, medications, and all professional contacts/visits. This record keeping is known as 'listing'. A standard family doctor practice provides medical services to approximately 2300 persons.

An important characteristic of the Dutch family doctors is 'family orientation', which means that they serve as personal physicians for the entire family or household. This is also reflected in the fact that the family doctors make home visits in acute situations. Chronically sick patients and elderly patients are also visited at home.

The family doctor serves as a 'gate keeper'. Patients do not have free access to specialists or hospital care. Consultation of a medical specialists only takes place after referral by the family doctor; the second step. This happens in only 6% of the contacts. After consultation and after treatment the medical specialists report back to the family doctor.

Primary care consists further of dental care, home nursing, home care, and social work. Most medications are only available on prescription by a doctor. They are provided by specialized pharmacies.

In the Dutch public health system prevention plays an important part. Local authorities are responsible for keeping a local public health service. This service includes infectious disease control, general hygiene, school health, public health education, and the dissemination of information on child rearing. They often cooperate with a wide range of health care professionals and resources.

Apart from these preventive tasks the local health care services focus on epidemiology, policy advice, and disease surveillance. They deliver few curative direct services.

Home care organizations provide services in the homes of clients enabling them to remain at home as long as possible. A gross disctinction can be made between home nursing, provided by registered public health nurses, and home help, provided by home carers or home helps. Home nursing refers to nursing care such as supervision of medication, therapy, diet, and certain medical activities. The activities of home carers or home helps include care and support in activities of daily living, and domestic help of all kinds.

Hospital care is available for all Dutch inhabitants. Standards for the number of hospital facilities per 1.000 inhabitants are given by the Hospital Facilities Act. This Act applies to general hospitals, nursing homes, psychiatric hospitals, and institutions for the mentally handicapped.

Private clinics hardly exist in the Netherlands, due to strict regulation.
Patient's rights are guaranteed by Dutch legislation which provides in freedom in choosing a medical practitioner, in the right to self-determination and in a complaint service system.

2.1.2 Financing and insurances

All persons employed and earning less than 40.000 dollars per year are insured under the Sociale Health Insurance Act. They pay contributions which are partly income-related and party flat rate. The benefits package contains of regular medical treatment and care: the family doctor, hospitalization and specialty medical care, and midwifery, para-professional services such as physical therapy, speech therapy and dental care for youth. The insured must register with a Sickness Fund, which carries out the insurance. Benefits are also extended to social security recipients and certain groups of elderly people. People have a free choice as to with which Sickness Fund they register. People who are not insured through the Social Health Insurance Act (35% of the Dutch population) can effect a private insurance.

Exceptional costs, the risk of which cannot be borne by an individual or insurance, are covered by a compulsory national insurance under the Exceptional Medical Expenses Act. The premiums are compulsory for all Dutch inhabitants. Each Dutch inhabitant has a right to the benefits.

In 1996, 80% of the total health care cost was covered by insurances (65% Social Health Insurance and 15 % private insurance). 10% was paid by government, and the remaining 10% 'out of pocket', by the patient.

2.1.3 Current discussions

In the Netherlands developments the field of health care give rise to discussion. Some examples:

For several medical treatments, such as orthopaedic surgery, heart surgery, and eye surgery, long waiting lists exist. All together these lists contain of some 127.000 persons. How to shorten the time patients have to wait for medical treatment is a subject of consultation between all parties in health care: medical specialists, hospital organizations, government, patient organizations, and health insurance companies.

An especially 'hot' item is the wish of employer's organizations to give priority to people who are employed, in order to reduce the cost of sick employees. Possibilities as seen by the employer's organizations are medical treatment in private clinics, or company out patient departments, or medical treatment in the evening hours, especially for the employed. Arrangements like these already exist on a small scale.

Patient/consumer organizations have pointed out the injustice of this idea for people without jobs, such as elderly people, chronically ill people, children and handicapped. Besides, they argue, costs are reduced more structurally by health promotion for employees. According to these organizations the waiting list problem can be solved partly by publishing information about waiting times for several hospitals. This will lead to hospitals trying to work on reducing their waiting lists.

In February 1998 the Minister of Health, Welfare and Sports, has written a memorandum in which she rejects priority health care for working people. Indication for (medical) care should be based on medical and socio medical criteria. The matter if patients have a job or not is not relevant. Waiting lists should be shortened for the interest of all patients, not just for certain categories.

It is broadly recognized however, that regular doctors are not well acquainted with work related health disorders. This recognition may lead to the establishment of expertise centers for this type of complaints, but these should also be open to unemployed patients.

A striking aspect of this debate is the absence of any attention for the specific position of women. In the Netherlands relatively few women participate in the labour market as compared to most other European countries which means that women in general will be harmed more than men by priority arrangements for the employed. Although the discussion seems to be gender-neutral, in fact it is not.

Cost containment in general is a topic that provokes many discussions. In 1992, the Dunning report 'Keuzen in de Zorg' (Choices in health care) appeared. The report recommended that public financing should only apply to those health care services that are absolutely necessary. These services should be provided in the most effective and efficient way. All other services should be insured privately. This point of view was called the funnel model.

Several government attempts to effectuate this view failed because of massive opposition. One of these was the plan to exclude oral contraceptives from the sickness fund benefits. Protests from doctors and women led the government to withdraw the plan. However ideas from the Dunning report remain a trend in government policy.

2.2 Women in the Dutch health care system

2.2.1 Facts and figures

'Women get sick and men die' is a popular saying. At first glance it seems to be true for the Netherlands. The average life expectancy of men is shorter that women's: in 1996 the difference was 5,7 years (women 80,4, men 74,7).

However, women are greater health care consumers. They visit the family doctor more often, as well as medical specialists. More women are admitted to hospitals on a yearly basis than men.

However when corrected for health care consumption related to contraception and childbirth, the balance turns much less uneven. Moreover, the higher frequency of visits to general practitioners by women can further be explained by socio demographic characteristics and by the presence of specific diseases under women.

Chronic diseases, physical impairments, mental problems, and multimorbidity are all more common under women than under men. Partly this is related to the fact that women live longer than men.

The stereotypical, but wrong idea that a big part of female health care consumption is unnecessary, has consequences for women.

One of these lies in communication with doctors. Women's complaints are often regarded as psychosocial - women who present their complaints in a typically female way get a physical examination or a somatic diagnosis less often.
A second consequence is that measures aimed at reducing health care consumption have more negative effects for women, because they need more care.

The consequences of disease are different for women than for men. E.g. working women tend to 'silently' withdraw from work when they run a risk of falling ill, thus missing the benefits of disability insurance. If they do get disability insurance benefits, they have less chance to re-enter the labour market than men.

2.2.2 Specific health services

In the Duch health care system there are several health services aimed at women. These include obstetric care, breastcancer screening, cervial carcinoma screening, infertility treatment and abortion centers.

Obstetric care
In priciple in the Netherlands pregnancy and birth are supervised by a midwife or a GP (the family doctor). Women who prefer gynaecological supervision have to pay the fees by themselves, unless when they are at risk for any kind of complications.

Low risk women have the choice to deliver at home or in hospital. In either case, the midwife or GP attends the delivery. A relatively large number of women give birth at home. However, this number is declining. The professional organization of midwives strongly advocate home deliveries, since it has been shown that a rise in hospital deliveries leads to a rise in medical interventions in the birth process, while outcomes for mothers and infants do not differ. Opposite to medicalisation in hospital deliveries they promote natural home deliveries, which are less stressful and more satisfying for both mother and infant. Women who deliver in hospital are discharged within 24 hours after delivery. There are specialized carers who provide care in the home to mother and infant in the first week after birth.

This system works well because there is a good referral system. Protocols are used to tell whether a pregnant woman should be referred to a gynaecologist. Moreover, in densely populated Netherlands, hospital care is always within reach should any complications arise during delivery at home.

Most professionals involved in care during pregnancy and birth agree that the Dutch system is satisfactory. There are some gynaecologists who claim that each woman should be screened by a gynaecologist to check out any risk factors. Government policy however is aimed at strengthening the first line health care in general, which includes pregnancy and delivery supervision.

Abortion clinics
Abortion services are easily accessible to women. Abortion is legally permitted up to the twentieth week of pregnancy, and is usually carried out in specialized clinics. It is also done in hospitals in about 13% of the cases. The actual frequency of abortions is low. One in every six women ever has an induced abortion in her lifetime. Most abortions are carried out before the eighth week of pregnancy. Women view abortion as undesirable; it does not function as a regular family planning method.

The law says that an abortion is permitted if the pregnant women is in a situation of emergency. Moreover, it can only be the woman herself who decides whether such an emergency situation exists. After a request for an abortion, the law obliges women to think it over for 5 days, before the operation can be carried out.

Usually a woman goes to see her family doctor, who refers her to an abortion clinic. There are some family doctors who oppose abortions. In those cases the woman can go straight to the clinic.

Late abortions are performed in one of three specialized clinics. Abortions are practically always granted, except in cases when a woman is being forced by others, e.g. her family. Illegal abortions never occur.

Abortion rates are higher under immigrant women then under native Dutch women. This may be seen as a sign that effective contraceptives are not sufficiently acessible for these women.

The liberal Dutch climate concerning abortion is in contrast to some other countries. Women from abroad therefore come to the Netherlands to undergo the operation.

Breast cancer and cervical carcinoma screening

All women between the ages of 50 and 70 years are invited every second year for a breast check up by mammograpy. The screening is voluntary and free of charge. The aim is reducing mortality due to breast cancer. However, critical questions can be posed. The procedure itself is unpleasant for the women. Most women experience pain during the mammograpy, and many women experience anxiety, waiting for results.

Discussions are going on about the effectiveness of the screening. Although approximately 630 breastcancer deaths per year are prohibited by the screening, the quality of life for the women involved is reduced by treatment and it's by-effects. Quality of life is also reduced for women who do not survive, and who would not have lived a patient's life for such a long period, if they hadn't known the diagnosis. False-positive X-rays are disturbing for the women concerned, while false-negative outcomes lead to false security and -ultimately- disappointment. On the other hand, early diagnosis means that less radical surgery will have to be done, e.g. a breast saving operation instead of an amputation. Physicians, prevention workers, epidemiologists and women all take part in these debates.

There are less doubts about the usefulness and effectiveness of cervical carcinoma screening. Women between 35 and 50 years are invited once every 5 years, to have a pap smear test, carried out by their own family doctor. It is free of charge to have the examination done. Apart from the screening, women with complaints have pap smear tests done by medical indication.

Infertility treatments

The average age for women to give birth to their first child is relatively high in the Netherlands. Currently this was around 29 years. It has been suggested that this is the cause of reduced fertility of many women. Recently a government campaign has been launched to encourage women to have their babies at an earlier age. The women's movement and others however have argued that attention should be paid to the social and economical position of women. Since necessary provisions such as adequate day care centers for children are not sufficiently present especially young working women will rather postpone procreation than give up their jobs at the start of their careers.

The last decennia infertility treatment has developed in high speed. There are around 25 institutions where donor insemination is carried out. In the majority of these, lesbian couples and single women are also admitted.

New techniques such as in vitro fertilisation invoke debate. Some forms of in vitro fertilisation are actually not ways of treating women's infertility, but men's, e.g. in cases of diminished

mobility of spermatozoa where the ICSI method is implemented. Thus women are subjected to medical treatment for problems that are located outside their bodies. Critical questions can be asked concerning the consequences of these treatments for the children born.

Both donor insemination and in vitro fertilisation are in many cases paid by the insurance companies or the sickness funds.

2.2.3 Professional women

Many women are working in the health care system. However, they are not evenly represented in all levels of organizations.

In home care, most workers are women. The home carers are for 99% women, 92% of the workers in management positions is female, but of the higher management only 42% is female.

In nursing we see the same situation. The higher the ranking in the organization the smaller the relative representation of women.

As for doctors we can make the following remarks: The past few years more than half the medical students starting their training are women. In the past, women doctors were mostly to be found in social health, in youth health and as doctors in nursing homes. More women are now working as family doctors. At this moment there is a growing shortage of family doctors. One of the reasons is the wish of more doctors to work part time. It is interesting that female doctors who want to work part time do so because they want to spend more time on their families, and (usually older) male doctors do because they want more time for leisure activities.

The number of female medical consultants is growing. Still it is hard for a woman to train as a consultant. A serious problem is that the training is difficult to be combined with having a family. This means that many women doctors with ambition to become a medical consultant postpone having children, or decide to remain childless, while others give up their training plans. In some hospitals, women applying for consultant training have less chance of getting the vacancy than men. Some women in consultant training experience pressure not to become pregnant.

Some figures: In 1996, of the 7000 GP's, 18% were female, of the 12000 medical specialists, 16% were female, and of the doctors in remaining categories, such as medical officers, 38% were female.

There are few women in high medical or managerial positions in hospitals.

3. Women's Health Movement

3.1 History of the Dutch women's health movement

3.1.1 The struggle for self determination

Around twenty years ago insights from the general women's movement concerning the specific social position of women gave rise to questioning the position of women as patients and consumers in health care. This was the onset of what has come to be known as the women's health care movement. In those early years criticism mainly concerned the care around sexuality and procreation, and mental health services. Here stereotypes about women were very obvious.

The critical vision about regular health care resulted in the development of alternative ways of health care. A key word was self determination. In 1975, a translation of the Boston Women's Health Book Collective 'Our Bodies, Our Selves' appeard. This inspired women to start self help groups about health. The message was that women should have knowledge about their own bodies, including their genital parts. Here women themselves learned to perform vaginal examinations which before were only being done by doctors. This knowledge would make women less dependant on (male) doctors. From 1980 many women's health centers were started up where information and self help were central objectives.

Womens' self help groups were also started concerning mental health. Instead of individualizing women's psycho-social problems, similarities between women were stressed. Inspired by the anti-psychiatric movement, societal influences, predominantly the social position of women and female socialization, were recognized as important factors in the development of mental problems of women.

3.1.2 De-medicalisation

One of the reasons why self determination was seen as such an important issue was that women felt that doctors had too much control over women's lives. An important issue was the unnecessary prescription of drugs, predominantly tranquillizers, to suppress feelings of discomfort in women.
Also, women criticized the bringing under medical supervision of 'natural', or physiological processes such as pregnancy, sexuality, and menopause.
The third objection concerned the expansion of the working field of doctors to all kinds of psycho-social problems. Medical solutions were thus formulated for non-medical matters. The women's health movement thus adopted the principle of de-medicalization.

3.1.3 Women's lives, women's health

One of the central features of the women's health movement was, and still is, the recognition of the influence of the social position of women on their health. In the first years of the women's movement the slogan 'The personal is political' was an important source of inspiration. This applied for the women's health movement as well. Women's health care, it was said, should politicize women. It should make them conscious of social constellations which were oppressive for women. A premiss for this statement was the notion that social position of women (and men) was not fixed, but that it could be changed.

Politicizing women thus meant that women were helped to react more adequately to circumstances that made them sick. If women could be encouraged to gain a more independant

position there would be no need for them to release their discomfort in physical or mental complaints.

3.1.4 Social services for women

In the slipstream of the women's health movement the field of social welfare also became a focus of attention. Important gaps in welfare work concerning women were identified. The women's movement reacted by realizing it's own services, such as shelters for battered women and services which provide advice and support to women who are victim of sexual abuse. By doing so, these important societal problems were placed on the political agenda. Topics that never had been spoken about, such as violence in the private sphere, and sexual intimidation thus became open to discussion. The effects can still be seen today. Big companies realize policies to prevent sexual imtimidation in the working place, schools have a trusted person to deal with the problem, and health care workers are more attentive to problems related to experienced sexual abuse.

3.2 Women's health movement in the 90s

3.2.1 Integration versus autonomy

The women's movement has been relatively influential in the Netherlands. As we have seen topics which are important for women have been recognized as such in broad circles.
Spreading women's health views, methods, and knowledge has been one of the objectives of the women's health movement. Much work has been done to integrate these in regular health care, with varying success.

The Dutch government would like to see that methods, views and expertise of women's health care organizations be integrated in regular health care. Women's health care is seen as important in improving the quality of the Dutch health care. Therefore the government supports women's health organizations. The organizations themselves combine working independently with working to integrate their methods, views and expertise. Their independence is necessary to keep a critical distance towards regular care and the developments in this field.

A problem is, that the extent to which integration can be achieved is highly dependent on the level of personal commitment and individual interest. It is not umcommon to see that integration processes are slowed down or actually stopped when key persons who have this commitment are no longer involved in the activities. Actual and structural integration of women's health in regular organizations therefore requires a more profound change in culture, policy and organization.

The situation as it currently is, with women's health integrated in parts of regular care, and at the same time autonomous women's health organizations, is to be preferred at this moment in time. Without these autonomous organizations, further integration of women's health views will be difficult, and maybe impossible to effectuate.

3.2.2 Recognition of diversity between women

In the early years of the women's health movement one of the basic ideas was that women's health should politicize women. In the twenty years that women's health movement exists, the ideas about this premiss have changed strongly. Firstly, the concept of politicizing was found to be moralistic. Who determines which behaviour and which norms are politically correct?

Secondly, it was recognized that women do not all have the same interests. Their social positions differ and their coping abilities differ. Instead of 'politicizing' health care the women's health movement now advocates health care which takes into account in which positions women live and work. The factor 'gender' is however crucial here.

Diversity between women is not just a matter of individual differences. There are groups of women who have a very specific position. In the work of the women's health movement target group segmentation has become customary. Differences concerning socio-economical position, ethnicity, and age/generation are taken into account.

A very important group are migrant women. Views and methods developed in the women's health movement need to be adapted for these women. There is a lot of work being done in this respect. Participation of migrant women is necessary in this process. Another group of women for whom specific attention is needed are elderly women. Further on in this report the work currently being done concerning these groups will be discussed.

3.2.3 Professionalization of the women's health movement

In the early years of the women's health movement women's personal views about health and sickness were central. For the first time, women's own experiences were recognized as an important source of knowledge and strength.

However more and more it was found that in addition to this, professional (e.g. medical) knowledge was necessary to realize a true alternative to regular health care. At the same time, views from the women's health movement became substantiated by scientific research and professional insights and experiences.

These developments were crucial in a process of professionalization of women's health care. Women's health organizations today are widely appreciated for their expertise on matters of gender specificity in health and health care.

Professionalization also means that the high quality services women's health organizations can offer (such as training, development of innovative methods and materials, and advice to regular health care organizations) have to be paid for accordingly. For instance, in the past, women engaged in the women's health movement did so on a voluntary basis, whereas currently many women's health professionals earn a salary for their work. The women's health finances thus have become much more complex.

A third aspect of professionalisation is that the level of women's health work is shifting. The first women involved did practical work for women coming to the women's health centers. Nowadays a substantial part of women's health work consists of skill development services and monitoring/policy making.

3.3 Different working fields and women's health

Although the women's health movement is active in most working fields, the activities and the accomplishments differ. In this chapter several working fields will be discussed: what kind of activities are carried out by the women's health movement, how far the implementation of women's health within regular care is accomplished and what remains to be done.

3.3.1 Mental health care

Mental health care in the Netherlands is organized in a somewhat different way than other health care provisions. As we have seen, one needs a GP referral to be able to consult a medical specialist. In mental health care however, the family doctor only partly has a gate keeping function.

Extramural mental health care can be consulted on one's own initiative, although it is also possible to be referred by the family doctor. Admittance to a psychiatric hospital, or another type of residential mental health care institution can only be realized after referral.

As for the extramural sector, a wide range of women's health care is available. There is both autonomous women's mental health care and women's mental health care within regular organizations. Regular contacts are maintained between the two fields.

The autonomous sector has served strongly as an example and an inspiration in realizing women's health care in the regular sector.
The autonomous women's mental health care provides group work (self help groups, group therapies, support groups, telephone lines for women, and individual forms of mental health care such as individual psychotherapies. Some social services for women such as shelters for battered women, could also be viewed as a specific form of mental health care.

The autonomous women's mental health care provides care according to the following women's health principles:

- involvement of community and situational factors in the treatment;
- taking into account of gendered factors such as socialization to (man or) woman;
- avoiding unnecessary medicalization;
- a respectful approach towards the patient;
- strengthening of the ability to manage for oneself;

The extramural mental health care consists of approximately 55 Regional Institutes for Outpatient Mental Health Care, around 140 psychiatric outpatient departments attached to general hospitals, university hospitals and psychiatric hospitals, and 16 health centers for drug and alcohol abuse. There are several hundreds of private practices run by independently established psychiatrists and psychotherapists. The Regional Institutes provide care for the largest number of clients.

Practically all regional institutes have staff members working according to women's health care principles. They provide group work for women around specific types of problems, such as autonomy problems, eating disorders, phobias and depression. The social position of women can also be the basis for a women's group: mothers with young children, lesbian women, Turkish/Moroccan women. Women with psycho-somatic complaints are also treated in groups. However, 75 % of the women's mental health care in the Institutes is performed on an individual basis.

Implementation of women's health care in the institutes has high priority. The consequence is that procedures are being changed. An example is the intake procedure. Information about clients will have to include living circumstances, social position and experiences of (sexual) abuse. Women's health views also implicate that the intake procedure is less strongly directed towards fitting the client into categories and provisions of the organizations but more and more towards trying to find ways to involve the client's own views in decision making about what help or care should be provided.

In most health centers for drug and alcohol abuse there are staff members specialized in women's mental health care.

Women's mental health care workers have formed networks for exchange of expertise and experiences. Expertise is also furthered by national organizations such as TransAct, which has as one of it's tasks providing of training in the field of women's mental health.

In residential mental health care women constitute half the patient population. Women's mental health methods and views are becoming more integrated in this field. Individual women's mental health is provided in more than half the psychiatric institutions and many have women's groups which are run according to womens' mental health principles.

However, women's health initiatives are not yet an integral part of institutional policy. Structural changes are still to be made, although a number of initiatives have been started. A problem is the tradition of the monocausal, medical and individual-centered approach in residential psychiatry, which is hard to reconcile with the multicausal women's health approach. Another factor is the tendency to overlook patients' own expertise and autonomy. There is a shortage of female therapists and policy responsible persons. Because of the organizational complexity of residential mental health care, being 24-hour care, introduction of change in methods and policies demands a lot of time and energy. Moreover, gender-specific care is often not seen as a policy priority. However the National Inspection for Mental Health advocates the implementation of women's mental health care in the institutions.

3.3.2 Physical health care

Central in somatic health care are a number of women's health centers. Their working field in the early years of the women's health movement was the local community. Nowadays, most of them are still locally active.Aletta used to be an exaption. Aletta has been closed down at the end of 1998. Transact now is making a plan to integrate the work of Aletta within their organisation.

Regular somatic health care shows interest in the views and expertise of women's health care. There is a number of GP practices where women's health care is being provided.

Principles from the women's health movement, such as de-medicalisation and a holistic view on sickness and health, have been adopted by many GP's. In gynaecology, there is more attention for the psychosocial background of women's problems, and the number of other health care workers interested in women's health care is growing.

Still, a lot of work remains to be done. Gender specificity of health complaints and of health experience is not recognized everywhere. This is especially the case where supposedly 'gender-neutral' complaints are concerned. A campaign launched by the Dutch Heart Foundation and Aletta drawing health workers' attention to the fact that women suffering from coronary heart disease or infarct have a different problem presentation than men was highly necessary due to the underdiagnosis and thus lack of treatment for women.

An important part of the women's health movement have been self help groups. Currently a number of self help organizations exist, centered around certain health problems such as menopausal complaints, mastopathy and gynaecological cancer. These organizations provide information, advice and support for women, and sometimes function as a pression group for

change of (government) policy. Some of these collaborate with regular care providers, supplementing the work of these providers with their experiential knowledge and views.

3.3.3 Home care

Home care is a field which is important for women from different ponts of view. Firstly, 66% of the clients receiving home care is female. If we look at elderly people, we see that most clients over 75 are women. Since home care takes place in a person's private domain, personal backgrounds, feelings, views and habits of the client are important in the care process. Insight in gender specific aspects therefore is important for good quality care.

At the same time, 99% of the home carers are female. This has consequences for the culture of the organization and for the work of each individual home carer. Only recently has attention been paid to gender aspects of home care. Home care organizations are becoming more interested in the subject. On an experimental basis a curriculum has been developed for training of home care workers, in which improving quality through implementation of women's health principles is central.
Unfortunately, re-organizations in this field limit the possibilities to move towards actual innovation.

3.3.4 Health education

Health education is traditionally a field in which women's health organizations are active. At the outset of the movement the term used was 'information' rather than 'education'. However, 'education' implies that women's health activities are more than just informing women. They are also aimed at showing alternative visions, methods, and approaches.

Women's health organizations provide health education services in many ways. Group information, telephone lines, individual advice lectures, courses and workshops and a large number of leaflets and books are available. Women's self help organizations, centered around different medical problems, are very active in health education. The women's health centers consider the provision of woman friendly health education as an important task.

Women themselves are one target group, but currently the women's health organizations also aim at informing and influencing professionals working in health care.

A specific target group of professionals are health educators in regular organizations. programmes have been started to implement women's health in regular health education/health promotion.

3.3.5 Social work

In 26% of the social work organizations, gender specific aspects are being paid attention to on the level of client contacts. This is mainly due to individual workers within the organizations who are interested in women's mental health views and are committed to implement these in their work. On policy level, women's mental health views are not implemented. However, 30% of the organizations wish to do so in the future, while 18% has already formulated policy concerning implementation.

Social work is a field in which the underprivileged are an important target group. Since socio-economical factors influence health, in several places social work and health promotion go hand in hand. Innovative methods and structures are being developed. Gender specificity in the work

here is often seen as self-evident and a number of initiatives are undertaken for health promotion under women with a low socio-economical status. These initiatives are locally based, and are linked to social work, social welfare and psychosocial care.

3.3.6 Patient/consumer movement

Although many views and ideas of the patient/consumer movement are similar to those of the women's health movement there is one big difference between the two. Gender specificity or specific attention for women is lacking within the patient/consumer movement. However, women's health care organizations and patient/consumer organizations do work together in various projects.

Some patient organizations are in fact women's organizations when they are organised around a specific women's complaint.

3.3.7 Scientific research

At universities and in independent research institutes quite a few studies are being carried out which are relevant to women's health. An inventory made by The International Information center and Archieves for the Women's Movement in Amsterdam showed some 90 projects which are currently performed. Not all of these projects can be seen as women's studies in the sense that the factor gender is being questioned, even though they deal with women. The types of studies vary from philosohical and historical dissertations to development of new medical technologies.

Subjects are very often specific women's health problems such as osteoporosis in elderly women, breast cancer, and menstrual pain. Sexual harrassment is relatively well represented, as are health problems of migrant women. A considerable number of studies deal with differences between women and men concerning certain complaints or diseases. There is little research being done about women's health in the work place, and we found only one study concerning female health workers.

Most universities have women's studies units at different departments: social sciences, medicine, and health sciences, which provide research and training in women's health subjects. There are regular contacts with women's health organizations. The Dutch Foundation Women and Health Research is a network where women researchers from within and outside the universities meet.

3.3.8 Specific target groups

As stated before, the Dutch women's health movement regards differentiation between groups of women as a necessity for quality health care.

Migrant and refugee women

In the Netherlands around 665.000 persons are living who orininate from Morocco, Turkey, Surinam or the Duch Antilles. Half of these are women. They make out approximately 2,5% of the Dutch population.

A smaller portion of migrant women, refugee women, are often called in one name with other migrant women. However, due to their specific background their position and problems differ from other migrant women. Traumatic events in the country of origin may often lead to different kinds of health problems such as psychosocial problems or psychosomatic complaints.

Migrant and refugee women have specific health problems which are related to their specific social, cultural and economical position. Moreover, this position also influences their health experience. Within the women's health movement the necessity of realizing an improvement of health care for these women is felt. It is also recognized that e.g. translating information material does not suffice to adequately meet these women's needs and wishes. Active participation of this target group is necessary. Realizing women's health for migrant women also means that the women's health movement finds that some of it's concepts might not appeal to migrant women, e.g. the concept of autonomy, and new concepts, such as authenticity, will do better.

Women's health care for migrant women is being developed on a local level with e.g. group work for Moroccan or Turkish women in women's health centers. On a national level the women's health organizations Aletta and TransAct worked together with three organizations dedicated to migrants (FORUM, Pharos and Netherlands Centre for Migrants) in a project aimed at developing views and methods on multiculturality in women's health care. The project, Targuia, is finished but the work goes on. For the women's health organizations this means that programmes on migrant women will be developed, while the three organizations for migrants will implement gender specific views and methods in their work.

In regular health care attention is being paid to the specific problems of migrants and of migrant women. In health education organizations migrant women are being trained as peer educators. In social work migrant women are being recruited to be able to improve the work concerning migrant women. The need for participation of the target group seems to be felt here as in the women's health movement.

Older women

Women grow older than men: on the average six years. In the year 2010 there will be by estimation 2,5 million women over 55, of whom 433.000 will be over 80. They are an important target group for the women's health movement, not only because of their large number, but more important, because they experience health problems caused by the combination of age (or generation) and gender.

Older women are confronted with a negative image which influences the way they are approached by health care workers. Many women who are currently over 55 have filled their lives taking care of their families, and had little opportunity to build up a life of their own. Older women's income is lower than the income of older men, they have poorer housing and relatively high housing costs. And of course, they have health problems wich are related to growing older, some of which are specific for women, such as osteoporosis.

In regular health care older women are confronted with medicalization. Health care workers tend to approach their problems in a medical way.

Women's health organizations develop views and methods concerning older women's health. They try to bring the issue of gender specificity into fields such as home care and residential provisions for the elderly. Projects are carried out to provide health information and to increase older women's strength. Examples are health courses for women over 50 and older women's self help groups. For professionals working with older women training and information is provided. Older women themselves participate actively in the projects.

Older women are also an important target group for different commercial organizations, such as producers of appliances for the handicapped, and the pharmaceutical industry. Women's health care organizations follow the developments critically but with interest.

The specific problems of older women are not recognized in every sector of the regular health care. An exception is formed by mental health care which provides programmes for older women, sometimes older widows. These programmes are related to the women's health care workers within the mental health care organizations.

The Dutch elderly people's unions pay attention to gender aspects. Health care is one of the fields in which they are active. They work together with women's health organizations in programmes concerning older women.

Women with a low socio-economic status

Women's health care activities for the group of women with a low socio-economic status are mainly locally based. We have already described the cooperation between social work and women's health work for this group. Only recently a cooperation has started between a national organization for social and community work, LCO, and a national organization for women's health, Aletta. The expertise of both organizations is put together to work on training of local community health workers and volunteers.

Women's health care centers are easily accessible for low income women because the cost of information and advice there is low. Women's mental health care is somewhat different. Mental health care through the Regional Institutes for Mental Health Care is paid for by sickness funds or insurance companies, but mental health care provided by the autonomous mental health care organizations is often not part of the benefits package.

Women with HIV/AIDS

Women who are seropositive for HIV, or women who have aids, are a group with very specific problems. It has become clear that a wide approach of sexuality, STD's, HIV/AIDS and safe sex responds best way to women's needs. Women's health care organizations work together with organizations in the field of STD/HIV prevention and other professional organizations, with patient organizations, and with policy makers. Health education methods and materials are being developed for different groups of women. Quality of care is increased by training professionals and by developing care services geared to HIV infected women.

4. Government policy

4.1 General policy

The Dutch government has been active on women's Health care for a few years now.

The policy on women's health care is mainly focused on integration within the established settings. In a good quality of care it is important that men and women get good care, that means to take in consideration the cohesion between help-question and the context the person lives in.

Within the women's health care the meaning of gender is a central issue.

From 1996 until 1999 the government has installed a steering committee, with as main task to stimulate integration of women's health care on policy levels and to broader the interest of women's health care.

The steering committee installed 5 working-groups on the topics of Health professionals; care on regional level; quality of care; positioning of women's self-help groups; patient/consumer perspective.

The working-groups came with recommendations that the steering committee implemented in their final report.

The main recommendations were:
- It is necessary to remain a strong top-down model to integrate women's health care on a policy level. The vision and the instruments of women's health care need to be integrated on all policy levels as well in field organizations as in government departments.
- Women's health care should be extended to gender specific care, specific care questions and needs from as well women as men will become clear.
- Within our multicultural society it is evident to combine gender and ethnicity within the healthcare.

4.1.1 Plan of action

As a result of the recommendations of the working-groups and the steering committee the government made a proposal for an action plan for the next 4 years, consisting of the following elements:
1. To develop 4 implementations routes for regional care policy making; patient/consumers policy; quality policy and policy for education programs for healthcare professionals, to start with doctors.
2. Scientific research: collect information on health problems and needs, further development about gender, ethnicity and healthcare.
3. Positioning women's self-help organizations within the regular care structures. They need to become a structural part of the implementation routes.
4. To install a new national steering committee "gender and ethnicity" to guide the process.
5. To install an intradepartmental "taskforce gender and ethnicity" in charge of implementing gender and ethnicity aspects within the government policy's.

4.2 Program proposal

The Dutch government has asked the National Research center for the healthcare (ZON) to develop a program proposal to integrate gender specific healthcare within the established structures of the healthcare system.

The program proposal consist of 6 subjects:

1. Regional care policy. The program will initiate and guide pilot projects to integrate gender specific methods within the regional vision. The program committee will invest needs and possibilities from different regions and select themes.
2. Quality of care policy. Each care providing institute needs to have certain quality control instruments. The program will stimulate to integrate gender specific care within the quality systems of the institutions. Quality of care providers within institutions are invited to make project proposals together with representatives of gender specific caregivers.
3. Patient/consumers policy. The program will stimulate the cooperation between regional women's self-help groups and patient/consumers organizations and will also look for the integration of gender specific work in the policy towards the government, care givers and financiers within the region.
4. Women's self-help. The program will invite women's self-help organizations together with organizations in the healthcare to make project proposals for structural cooperation. The program wants at least two women's self-help organizations to find structural financing for their activities together with other organizations.
5. Curriculum The program will stimulate integration of gender specific healthcare within the basic studies of medicines. It will formulate study final terms and make specific curricula on gender. Also will it look into the possibilities to combine gender and multicultural aspects within the programs.
6. Scientific research. This program will stimulate the so-called "evidence based" research. First it will collect recent research on this subject. It will be kept updated and accessible for healthcare workers. On the analyses of these researches a strategic plan will be made to stimulate further more targeted research.

It is an ambitious program and all together hopefully will eventually lead to a synergy to improve the healthcare for men and women. Daily life and reality have to prove if and how it will work, but the intentions are there.

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6. Organizations within the Women`s Health

These pages contain a description of a number of women's health organizations. They all operate on a national level. Organizations which are not specifically aimed at women but who do work in a gender specific way are not included, except for one, The Dutch Federation for Care Centres and Shelters.

Name of the organization:
Dutch Foundation of Women and Health Research

Address:
Roetersstraat 15
kamer 808
1018 WB Amsterdam
phone: ++31 / 20 / 525 68 10
fax: ++31 / 20 / 639 13 69

Contact persons:
Drs. Annemarie Kolk, chairwoman

Short description of the goals of the organization:
promoting knowledge and research in the field of women and health

Main working fields:
scientific research: women's health

Members of the organization:
researchers active in women and health research

Number of members:
approximately 125

Year of foundation: 1991

Legal form:
foundation

Financing:
donations

Regional branches: -

Working groups within the organization:
financial committee
pr committee
committee study days

Publications:
Magazine Vrouwen en Gezondheid
Towards a gender sensitive health care, congress book
Inventarisation on women and health research

Name of the organization:
Federatie Opvang

Address:
Kromme Nieuwegracht 7
3512 HC Utrecht
phone: ++31 / 30 23 / 16 403
fax: ++31 / 30 23 / 14 561

Contact persons:
Mr. W van de Giessen, director
Ms. Drs. M.D. van Gils, Staff member research, innovation and experiments, specific field of attention women's shelters

Short description of the goals of the organization:
Promotion of shelter facilities / organizations.

Main working fields:
welfare work: shelter accomodations: youth, homeless, people in crisis, refugees, women, battered women

Members of the organization:
Members are organizations providing shelter or temporary care services. The 'Blijf Van Mijn Lijf' shelters for battered women in different towns are members. Some other member shelters; Vrouwenopvang Pepita van Rijn (Pepita van Rijn women's shelter), The Hague; Saadet, Opvang Islamitische Vrouwen/Meisjes (Saadet, Shelter for muslim women/girls), Rotterdam; Vrouwenopvangcentrum Rosa Manus (Rosa Manus women's care center), Leiden.

Number of members:
97

Year of foundation: 1992

Legal form: -

Financing:
mixed

Regional branches: -

Working groups within the organization: -

Publications:
Grensoverschrijdende Zorg (care beyond boundaries)
Annual report 1995, 1996
De maatschappelijke opvang in cijfers; 1995 (care & shelter in numbers)
Opgevangen,; de maatschappelijke opvang (Sheltered; social shelter) 1994-1995
Bewogen in beweging (committed in motion), report flow stimulation
Handleiding Meldpunt Open Plaatsen (Manual, office for reporting center vacancies)
Belangrijke vragen over klagen (importandt questions about complaints), leaflet
Leaflet training facilities, spring 1996, Leaflet training facilities, autumn 1996

Current interests:
Under capacity in social shelters, regulations and local policy, quality-focused policy, international cooperation

Name of the organization:
Fort Nederland

Address:
Nieuwegracht 24a
3512 LR Utrecht
phone: ++31 / 30 236 / 82 62
fax: ++31 / 30 236 / 82 42

Contact persons:
Ms Margriet de Jong, chairwoman

Short description of the goals of the organization:
self help for women aimed at personal growth and social consciousness

Main working fields:
mental health

Members of the organization: -

Number of members: -

Year of foundation: 1975

Legal form:
foundation

Financing:
mixed

Regional branches:
there are 6 regional branches

Working groups within the organization: -

Publications:
information leaflets

Abstract from a publication

Current interests

Name of the organization:
Landelijk Contactorgaan Begeleiding Borstkankerpatiënten (national contact organ for support of breast cancer patients)

Address:
Secretariat LCBB
Kalkestraat 87
6669 CN Dodewaard

Contact persons:
See above
phone: ++31 / 488 / 41 22 63 (office)
++31 / 488 / 41 22 58(patients)
fax: ++31 / 488 / 41 27 40

Short description of the goals of the organization:
Information and support for breast cancer patients, promotion of the interests of breast cancer patients

Main working fields:
support, advice, counselling: breast cancer patients
policy-advice breast cancer (screening, treatment, medication)

Members of the organization: -

Number of members: -

Year of foundation: 1978

Legal form:
association

Financing:
mixed (non governmental)

Regional branches:
There are 13 regional branches (adresses via the central Secretary):

- Friesland
- Groningen
- Drenthe
- Gelderland
- Overijssel/Noordoostpolder
- Mid Netherlands
- Noord-Holland
- Amsterdam & around
- Zuid-Holland North
- Zuid-Holland South
- Zeeland and west Noord-Brabant
- North east Brabant
- Limburg

Working groups within the organization:
- Interest promotion committee
- Training committee
- Breast prothesis information centers committee
- Newsletter committee
- PR committee

Publications:
- Newsletter Mammazone
- annual report
- general information leaflets about the organization

Current interest:
- participant in Europa Donna (European breast Cancer Coalition)

Name of the organization:
Landelijk Overleg Vrouwen arbeidsongeschiktheid (contact group women who are unfit for work or disable)

Address:
Keetwaltje 1
8921 EV Leeuwarden
phone: ++31 / 58 / 212 81 29

Contact persons: -

Short description of the goals of the organization:
Improving the position of women who are unfit for work
Information
Influencing policy and politics.

Main working fields:
Health at work, social security

Members of the organization: -

Number of members: -

Year of foundation: 1984

Legal form:
Association

Financing:
Mixed

Regional branches:
Regional support groups

Working groups within the organization:
Prevention groups and reintegrates groups

Publications:
Information booklet, brochure and reports

Name of the organization:

The Selene Foundation (for Post Partum Depression and Premenstrual Tension and Post Partum Psychoses)

Address:

Nieuwegracht 24a
3512 LR Utrecht
phone: ++31 / 30 / 233 17 77
fax: ++31 / 30 / 236 82 42
e-mail:fvzh@planet.nl

Contact persons:

Administration: ++31 / 30 / 234 18 63

Short description of the goals of the organization:

Promoting the recognition and acknowledgement of Post Partum Depression, PreMenstrual Tension and Post Partum Psychoses as well as the support and supervision of women who struggle with PPD and/or PMT and/or PPP.

Main working fields:

Policy making, advice, support, counselling, self help: Post Partum Depression, Pre Menstrual Tension and Post Partum Depression.

Members of the organisation:

Ca.60

Number of members: -

Year of foundation: 1981

Legal form:

Foundation

Financing:

mixed

Regional branches:

local self help groups

Working groups within the organization: -

Publications:

information leaflets and brochures

Name of the organization:
Steunpunt voor Vrouwen met Siliconen-implantaten SVS (Support center for women with silicon breast implants)

Address:
Kogge 11 37
8243 AD Lelystad
phone: ++31 / 320 / 24 01 02
++31 / 30 / 261 28 87
fax: ++31 / 320 / 28 20 56

Contact persons:
Ms. Marlou Boots
Ms. Tiny Adelaar

Short description of the goals of the organization:
Providing information and support to women with questions about silicon breast implants.

Main working fields:
information/support: women with silicon breast implants

Members of the organization:-

Number of members:-

Year of foundation: -

Legal form:
Foundation

Financing:
subscription fees, donations

Regional branches: -

Working groups within the organization: -

Publications:
Kontaktblad SVS (news letter)
Leaflets:
Algemene informatie over Stichting SVS (general information about SVS)
Ziek van de siliconen? (sick of silicone?)
Kinderen en siliconen (children and silicone)

Name of the organization:
Stichting Ambulante Fiom (Fiom Foundation)

Address:
Kruisstraat 1
5211 DT 's Hertogenbosch
phone: ++31 / 73 / 612 88 21
fax: ++31 / 73 / 612 23 90

Contact persons:
Mevr. C.P.M. van Kessel, Director ad interim

Short description of the goals of the organization:
providing help and information about (unwanted) pregnancy and involuntary childlessness, surrender of a child, adoption and search , sexual violence and incest,.

Main working fields:
pregnancy, adoption, sexual abuse

Members of the organization: -

Number of members: -

Year of foundation: 1930

Legal form:
foundation

Financing:
Government subsidy

Regional branches:
There are 15 regional branches

Working groups within the organization: -

Publications:
Annual Report, information leaflets

Name of the organization:
Stichting Anorexia en Boulimia Nervosa

Address:
PO BOX 67
6880 AB Velp
e-mail: info@sabn.nl
internet: www.sabn.nl

Contact persons: -

Short description of the goals of the organization:
promoting support to persons who suffer from anorexia/boulimia nervosa

Main working fields:
mental health, eating disorders

Members of the organization: -

Number of members:
1000

Year of foundation: 1978

Legal form:
foundation

Financing:
mixed

Regional branches:
there are regional contact persons in all parts of the country

Working groups within the organization: -

Publications
contact organ Antenne,(6 issues a year) information leaflets

Name of the organization:
Stichting Mastopathie (Mastopathy Foundation)

Address:
Nieuwegracht 24A
3512 LR Utrecht
phone: 0031 30 233 21 91
fax: 0031 30 236 82 42
e-mail: mastopat@xs4all.nl
internet: http://www.xs4all.nl/~mastopat/

Contact persons:
Ms. Wilma van Drie, advisor

Short description of the goals of the organization:
promoting good information for women with mastopathy

Main working fields:
information, avice and support: women with mastopathy

Members of the organization: -

Number of members: -

Year of foundation: 1990

Legal form:
foundation

Financing: -

Regional branches: -

Working groups within the organization: -

Publications:
Newsletter, Annual Report, Annual Plan, leaflets, relaxation tape

Current interests:
information about mastopathy via internet

Name of the organization:
Stichting Olijf

Address:
PO Box 1478
1000 BL Amsterdam
phone: ++31 / 20 / 615 74 30

Contact persons:

Short description of the goals of the organization:
providing a network for women with gynaecological cancer
improving communication between women and doctors

Main working fields:
gynaecological cancer

Members of the organization: -

Number of members: -

Year of foundation: 1986

Legal form:
foundation

Financing:
mixed

Regional branches:
there are 11 regional branches

Working groups within the organization: -

Publications:
information booklets for women, magazine OLIJF, Annual Report, information video

Abstract from a publication

Current interests:
new media in health promotion

Name of the organization:
Stichting VIDO Nederland (VIDO Foundation Netherlands)

Address:
Nieuwegracht 24A
3512 LR Utrecht
phone: ++31 / 30 / 234 11 42

Contact persons:
Jenny Hille, Secretary

Short description of the goals of the organization:
promotion of the interests of women at menopausal age

Main working fields:
support, counselling: menopause

Members of the organization: -

Number of members: -

Year of foundation: 1974

Legal form:
foundation

Financing:
Government subsidy

Regional branches:
There are 20 local VIDO self-help groups and a service of 6 female experience experts for answering questions about menopause and healthcare for women at the age of about 40 - 60 years.

Working groups within the organization: -

Publications:
general leaflet about VIDO
poster
VIDO information pack
Newsletter
book: 'Overgangsjaren, feite en fabels' (with Aletta), (menopause, facts and fiction)
video: 'De uitdaging van de overgang' (the challenge of menopause)

Abstract from a publication

Current interests:
Stimulate women to use their own strength to work on personal growth and development and establish a positive image of ageing women. Also the demedicalisation of women at menopausal age.

Name of the organization:
Stichting Vrouwen en Medicijngebruik (women & drugs foundation)

Address:
Bomanshof 6
5611 NJ Eindhoven
phone: ++31 / 40 / 212 1746
++31 / 40 / 212 4987
fax ++31 / 40 / 211 2179

Contact persons:
Ms. Marianne Snoeys

Short description of the goals of the organization:
Information, advise, support for women who have a tranquillizer addiction. Research on women and tranquillizer use

Main working fields:
advice, support, research: tranquillizer addiction, self help groups, counselling, courses

Members of the organization: -

Number of members: -

Year of foundation: 1978

Legal form:
Foundation

Financing: -

Regional branches:
activities such as self help groups and courses are carried out locally in cooperation with other organizations

Working groups within the organization: -

Publications:
Leaflet Stichting vrouwen en Medicijngebruik (general information)
Leaflet "Verslik je niet"
Leaflet "Wat slik je weg?"
Annual report
video about medication abuse

Name of the organization:
Stichting Vrouwen tegen Seksueel Geweld door Hulpverleners (foundation women against sexual abuse by care providers)

Address:
P.O. Box 277
6500 AG Nijmegen
phone: ++31 / 24 / 323 29 56

Contact persons:

Short description of the goals of the organization:
Registration of cases of sexual abuse by care providers, promotion of contact between victims, providing information to the public

Main working fields:
sexual abuse

Members of the organization: -

Number of members:-

Year of foundation: 1985

Legal form:
foundation

Financing:
mixed

Regional branches: -

Working groups within the organization: -

Publications:
Information booklet

Abstract from a publication

Current interests: -

Name of the organization:
TransAct, National centre for gender specific care and prevention sexual intimidation

Address:
PO box 1413
3500 BK Utrecht
phone: ++31 / 30 / 230 40 06
fax: ++31 / 30 / 234 38 18
e-mail: transact@antenna.nl

Contact persons:
Ms Karin Klijnsma, director

Short description of the goals of the organization:
Promotion of gender specific innovation in the care sector, prevention of sexual abuse

Main working fields:
Mental health: gender specific therapy, prevention of sexual abuse and child pornograpy, gender specific care for migrant women, for older women, gender specific care/therapy for men

Members of the organization: -

Number of members: -

Year of foundation: 1995

Legal form:
Foundation

Financing:
mixed

Publications:
Literature lists
Social maps and address lists

- Hoe om te gaan met - een vermoeden van - seksueel geweld? Aandachtspunten voor een aanmeldingsgesprek: Handleiding; tekst Lisette van Gurp, TransAct 1996.
- Aan den lijve. Hulpverlening na seksueel geweld. Eindredactie: Marianne Cense. TransAct 1996.
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- Met een sleutel in de hand. Meer vrouwen op sleutelposities in de gezondheidszorg. Projectverslag. Eindredactie: Els van Dinteren, Annemies Gort. TransAct 1996.
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- Schrijven over je vak. Impressies van zwarte en migrantenhulpverleensters. Eindredactie: Arlette Dwarkasing. TransAct 1996.
- Kwaliteit met beleid. Een kwaliteitsmeter voor zelfstandige aanbieders van vrouwenhulpverlening. Tekst: Annemiek Goes. TransAct 1996.
- Kwaliteit van zorg. Het perspectief van vrouwen. Redactie: Mieke Hartveld, Nonja Meintser. Wemos i.s.m. TransAct.
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Current interests:
sexual violence, war victims and refugees abroad

Name of the organization:
Vereniging van Nederlandse Vrouwelijke Artsen VNVA (Dutch Association of Woman Doctors)

Address:
VNVA Secretariat
graaf Florisweg 97
2805 AH Gouda
phone: ++31 / 182 / 58 53 91
fax: ++31 / 182 / 58 53 91
e-mail: vnvamail@xs4all.nl

Contact persons:
Ms. Evelien Kingma-Taphorn, Secretary

Short description of the goals of the organization:
Contributing to the improvement of the position of woman doctors and to further development of gender sensitive health care. Providing inspiration for the members in this sense.

Main working fields:
Woman doctors: position and working conditions
all health care fields

Members of the organization:
Woman doctors

Number of members:
2400

Year of foundation:
1933

Legal form:
Association

Financing:
membership fees, donations

Regional branches:
there are 9 regional branches; adresses via the secretariat

Working groups within the organization:
Committee National Affairs
Committee Policy Document
Committee Corrie Hermann Prize
Committee Woman Doctor and Peace Issues
Committee Part Time Work

Publications:

Policy Document 1998; VNVA Jubilee Book 1933-1998
VNVA Jubilee Congress 1998
VNVA Krant (newsletter)

Abstract from a publication

Current interests:

Networks within the VNVA and with other organizations

Name of the organization:
The VZG Foundation, Information and Self-Help on Gynaecological Problems

Address:
Nieuwegracht 24A
3512 LR Utrecht
phone: ++31 / 30 / 231 05 58
fax: ++31 / 30 / 231 05 58

Contact persons: -

Short description of the goals of the organization:
Support and counselling of women with gynaecologic complaints
Support and counselling of women with involuntary infertility connected with gynaecologic problems
Support and counselling of women who are in menopause early in life
Promoting emancipation of these women
Improving information about medical treatment

Main working fields:
counselling, support, advice: gynaecologic complaints, early menoapause, infertility

Members of the organization: -

Number of members: -

Year of foundation: -

Legal form:
foundation

Financing:
Mixed

Regional branches:
there is a shifting number of local self help groups

Working groups within the organization

Publications:
general information leaflet
book "En de vrouw die kiest" (and the woman chooses)

Name of the organization:
Women's Global Network for Reproductive Rights

Address:
1012 RZ Amsterdam
Netherlands
phone: ++31 / 20 / 62 09 672
fax: ++31 / 20 / 62 22 450
e-mail: office@wgnrr.nl

Contact persons:
Annette Will/ Sumatri Naim

Short description of the goals of the organization:
Promotion of women's reproductive rights worldwide

Main working fields:
policy advice, support of local organizations: sexual health, reproduction, population policy's, violence against women, contraception etc.

Members of the organization:
Members of the International Advisory group
Loes Keijsers (ISS, Netherlands)
Maria Betania Avila (SOS Corpo, Brazil)
Martha Rosenberg (Foro por los Derechos Reproductivos, Argentina)
Jessica Nkuuhe (ISIS Uganda)
Ana Maria Nemenzo (WOman Health, the Philippines)
Daisy Dharmaraj (PREPARE, India)
Justa Montero (Comision pro Derecho al Aborto-Asamblea Feminista, Spain)
Betsy Hartmann (CWPE, USA)

Number of members:
8 members of IAG, total number of members and subscribers 1707

Year of foundation: 1978

Legal form:
Network/association

Financing:
mixed

Regional branches:
autonomous members worldwide

Working groups within the organization: -

Publications:
Newsletter, Annual Report, Proposal 1997-1999, international meeting reports

Abstract from a publication

Current interests:
prevention of maternal mortality and morbidity, campaign against anti-fertility 'vaccines', promotion of women's sexual and reproductive rights

Name of the organization:
Women's Self-Help Federation

Address:
Nieuwegracht 24a
3512 LR Utrecht
phone: ++31 / 30 / 236 82 62
fax: ++31 / 30 / 236 82 42

Contact persons:
Marjan Karsemakers, Director

Short description of the goals of the organization:
The Federation is a cooperation of a variety of organizations in the field of self-help for women

Main working fields:
Self help: different fields:medication addiction, menopauze,depression after birth, nonmalignant breast problems, premenstrual tension

Members of the organization:
Foundation for Woman and Medication
VZG Foundation, Information and Self-Help on Gynaecological Problems
Mastopathy Foundation
The Selene Foundation for Post Partum Depression and Premenstrual Tension
The VIDO Nederland Foundation for Women at Menopausal Age

affiliated members:
Fort Netherlands
The Anorexia Nervosa Foundation
The SVS Foundation
Vulva foundation

Number of members:
5

Year of foundation: 1994

Legal form:
Foundation

Financing:
mixed

Working groups within the organization:
see: members

Publications:
Annual report, information leaflet, magazine self-help for women

Abstract from a publication

Current interests:
quality-focused policy, sexual intimidation, unempowerment
elderly women
intercultural