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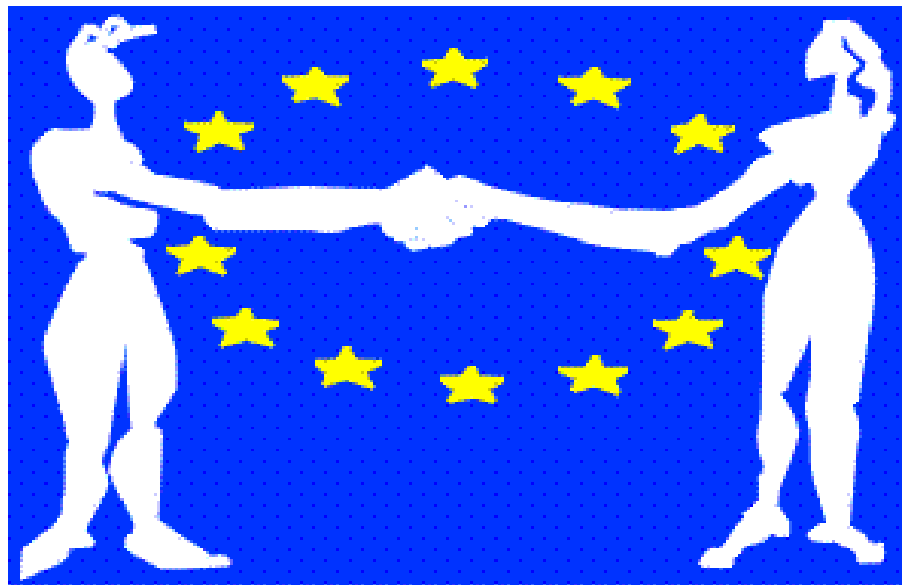
European Women's Health Network

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**Municipal strategies for
women's health -**

Women's health in municipalities

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Workshop documentation

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(1999) 2001

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women's health in municipalities

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European Women's Health Network

EWHNET

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1. Preface

"Municipal strategies for women's health - women's health in municipalities" was the topic of the workshop documented in this report. The workshop took place in the context of the European Women's Health Network (EWHNET).

The workshop had two objectives:

- The first objective was to give the recently founded centres of women's health of the partner organizations in Austria a platform for a mutual exchange on strategies in the field of women's health.
- The second objective was to reflect on the experiences related to equality and health on a municipal level. The goal was to report on models of good practice, as well as address obstacles in the work.

We hope that the exchange of experiences documented in this report provides the coordinators of existing projects with new incentives and motivates them to reflect on and further develop their work. In recent years decisive criticism of the health care-system emerged. Key words are a "pathogenetic view" versus strengthening of health-resources, high-tech-medicine versus communicative medicine, technologization versus a holistic treatment. The demands on the health system do not merely consist of the ethical clarification of recent developments (as in the field of gene technology), but also include the solution of growing problems, as for example the increase of chronic diseases, and the application of newly gained knowledge. Understanding illness, health, healing and alleviation has become more complex. The role of patients has to be reconsidered. Strategies of empowerment, gender-sensitive forms of care, the consideration of the life-situation and difference, but also of equality, are demands that require new strategies in the health system.

In recent years, the women's health movement has produced new organizations that can be considered to be critical voices. The competences that are collected here relate to problems of women, strategies of empowerment and the realization of women specific concerns. All over Europe a multitude of new strategies in the field of women's health were developed - and not only regarding pregnancy and birth. With their voice and their critical competence the organizations of the women's health movement are becoming important partners in the discussion of new structures in the health system. But they are only able to take up this role if they actually face that development. In this spirit we hope for a more extended network, new political strategies and an exchange of experiences and competences in the field of women's health all over Europe.

The following contributions show experiences with women's health strategies at a community-level in different European countries. Sylvia Groth discusses different accents in women's health work in Austria. For the Netherlands a women's health centre with a wide range of highly qualified activities and developments in the field of policy-implementation is presented. Nevertheless this centre has lost its fight for survival (Lea den Broeder). Great Britain is represented with a contribution by Ann Hamilton giving insight into the work with a social model of women's health in urban politics, which as the first "Healthy-City-Model" has realized women's health in a comprehensive way. For Germany, Brigitte Stumm and Vera Lasch present the spectrum of municipal women's health projects and Ilse Scheinhardt and Ulrike Hauffe describe an example of the cooperation between the provision of resources and networking. Sabine Overkämping portrays the development of the political framework at the

European level. Carol Hagemann-White, Ute Sonntag and Ingrid Helbrecht-Jordan reflect on issues of a transnational or European cooperation and its implications on political addressees and organizational structure.

We hope reading this documentation will be as interesting and inspiring to you as the workshop was to the participants!

Enjoy the reading!

Vera Lasch

2. Local Strategies Using the Example of the Austrian Women's Health Centres

- 2.1 F.E.M. (Frauen = women, Eltern = parents, Mädchen = girls): WHO Pilot Project Vienna Women's Health Centre
Daniela Kern

- I. Initial Situation**
- II. Organisation**
- III. Objectives**
- IV. Special Features**
- V. Our Strengths**
- VI. Our Weaknesses**
- VII. Threats**
- VIII. Supportive Groups**

I. Initial Situation

The starting point for the WHO pilot project to construct a women's health centre were the recommendations made at the 1992 WHO Conference in Vienna, entitled: "Women's Health and Urban Policies". The guidelines of the WHO Ottawa Charter on Health regarding health promotion set the trend for the project. For this reason, the WHO pilot project was implemented as part of the WHO's Healthy City project. One of the project's major concerns was to offer health promotion to the highly frequented gynaecological clinic and to women beforehand. Furthermore, together with staff from the clinic, structural improvements were to be implemented for women, in order to convert an illness-oriented and male-dominated physical paradigm of women into a psychosocial, holistic understanding of health resources, or at least to supplement the present situation.

The starting point for the further measures which were to be implemented included, on the one hand, a social science-related basic survey of health-care requirements of women in the surrounding districts, and an enquiry among the hospital patients regarding their needs for a women-oriented hospital, and on the other hand, a study on staff requirements. The implementation of the Women's Health Centre was carried out with the help of the organisational development and networking of psychosocial and medical institutions in the surrounding area.

In order to implement the health promotion aspect focussing on women's health in the setting of the hospital, to utilise the personnel, material and medical resources, and to be able to offer a range of health promotion services for women, the women's health centre was consciously implemented in a gynaecological clinic as a WHO project. The following graduated plan was followed:

1. Ascertainment of the socio-economic and socio-demographic regional structure of the female population in the surrounding districts.
2. Determination of the extent of health problems, quality of life and resources of women in the surrounding areas, in order to organise a target-group and requirement-specific service spectrum.
3. Testing the client satisfaction of female patients at the clinic, in order to ascertain expectations and requirements.
4. Interviewing the whole staff of the clinic, in order to be able to identify expectations and requirements with regard to mutual cooperation.

II. Organisation

The Women's Health Centre (F.E.M.) sees itself as a political forum for women-specific concerns in the field of the health service. Since its establishment in 1992, 10,000 women have made use of the F.E.M.'s services. The fact that the Women's Health Centre (F.E.M.) has become a subliminal meeting point for the solution of women-specific issues is shown by the continued increase in the number of phone calls requesting information, assistance and advice (1,500 calls in 1993, rising to 4,700 in 1998).

Over 60 different services are organised by 50 free-lance collaborators, including gynaecologists, general practitioners, psychologists, psychotherapists, midwives, social physicians, physiotherapists, nutritionists, children's nurses, etc.

In order to guarantee cooperation between the clinic and the Women's Health Centre, joint projects to improve patient care and to relieve staff were implemented with the help of organisational development and quality management. The process ends with the joint drawing up of a model that centres on patient requirements.

The working principle is based on current social scientific programme evaluations, as well as current research on subjects related to women's health. The reason for this principle is to aim to achieve improvements for women regarding structure, contents and service, in particular in the field of medicine, which remains considerably male-dominated to date.

Project Sponsor:	Institute for Health Promotion and Model Development; Women's Health Centres F.E.M.
Governing Body:	Prof.in Dr.in Beate Wimmer-Puchinger, Commissioner for Women's Issues Prof. Dr. Peter Wagenbichler, Medical Director of Ignaz Semmelweis Gynaecological Clinic Prim.a Dr.in Margit Endler, Medical Director of Kaiser Franz Josef Hospital Mag.a Hilde Wolf, Director of F.E.M. South Mag.a Daniela Kern, Director of F.E.M.
F.E.M. Team:	Collegial management of Ignaz Semmelweis Gynaecological Clinic Mag.a Daniela Kern, Director Susanne Schmölder, public relations Martina Nöster, youth work Dragana Balvanovic, administrative and course organisation
F.E.M. Team "South":	Mag.a Doris Gartner, Director Mag.a Hilde Wolf, Director Mag.a Kathleen Löschke, organisation Mag.a Bedrija Cero, foreign language advice Mag.a Serpil Öszoy, foreign language advice Safile Akbal, coordination in the field of women migrants

III. Objectives

The main objectives of the Women's Health Centre are as follows:

- Promotion of health
- Prevention
- Model reorientation of the health service towards "women-friendly services"
- Cooperation and networking with medical allocators and other health institutions
- Further and continued training of personnel in caring and social vocations.

IV. Special Features

The Women's Health Centre "F.E.M." offers advice, courses, talks and workshops on subjects that are relevant to women and their health resources.

Together with the Semmelweis Gynaecological Clinic, the Women's Health Centre sponsored a model entitled "Born into Security", which is unique to the whole of Austria. This model enables women to have the "midwife of their choice" present at the birth of their child. This ensures that pregnant women receive continual, midwife-oriented antenatal care and birth assistance. Furthermore, joint breast-feeding guidelines were set out in accordance with WHO and UNICEF recommendations. In 1996, the Austrian Osteoporosis Self-Help Group (ÖOS) was established. In collaboration with the WHO project "Healthy School", workshops for girls on the subject of sexuality were organised, as well as a video workshop run by girls for fellow-girls, a medical information medium. Around 30 school classes visit the F.E.M. annually. Staff also teach at social and educational academies, nursing colleges, midwife academies and the Universities of Vienna and Salzburg, in order to build networks and to ensure cooperation with the teaching world.

In May 1999, the F.E.M. South was founded to also implement the concept in one of Vienna's largest municipal hospitals, the Kaiser-Franz-Josef Hospital, which is situated in one of the most highly populated districts of Vienna, and to also offer services to highly stressed women. This was accompanied by the extension of services to women from all ethnic backgrounds. The project development intended to ascertain the burdens and requirements of women from extremely varied income groups, educational levels and cultures. Furthermore, the project planning team, together with the various departments of the hospital (internal medicine, psychiatry, oncology, geriatric medicine, etc.), aimed to develop special preventive treatment, health promotion and aftercare treatment.

V. Our Strengths

Direct implementation into a renowned and progressive gynaecological clinic opens up new possibilities with regard to customer-oriented women's health promotion, which looks critically at the medical system as a whole and tries to improve existing hospital structures by making them more women-friendly, offering further training for doctors and operating quality criteria for medical examinations and care. In 1998, the project "Women's Health Centre F.E.M." was awarded the "Model of Good Practice" prize by the WHO.

The Viennese Women's Health Programme, which was completed in November 1998, and which is the working basis of the Viennese women's health officer, shows a variety of requirements and fields of action that point the way for work in the Women's Health Centre, the implementation of which are presently underway.

Health promotion within a hospital facilitates the utilisation of the organisational structure, infrastructure and the medical know-how of the hospital, as well as the implementation of women-promoting measures.

Besides, the Women's Health Centre "F.E.M." sees itself as a local 'turntable' between extramural and intramural institutions (general practitioners, pharmacists, local institutions, as well as outpatient clinics and hospital wards).

VI. Our Weaknesses

Our objective to reach socially disadvantaged women and female migrants through a subliminal range of services has only been fulfilled to a certain extent. The main cause for this is the location of the Women's Health Centre in a predominantly middle-class area. For this reason, a second branch of the Women's Health Centre, "F.E.M. South", opened in May this year in the Viennese Kaiser-Franz-Josef Hospital. The main aim of this branch is to gain the interest of migrant women and socially disadvantaged women by offering advice in foreign languages, as well as special courses and workshops.

VII. Threats

Guaranteed long-term securing of funding has not yet been achieved.

VIII. Supportive Groups

The Women's Health Centre has a multitude of national and international partners, with which it cooperates. These partners include institutions from psychosocial and medical fields, general gynaecologists, general practitioners, the Viennese Hospitals Association, the regional health insurance company, the General Medical Council, the Viennese Integration Fund, Austrian Cancer Relief, the Women's Office, as well as the WHO and other international institutions.

2.2 Graz Women's Health Centre
Sylvia Groth

- I. Organisation**
- II. Objectives and Special Features**
- III. Supportive Groups**
- IV. Bibliography**

I. Organisation

Graz Women's Health Centre is a small, autonomous organisation, which is run on a charitable basis. In Graz, there are five members of staff; three women are also employed on our pilot project: Leibnitz Women's Health Centre. We always work on two different perspectives simultaneously: direct services for women as well as health policy work to bring about structural change.

Project Sponsor:	Society for Women's Health Centres in Graz
Project Management:	Sylvia Groth M.A.
Project Team:	Doris Egger Christine Saiko-Jogan Monika Vucsak Marianne Stöger

II. Objectives and Special Features

Since our establishment in December 1993, we have been working on the basis of three strategies:

- The empowerment of individual women, clients, patients, users and consumers, as well as the empowerment of groups within the framework of direct services (information management, advice, further referral, psychotherapeutic orientation and therapy, gynaecological talks, diagnostics, therapy, as well as seminars, workshops, events and group programmes)
- Cooperation and networking to gain ideas and assistance and to implement structural change through institutionalised working groups, expert cooperation and political advice, in order to facilitate health care and health policy that fulfil needs and take women's issues into consideration
- Representation of interests, advocacy and lobbying as a provider of impulses, counterweight and corrector to other articulate interest groups within the health system, in order to achieve public awareness and long-term change.

Empowerment means expanding the competence of both individuals and social groups, e.g. disadvantaged women with regard to controlling their own living conditions and ways of life, and accessing resources, and regarding their participation in political decisions. The objectives are to dismantle social differences and bring about equal opportunities in the field of health, to make gainful employment and domestic work more health-oriented, as well as the equal participation of both men and women in the planning, implementation and evaluation of health-promoting actions.

This is the reason why we understand health promotion not only as a social or medical service, but we also assume the emancipated demand of the concept of the World Health Organisation. We are therefore more interested primarily in strengthening the competencies of those involved, including the destabilising factors in the private and public sector, such as violence, health standardisations (e.g. eating disorders, medication during the menopause), inadequate access to health care and discrimination.

Our practical experience in working directly with women is a corrective and an important source of information for our political work and endeavours to bring about structural change.

These strategies require various different abilities, and have different, or sometimes overlapping, target groups. In order to enable us to introduce our approaches towards a local women's health policy, I concentrate on the strategies of cooperation and representation of interests.

Our forms of cooperation range from concrete collaboration with various different institutions on a certain project, such as women's health days or joint series of talks, to long-term forms of joint work, such as in the women's health forum. This network is an amalgamation of professional women in the health system, which has set its objective to develop a women's health programme for Graz and Styria, and become politically involved in order to bring about its implementation.

In September 1996, we were able to hold an international conference on women's health promotion in Graz, which was entitled: "European Impulses for Graz and Styria", during which we cooperated with the Women's Issues Department of Graz City Council and the Department of Health of the Land Styria. At this conference, first demands were made for a women's and girl's health report, which was drawn up in 1998 by Èva Rásky from the Institute for Social Medicine at the Karl Franzens University of Graz, commissioned by the Women's Issues Department of the Graz City Council and the Department of Health of the Land Styria. The report forms the conceptional basis, the data material and strategic perspectives, according to which we and our counterparts are now fighting to establish a women's health programme. The women's health report was made public in autumn 1998 at a women's health enquête, which was attended by politicians and especially by those involved in health projects, the administration or organisations active in health promotion.

The working group on abortion, which was initiated by us and is coordinated by the Public Health Department of the City of Graz, also aims to bring about structural change. Representatives of advice centres, the General Medical Council, the Social Security Department and a general practitioner meet to implement concrete qualitative improvements for affected women. On the one hand, emphasis is placed on improved transparency for women, but on the other hand, improved knowledge and coordination of the service among those professionals working in this field are also of vital importance.

A working group on eating disorders, which has held meetings at our premises for the last two years, brings together the psychotherapists who work in this field. Graz Women's Health Centre has many years of experience in the field of therapy, further training and the support of the families of women who suffer from eating disorders. We are currently endeavouring to become a coordination centre for eating disorders in Styria. We view eating disorders in the context of physical and health standardisations for women - a connection that plays an important role in our public relations work. For a number of years, we have also offered courses for obese women, in order to give them psychotherapeutic support to help them gain

physical self-confidence by carrying out physical activities. Together with Dr. Sylvia Titze from the Institute for Sport Science of the KFU Graz and Mag. Karin Totter, this innovative course is also being scientifically evaluated. A study which is currently being made endeavours to ascertain and assess the range of sports activities on offer for women in Styria. Our objective is to encourage rural and urban sports clubs to change their spectrum to make them more women-oriented.

Our various different forms of cooperation require a great deal of sensitivity, in order for us, in close collaboration with other institutions and organisations, to make deficits expressed by clients in the range and sectors of the health system and health policy in Graz and Styria more oriented towards the needs of women. This sensitivity requires the basic recognition of our cooperative partners, as well as the skill of moderation and negotiation management. We aim to work with all political parties, in order to propose and promote subject-related changes.

Our cooperations are supported by intensive European contacts, as well as international declarations by the European Council, the EU, the World Health Organisation etc., which provide us with a link to international aims. We take up and disseminate these declarations, in order to bring about local and regional women's health objectives.

The field of the representation of interests and lobbying consists of information management, public relations with regular press releases, interviews and our magazine, as well as presentations at scientific congresses and panel discussions. Our strategy in this field is based on using in-depth knowledge and the analysis of interests and conflicts of interest in the field of health to critically present a corrective and counterweight. Our strategy is not to shun confrontation in critical discussions, in order to clarify interrelations and to implement a political representation of interests for women.

Here, I would like to particularly mention our press and public relations campaigns to bring to the public's attention the fact that there are very few female national health gynaecologists in Graz and Styria. We were successful in enabling two national health positions to be filled with women; in one case we failed to do so. In this process, we went into confrontation against the gynaecological sector, but we also managed to gain a great deal of publicity and attention in the eyes of the general public. We can be relied upon to sound our critical voice on subjects, such as having the choice between a male or a female gynaecologist, critical information on the morning-after pill, the medicalisation of women, i.e. the use of hormone treatment during the menopause, physical and health standardisations through slimness ideals, or the abuse of women by therapists in psychotherapy.

The field of information management provides us and other interested women with a basis of knowledge and information. It profits from close cooperation with the Institute for Social Medicine of the Karl Franzens University, which gives us easy access to international medical literature. We were able to establish this section, which is run by an information scientist, with the help of a subsidy provided by the Health Department of Graz City Council. Information from various different media sources on the subject of health is constantly increasing, and are manifold and sometimes even contradictory. Its orientation, assessment and evaluation is even difficult for experts.

The objective of our information management is to contribute to a reliable basis of knowledge for women and a basis as an interdepartmental women's health policy, and to facilitate transparency in the assessment of information institutions and services. With the help of critical perspectives regarding information, based on evidence, we can help support women in reaching their own decisions.

Our services therefore include:

- Academic research, collection and evaluation of critical and alternative information
- Documentation and publishing of information
- Offer of and access to critical and alternative information
- Conveyance (photocopies, sending) of material and supplying reference addresses
- Utilisation of new information media: own website with qualified links to other institutions in the field of women's health: <http://www.fgz.co.at/fgz>
- Further referral to other selected information-providers

Our simultaneous project work means that we work according to a specific process model that combines both project areas.

Besides the focus on providing those affected with critical consumer information, support and advice, opening up options within the medical and alternative medical care, as well as psychological care, our sphere of work also includes strategies regarding influencing structural change, like public relations for dissemination, the establishment and participation in structural working groups, the representation of interests, as well as networking and cooperation.

Reference to Shortcomings / User Criticism



Analysis of the Situation
Collection of Data

Research of Literature
Talks with Experts

Ascertainment of Demand
Development of Concept

Structural Changes

Empowerment
Participation of
Affected Women

Networking with
Experts/
Institutions

Involvement in Politics
Policy Advice

Provider of Impulses for Change

New Care Model
New Style of Activity;
Quality of Interaction

The strategies we follow have been included in the strategic activities of the World Health Organisation on health promotion, which also stress the objective to "facilitate a higher degree of self-determination of our own health, and to enable us to improve our health" (Ottawa Charter 1986).

III. Supportive Groups

Graz Women's Health Centre is active in the Network of Austrian Women's Health Centres, and is a project partner in the European Network of Women's Health, a project financed by the EU as part of its 5th Programme for Equal Opportunities.

IV. Bibliography

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Rásky, Èva, 1998: Frauen- und Mädchengesundheitsbericht Graz und Steiermark. Institut für Sozialmedizin der Karl-Franzens Universität Graz commissioned by the Women's and Health City Councillor Tatjana Kaltenbeck and the Land Health Councillor Günter Dörflinger, Graz (obtainable from the Women's Department of the City of Graz, Schmiedgasse 26, A-8010 Graz)

2.3 ISIS-Health and Therapy for Women Hermie Steininger

- I. Initial Situation
- II. Organisation
- III. Objectives
- IV. Our Strengths
- V. Our Weaknesses
- VI. Supportive Groups

I. Initial Situation

The society entitled "ISIS-Health and Therapy" for women was founded in December 1994 with the objective of establishing health promotion and health care oriented towards women in Salzburg.

The idea originated from the Salzburg Women's Health Report (Office for Women's Issues of the Land Salzburg, 1992), since the results of a survey revealed that over a quarter of the women interviewed expressed the wish for a special advisory and service facility for health and therapy-related issues.

The results of two studies commissioned by the Land Salzburg proved the necessity for the establishment of a special health care service for women (Salzburg Women's Report, 1992; Study "Being Healthy and Ill in Salzburg", 1994).

The Land Office for Women's Issues founded an expert-led working group, the objective of which was to establish a women's health centre.

II. Organisation

The Women's Health Centre ISIS is not a project of the autonomous women's health movement. The managing committee consists of five voluntary women from the professional fields of gynaecology, psychotherapy/psychology and communications science. The society also employs three part-time staff, two of whom are appointed to the management activities.

Project Sponsor:	ISIS-Health and Therapy for Women Society
Directors:	Mag. Petra Schweiger Mag. Aline Hulhuber
Project Team:	Mag. Petra Schweiger Mag. Hermie Steininger Mag. Aline Hulhuber-Ahlmann

III. Objectives

The following demands are to be guaranteed in accordance with the WHO definition of health:

1. Advice and information on the health of women for girls and women of all ages
 - Psychological and psychotherapeutic advice:
 - Advice in stressful life situations
 - Advice on eating disorders
 - Advice for women suffering during their menopause
 - Advice on nutrition
 - In 1998, we gave personal advice to a total of 256 girls and women
 - Gynaecological and general medical advice:
 - Advice on incontinence
 - Family planning
 - Talks, courses and group seminars on women-specific health subjects
 - Our ISIS programme booklet containing the above events is published twice a year with a circulation of 11,500.
 - In 1998, a total of 1,942 girls and women participated in our events that took place in the city of Salzburg and the surrounding region.
2. Public relations work, education and awareness on subjects such as health and illness in the context of women's lives. ISIS sees itself as initiator, as well as event organiser and location.
3. Construction of a network and an informative 'turntable' with existing institutions
ISIS is represented in the following institutions:
 - Salzburg Women's Council
 - ARGE Healthy Salzburg
 - Working Group for Older Women
 - Working Group for Girls
 - Network of Austrian Women's Health CentresISIS regularly organises round table discussions with experts on topics such as: "The State of Abortion in Salzburg", "Women and Psychotherapy", "Methods of Treating Eating Disorders in Salzburg"
4. Research on methods and contents of ISIS
In 1998, we took on the project management of drawing up the first Salzburg Women's Health Report and assisted in an academic report on the subject of "bulimia nervosa".

IV. Our Strengths

ISIS is a top-down project which, from the very beginning, did not require any justification. Various different interest groups and experts are represented on the advisory committee of the society, and are therefore involved in its running. This meant that there was a high level of trust in our activities from the very beginning.

During its first four years of existence, ISIS developed into a recognised specialist institution.

V. Our Weaknesses

Critical moments frequently fall by the wayside. The members of staff are somewhat limited in their freedom of action, as all decisions have to be made at the managing committee level in the end.

This strategy requires supplementary external criticism.

The following was not achieved:

The possibility of carrying out abortions at the Salzburg State Hospital

Female national health gynaecologists in the City of Salzburg

Secretarial position at the Women's Health Centre

VI. Supportive Groups

Health Department of the Land Salzburg

Women's Officer of the City and Land, Experts in the managing committee and as "free-lance staff"

Salzburg Regional Health Insurance Company Women's institutions in Salzburg

2.4 Kärnten Women's Health Centre Ingrid Waibel

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- V. Our Strengths**
- VI. Our Weaknesses**
- VII. Threats**
- VIII. Supportive Groups**

I. Initial Situation

Kärnten Women's Health Centre was opened in Villach on 11th March 1999 after an almost two-year planning period.

The centre was initiated by the former health representative of the Land Kärnten, i.e. from the top down. The plan of contents was worked out on behalf of the Land Kärnten by a body of experts, consisting of women from various different health or social care institutions.

II. Organisation

A team of three colleagues implemented the concept: a director, an event manager and a secretary. Furthermore, around 20 free-lance colleagues collaborate in the project.

The organisation is relatively new, and therefore needs time to develop. Its structures are given in the initial concept.

Project Sponsor:	Frauengesundheitszentrum Kärnten GmbH (Kärnten Women's Health Centre) Land Kärnten, Town of Villach
Overall Management: Management:	Kärnten Women's Health Centre Mag.a Regina Steinhauser

III. Objectives

The aim of the Women's Health Centre is to comprehensively promote the health of women and girls. According to a definition of the WHO, health promotion means "enabling people to have a greater say in the preservation and improvement of their health".

The starting point of the concept is an approach oriented towards different lifestyles and the different stages of women's lives. The state of mind of women represents the most important principle.

Due to the consideration of life-styles, the organisation of the Women's Health Centre was intended for the rural regions of Kärnten. This means that the premises in Villach are just the first step in the construction of five further branches in Kärnten. These regional branches are to be constructed within the next three years, depending on the financial situation. Not only the regional conditions, but also the regional requirements need to be taken into consideration.

The target groups are predominantly farmers, labourers, women employed in the tourist industry and women resident in rural areas.

At the same time, women at different stages of their lives are also viewed as target groups.

Prevention, information and empowerment are equally important aims in working with women.

Further objectives of the work of the Women's Health Centre are public relations, networking existing institutions and initiatives in the health sector, the promotion of basic conditions and policy change, i.e. structural work in collaboration with decision-makers in the health system and multipliers, as well as interested women from relevant institutions.

IV. Special Features

- Regional activities: Mothers in rural regions
- Qualitative study on breast cancer in Kärnten
- Further training for multipliers from the fields of health and women's issues
- Cooperation with school and extracurricular youth initiatives
- Establishment of subject-specific structural working groups
- Public relations
- Currently being planned: regional midwives

Specialist advice on the following subjects:

- Gynaecology
- Cancer check-up - post-cancer treatment
- Physiotherapeutic advice
- Advice on AIDS and Hepatitis
- Eating disorders: for sufferers and their families

V. Our Strengths

A very comprehensive concept.

The project was wanted "from above", i.e. we receive political support.

VI. Our Weaknesses

Does not have an autonomous status, which is why the project is very much exposed to political change.

VII. Threats

Interest groups feel threatened by the founding of the Women's Health Centre (doctors, existing organisations) and act contrary to our interests.
Some structures have yet to be clarified internally.

VIII. Supportive Groups

Interested women
Health parish Villach/Land

2.5 The f.a.m.: Frauen für andere Möglichkeiten (Women for Alternatives), Vorarlberg
Women's Health Centre
Jutta Platzgummer

<u>I.</u>	<u>Initial Situation</u>
<u>II.</u>	<u>Organisation</u>
<u>III.</u>	<u>Objectives</u>
<u>IV.</u>	<u>Special Features</u>
<u>V.</u>	<u>Our Strengths</u>
<u>VI.</u>	<u>Our Weaknesses</u>
<u>VII.</u>	<u>Supportive Groups</u>
<u>VIII.</u>	<u>Closure of the f.a.m.</u>

I. Initial Situation

The project was founded as a society in December 1996.
The project ended in December 2000.

The original idea for founding the project was prompted by the results of a Vorarlberg-based women's study, which was undertaken in 1993. This study revealed that the wish for a women's health centre had become their second-highest priority. Over 30 per cent of those women interviewed stated their request for a women's health centre.

Dedicated women experts worked out a concept, and subsequently founded an autonomous society.

The ensuing strategy was to initially establish a women's health centre, and then to carry out the search for funding. During its founding period, the f.a.m. was mainly supported by female politicians from the socialist camp.

Vorarlberg is a very conservative Land, in which domestic policy and feminist politics are closely linked to family politics. At the time, it was not at all clear whether the decision-makers even wanted an institution for women.

The above-described strategy was not completely fulfilled, since Dornbirn town council, for example, perceived that this method of procedure meant that their minds were being made up for them. We have still not managed to receive financial support from the council. However, our contacts to all political parties have proven to be of significant importance.

The founders of the f.a.m. believe that this result clearly demonstrates the demand for dealing with psychosocial problems from a gender-specific perspective. As a consequence, a working group came into being, and a concept was elaborated to establish a women's institution in the area of health promotion - the f.a.m.

II. Organisation

The f.a.m. was a charitable society, which had a committee and an advisory council. Its own resources originated from the organisation of events, and the collection of membership fees. The Land, the Federal Government, the social insurance scheme and various different foundations provided the basic funding. The f.a.m. was headed by a female club secretary (full-time). In addition, an administrative secretary was employed on a 50 per cent basis.

Project sponsor:	f.a.m.
Club Secretary:	Barbara Schröder-Offermanns

III. Objectives

The collaboration of various different professions under one roof aimed to promote women-related health provision, which takes female phases of life into consideration. The target group ranged from girls to mature and wise women.

The autonomy and self-determination of women were to be encouraged by supporting them and providing them with relevant information.

IV. Special Features

Giving Advice and Providing Information

- Gynaecological and general medical advice.(Questions related to gynaecological fields, often previous to or subsequent to gynaecological operations)
- Psychological advice, psychotherapeutic advice and treatment. Advice and support in stressful situations
- Advice for girls. Information and support with regard to all questions relating to womanhood: Menstruation, sexuality, contraception, etc.
- Advice on naturopathy. Female life cycles, femininity and natural cycles, transitional rituals. Herbal medicine, advice on blossom essence
- Eating disorders and healthy nutrition. Holistic advice and treatment
- Advice on midwives and midwifery. Advice and support in pregnancy, birth and the postnatal period
- Advice for families with infants and toddlers
- Family planning

Public Relations

The respective subjects were introduced in the media (print media, radio and television). Media work was aimed at sex education and building up self-confidence. A calendar of events was published twice a year.

Networking

In order to gain effective information and to be able to recommend its clients to other institutions, the f.a.m. was in contact with the region's existing psychosocial and medical institutions, and was a member of various different working groups and forums.

E.g. working group on feminist work with girls, Vorarlberg working group on women's projects, Vorarlberg Women's Council, family working group, anti-violence interest group, health working group, Network of Austrian Women's Health Centres, EWHNET.

The principle of the society was to assist in self-help. Informed women are in a better position to decide what is good for them.

V. Our Strengths

- Greater freedom to act, due to our autonomy
- Immediate commencement with the advice service and the organisation of events
- A multiprofessional team
- The critical voice of the f.a.m. was required on specific feminist issues (abortion, Mifegyne, etc.)
- Cooperation with various different sponsors, which built up mutual trust
- Presence throughout the Land was guaranteed
- Talks, workshops and courses were organised in the entire Land
- We aimed at co-operating with other institutions:
- we are currently making a Land -wide plan for combating eating disorders with the aid of institutions and specialists
- Targeted collaboration
- The three major women's projects in Vorarlberg decided to divide the tasks among themselves,
- both with regard to contents and on a regional basis:
- Education is carried out by Frauen getriebe in Bregenz,
- Provision of information is the task of femail in Feldkirch,
- The issue of health is dealt with by the f.a.m. in Dornbirn,
- The girls' refuge centre is organised by AMAzone in Bregenz.

VI. Our Weaknesses

- The women founders of the society were at the same time planners, committee members and advisors, which led to major role conflicts.
- Management, telephoning, public relations, project work, etc., carried out by just one person, led to excessive pressure on that person.
-
- The initial low-cost solution threatened to make voluntary activity a matter of course, and represented a hurdle when restructuring led to the introduction of paid work.
- Danger of becoming assigned to one political group
- The project's modest start (with regard to working conditions and its financial state) hampered its chances of expansion.

VII. Supportive Groups

The society was supported by networks covering a wide range of subjects, on a regional, national and international basis.

VIII. Closure of the f.a.m.

Excerpt from a letter on the closure of the f.a.m. by Barbara Schröder-Offermanns, from December 2000

Dornbirn Women's Health Centre was forced to close.

In our function as committee members, club secretaries and colleagues, we have come a long way in completing what we set out to achieve.

However, a definite change of values has emerged since the October 1999 elections and, in particular, following the formation of government in February 2000. Restrictive measures, dramatic budget shifts, and the dissolving, amalgamation and renaming of departments were the result of wrong decisions, and their incipient consequences.

The establishment of our society, and the tasks we set out to fulfil in the area of health care and health promotion for girls and women, were supported and carried out by a self-confident initiative, for which extremely large energy reserves were utilised.

The information and advice we offered were intended to create a consciousness for a holistic approach to health. However, the societal and political system was not willing to create a real basis for the project's extension beyond succinct lip service.

Our negotiations to acquire subsidies on a secure, long-term financial basis, failed. Neither the Federal Government nor the Land showed real interest in its development and promotion; a nonsense was made of the much proclaimed subsidiarity principle.

Numerous meetings with women in all kinds of situations have demonstrated to us that we are needed, and that our work is acknowledged. We were able to lay the tracks towards increased understanding for the special status of women. However, visions for a future culture could not be thought through, due to the lack of funding.

The closure of the f.a.m. has meant that an important pillar of feminist self-organisation in Vorarlberg has disappeared from the surface:

We continue to hope that many women will implement their flexibility in the emancipated building of self-confidence and self-organisation, rather than in conformity.

After the closure of the f.a.m. women's health centre, we will not give up our skills and ideas, and will continue to be actively involved in the issue.

The midwives, who carry out the indispensable task of offering alternative forms of assistance at birth, now have new premises, and will continue their work.

2.6 The Pilot Project "The Spider and the Web" - Leibnitz Women's Health Centre Eva Janes

- I. Initial Situation**
- II. Organisation**
- III. Objectives and Special Features**
- IV. Our Strengths and Weaknesses**
- V. Concluding Remark**

The region of Leibnitz, located in South Styria on the border to Slovenia, contains 48 municipalities, and has a population of around 72,000 inhabitants.

I. Initial Situation

Social Changes

The number of potential non-professional carers will fall in the future because of changing demographics, which demonstrates an increasing percentage of elderly and very old people, a reduction in the size of households, an increase in gainful employment among women and migration from the land. More professionalism in the caring system may also lead to better care by experts. The range of illnesses suffered has changed, resulting in the predominance of chronic illnesses; technological progress in medicine and, as a consequence, the increased utilisation of rehabilitation, lead to greater demands being made on the level of care practised by both non-professionals and professionals. Further causes of the future reduction in the number of non-professional carers are due to the current reorientation and reorganisation in the health system, leading to the use of holistic structures, preventive measures and rehabilitation. This reorganisation could meet the rapidly growing and changing demands more effectively.

The "Sandwich Generation"

Not only do women in the 40 to 65-year-old age category have to look after and care for their own children, they are usually also responsible for the older generation: their parents, parents-in-law or close relatives.

In over 80 per cent of cases, "care within the family" is carried out by the wife, daughter, granddaughter or daughter-in-law. These carers, however, are frequently already in need of care themselves. Studies reveal that carers suffer from a lack of contacts, not only to other non-professional carers, but also to other people in general. Their ability to participate in "normal" life is severely restricted. This is due not only to their time-consuming task, but also to stigmatisation and the fact that coping with illness is a taboo subject. Moreover, carers suffer from the conditions under which their task is carried out: in private, away from the public eye. Also, it is predominantly performed by just one person, i.e. a woman. Last but not least, the fact that caring is undertaken without payment and usually without social security insurance also plays an important role.

Most women carrying out this care are not very well educated, nor have they had much vocational training, which further reduces their chances of finding gainful employment.

As academic studies show, less educated women tend to use a strategy of coping that involves "enduring" the situation. The consequence of this could be that women suffer more from chronic complaints and illnesses than men; because at some time or other, even the greatest reserves of strength are worn out or exhausted. This usually applies to women between the ages of 40 and 65 years. The inexorable exhaustion of available reserves of strength, and the

frequently ensuing helplessness, need to be counteracted. Women who have the chance to meet other non-professional carers can learn to employ their resources more efficiently, i.e. to better utilise their potential, and also to learn to delegate tasks and co-operate with professionals.

State of the Rural Population

The poor and often nonexistent infrastructure in rural regions makes the lives of women even more difficult. There are not enough nurseries, day centres or rehabilitation centres available to take at least some of the weight off the women's shoulders. Most husbands cannot find work nearby, which is why they often commute, or are part-time farmers, usually leaving the women to cope with everyday problems on their own. Moreover, the women remain less likely to seek advice from advice centres, for example, if they actually exist. At the same time, conventional social networks are being destroyed by structural changes in agriculture and tourism, leading to a deterioration in support available for women.

Although the system of values and norms is changing, the acceptance of working women in rural areas is low. Moreover, decisions not to care for a member of the family, or to put a disabled child in a day centre, are met with disapproval.

The transport network in rural areas is usually scant. This means that caring women, who may not necessarily have use of the family car, need to make long journeys to specialist care facilities. Local stress-reducing psychosocial facilities are usually inadequate.

Such families are often financially insecure, since the husband is often unemployed. Furthermore, their domestic conditions, e.g. sanitary facilities, are not particularly suitable to care for people at home. In Austria, approximately 12,000 people are cared for in homes that do not have sanitary facilities.

Women carers in urban regions are finding it increasingly difficult to get to shops, doctors, chemists or other places, such as pubs and cafés. This state of affairs is tantamount to limiting the independence of both the carer and the person being cared for.

II. Organisation

"The Spider and the Web", which was a project run by Graz Women's Health Centre, was in existence up until the end of 2000. It operates politically for women.

Due to its affiliation to Graz Women's Health Centre and its link to the Institute for Social Medicine, the project received experienced assistance, even in the planning phase, which in turn promoted the academic accompaniment of the project.

The Women's Health Centre's Role as a Coordination Office for Care and Self-Help Assistance

As a subliminal meeting point for women with questions regarding care, the Women's Health Centre committed itself to strengthening and supporting people who care for family members in their own homes. The women were given the opportunity to have face-to-face conversations, and they received recognition and support. This is because the "Spider and the Web" operates according to the resources approach. Affected women had the opportunity to encourage one another in self-help groups. But the centre also acted as a place of contact for individual women who wanted to establish self-help groups in the field of caring. This resulted in the establishment of a system of exchange, in which services and goods were exchanged cash-free among women in the community. The advantage of the exchange system was that meetings

and relationships were promoted, and the women were able to "afford something" without actually having to pay for it.

Furthermore, the women had the chance to acquire knowledge and skills in courses, seminars and lectures, which the centre regularly organised on specific subjects, many of which were put forward by the women themselves. At the same time, informative events, seminars and courses were offered, following co-operation with priests, adult education organisations and women's officers in the municipalities of the district.

III. Objectives and Special Features

The main objective of Leibnitz Women's Health Centre was to strengthen and support women who care for members of the family at home. Caring, which until now has remained unacknowledged by the public, should be made visible for those affected, professionals and the general public.

Sustainable Structural Change

The approach of health promotion does not only stipulate the strengthening and support of individuals and their community activities, but also sets out structural measures to improve health. The Women's Health Centre achieved this in several different ways, making it a catalyst in this rural region of Styria. Contacts were made to priests, individual institutions and organisations active in the region, political decision-makers, as well as experts. The Women's Health Centre took on the role of "The Spider and the Web's" mouthpiece, undertaking the collection of facts and an analysis of the situation, in order to initiate its implementation with all the participants.

Sustainable structural changes were achieved by attempting to institutionalise the subject-related working groups, in which all affected organisations were involved, in order to work out a joint long-term feasible solution to the problem.

Quality and Interfacial Management

Several working groups were established, e.g. on the subjects of "discharge from hospital" and "care allowance". In Austria, there has not yet been much co-operation between inpatient and outpatient areas. For this reason, we initiated a working group on discharge from hospital and outpatient care, which elaborated discharge routines. Those involved in the project include nurses and doctors from Wagna Hospital, the Land parliament, directors of nursing homes and the Social Welfare Association, as well as all organisations active in outpatient care in the district.

Networking professionals in the field stemmed the process of isolation. The interests of organisations could also be constructively integrated, due to them working jointly on agreed objectives. The problems were solved jointly by the organisation by exchanging experience in the working groups. The supply of aid in the district was improved due to this networking and co-operation. The fact that a contact person was available at Leibnitz Women's Health Centre, specifically for networking and co-ordination, facilitated collaboration.

IV. Our Strengths and Weaknesses

The "Spider and the Web's" link to Graz Women's Health Centre meant that the project received support from an experienced team. The project was also supported academically by the Institute for Social Medicine. International networking facilitated an innovative working

approach and an innovative methodology. In particular, the "bottom up" approach offered many different forms of development to encourage reorientation in the hierarchy of power.

V. Concluding Remark

The project finished on 30 November 2000.

The continued existence of the various activities in the region was secured by other sponsors. Carers therefore still have the ability to make use of the support on offer. The sustainability of the project is therefore guaranteed.

3. Strategies and Challenges for Women's Health Centres in Austria

Sylvia Groth, centre for women's health, Graz

I. Introduction

II. Future tasks

III. Literature

I. Introduction

The Austrian women's health centres had a late start compared to their sister centres in other countries of Europe and the United States. FEM Vienna started out in 1993, closely followed by the Women's Health Centre Graz in the same year. ISIS Salzburg was founded in 1994, the Women's Health Centre Linz in 1995 and f.a.m Dornbirn, Vorarlberg in 1997. Graz opened its rural Women's Health Centre Leibnitz in 1998. This trend continues in 1999: the Women's Health Centre Carinthia was founded in March, FEM South Vienna in May, and the Women's Health Centre Tirol will open in May/June 1999. There is no women's health centre as yet in the Burgenland. These centres share common principles: They all advocate informing women about their choices, and seek to provide women-oriented services by improving the overall quality of women-specific health care. Central to their shared philosophy is the concept of women's health promotion based on empowerment and the consideration of the life context of woman both individually and as a whole. All work in the centres is performed in multi-professional teams. The centres remain connected through the Network of Austrian Women's Health Centres which was founded on March 20, 1996.

Nevertheless, the centres differ in their approaches, ranging from a general cooperation with medical services at hospitals to a resolute critique of medical practices and the overall medicalization of women, from an organizational focus more on the individual woman to an emphasis on the relevance of initiating structural policy changes. The centres show various degrees of autonomy, depending on the party affiliation and professional interests of their board of directors. Public funding and staff resources differ in every federal district in Austria, contingent on local and regional structural and political circumstances. The centres share common characteristics while maintaining significant differences in their conceptual outlook and service provision.

Women's health centres face a specific situation concerning women's health policies in Austria. Traditionally, social problems have been tackled from the "top down" and not "bottom up". This approach could be observed with the legalization of abortion in 1974, when women within the Social Democratic Party opposed the nation's existing law and forced their party to change it. This same "top down" approach also occurred during the general changes in obstetrics, initiated by physicians rather than by dissatisfied health care consumers. And a similar tendency was seen when the women's health centres were founded. Although there was an active movement for choice in the 1970s and women's self help groups were founded in several cities, neither the movement for choice nor the self-help groups demanded or initiated women's health centres, as they did in other countries. The battered women's shelters and subsequent women's counselling centres that evolved from the feminist movement of the seventies did not embrace, explicitly or implicitly, a stand on women's health. The health consequences of violence aimed specifically against women only reached public awareness in the 1990s. In the nineties, the counselling centres did change to provide services for unemployed women or women re-entering the workforce. Women working in these centres, however, did not see this intersectoral approach as women's health promotion.

In Austria, the practice of medicine has encountered little systematic critique. There has not been an organized women's health movement. Health care consumer organizations are established only within political parties. Health care advocacy is little developed. Only midwives and nurses are organized; women physicians have not united to further their professional interests. Women's health centres thus play a new and central role with their promotion and publicizing of women-oriented approaches and women specific services.

Because of the diversity and the different social and political circumstances of each centre, I will now concentrate on the challenges that I foresee for the Women's Health Centre in Graz.

As the medical profession strives to expand its general arena of responsibility, our foremost task, as I see it, is to counter this process of medicalization. Normal life phases of women, such as pregnancy, birth and menopause, have been pathologized and have become prime targets for medical and pharmaceutical intervention. New marketing tools of the pharmaceutical companies (such as Novartis' public relations profile as a "health consultant") make it increasingly difficult for health consumers to distinguish their actual needs from market promises. Providing women with information, support and a sense of orientation fosters empowerment and presents options for participation. In my opinion, women's health centres only justify their public funding and fulfil a social need when they have a critical approach, pointing out social injustice and discrimination as health risks and utilizing a social model of health when aiming at change. The challenge is to stay innovative and maintain a critical potential while cooperating with others towards the overall goal of improving the quality of life and health services. Organizational co-optation is a real risk here. Such modes of working put high demands on the competence and flexibility of the health centre's staff.

Women's health centres contribute towards the health of women who are not clients by serving as a model, innovating and collaborating with mainstream agencies. They train service providers, sponsor projects and develop widely used information and educational resources. The twin aims of supplying gender specific services and enriching the mainstream have guided women's services for many years (Broom 1998).

II. Future tasks

- to publicize a gender-specific approach, to encourage a demand for and promote a general awareness of programs for women-friendly services;
- to provide orientation for and support the credibility of women;
- advocacy;
- to change from an emphasis on counselling and direct services to structural changes: to promote a cooperative approach towards change;
- to reach out to disadvantaged target groups through specific approach strategies;
- to develop and implement a local and regional women's health agenda;
- to combine women's health promotion with Agenda 21.

Since social organizations in Austria will inevitably encounter cuts in public expenditure, I consider it all the more important to develop a clear public profile -of the women's health centres as fulfilling a necessary social need. Such a profile will allow us to be distinguishable as advocates for women's health.

Because the potential scope of tasks is very broad while funding and staff resources are very limited, our activities must be prioritised, depending on the social and political circumstances, local health care, and cooperation structures.

The core strategy is one of empowerment. In the process of networking, collaborative competence is of central importance; in public relations and in lobbying for structural policy changes we need to take a clear stance for the interests of women. Defining deficits, goals and outlining standards for care can be one central local strategy for women's health centres.

In the long run, the late start of the Austrian women's health centres as "top down" organizations conceived in close cooperation with party interests may actually prove to be an advantage. In contrast to the women's health centres in other countries, cooperation with established organizations and political parties has been central to Austrian women's health centres from the very beginning. This characteristic may prove to be the focal point for survival in times of diminishing resources. If we decide to remain defined as educational organizations, our closeness to party interests may allow for future financial support while our closeness to women's needs and interests will provide our future justification.

III. Literature

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4. Learning from Europe - How can we use the knowledge and experiences of other countries?

Vera Lasch, Institute Women and Society

- I. The political discussion in the field of "women's health" as an opportunity for a redefinition**
- II. Models of good practice - possibilities and potentials for exchange**
- III. Transnational exchange in the field of women's health - objectives**
- IV. Women's health at the municipal level. The workshop's objectives and the main features of co-operation**

- I. The political discussion in the field of "women's health" as an opportunity for a redefinition

Since the post-war period there has been an international discussion with the goal of developing a positive definition of health, as well as making women's health issues a focus of attention (as for example in the WHO's definition of health: 1988 emphasis of the field of action "health", 1992 Necessity, 1994 Women's Health Counts with an emphasis on the social context of women's health). At the same time, groups and projects within the women's health movement were established and consolidated. They not only criticized the public health system (e.g. the medicalization of women) or social conditions (violence against women and its impact on health), but also developed and implemented new ways of treatment, counselling and self-help. The movement also initiated the founding of interest groups representing women's health issues in public. I will not discuss the achievements and successes of these organizations and projects, but rather their current difficulties. A study at the Ludwig Boltzmann Institute in Vienna (1995) showed that within Europe, only one third of such organizations or institutions was protected financially.

The experience with our network leads me to suppose that the situation has not changed; on the contrary, it seems to get even worse. The financial support and the working ability of organizations and projects are and will be problematical. That is why, in my view, women's health is an area where political actions are called for and where it is necessary to develop and strengthen transnational co-operation.

- II. Models of good practice - possibilities and potentials for exchange

Of course I do not only regard transnational co-operation as a question of improved political support or political ability of assertion. The EWHNET's experiences especially have shown the importance of mutual understanding and the necessity of communication as a basis for exchange. Learning from each other, the opportunity to profit from the knowledge gathered by the others, requires a foundation. This foundation includes the knowledge about projects and working methods as well as the potentials of individual organizations and the knowledge of the state of discussion in individual countries. At the same time, one should know the learning field and the experts working within these fields.

In addition, the process of communication is an important milestone that should not be underestimated. The individual European countries have various health service systems with different structures, modes of functioning and financial procedures. Health support does not have the same status everywhere; women's health, as a political mandate, is anchored differently. The projects aimed at improving women's health are perceived to have varying political relevance and the local activities for an improved women's health exist within

country-specific conditions. In order to decide what is good practice and which lessons are interesting, it is necessary to know the qualities and successes within the framework of these national conditions.

From the experiences in the EWHNET, one can describe various levels of mutual learning:

- The description of organizations and their activities and approaches can stimulate one to contemplate one's own objectives, and possibly to re-structure them or to start co-operations.
- A comparison of strategies of public relations work and of political activities within different countries can result in an improvement or clarification of one's own strategies.
- A transnational exchange on strategies and working methods among projects which work on the same topics (e.g. bulimia, women and aids) can be very stimulating and productive.
- Apart from discussions on the structures of the organization, working methods or political strategies, there is the possibility to develop joint (international) projects, such as counselling booklets on certain topics or the joint planning of further training and education (foremost among similar projects which offer women-friendly treatment or counselling, as for example among women's centres).
- A debate on the evaluation of various developments, a discussion on the political and societal anchoring of approaches, and an assessment of success or failure are of great importance as well.

During our last transnational meeting in Graz we worked out structures that should make the experiences of individual projects more accessible to a joint discussion (the list was sent with the last minutes). Approaches of projects in the area of public relations work, implementation of projects, further education within projects, strategies of communication and models of good practice should be analysed according to the following points:

- starting points
- strengths
- weaknesses
- opportunities
- threats
- stake holders

Brigitte Stumm and myself have tried to consolidate the German experiences with municipal strategies for a better understanding of local strategies within the field of women's health. The topic "Basics of understanding" should be developed further. Some of the questions are: How can our experiences and knowledge be processed in order to make them understandable in a transnational discussion? How can quality and good practice be defined concisely?

III. Transnational exchange in the field of women's health - objectives

In my opinion, the most important levels for a transnational exchange are:

1. Registering and exposing the potentials and qualities within the field of women's health (this includes the knowledge about experts, possibilities of exchange, materials, and work and publication strategies).
2. This also includes the agreement on
 - transnational, national and regional political strategies,
 - determining the quality standards of work, goals or results of chosen projects and organizations,

- the identification of important topics and the possibility for further development.
3. The initiation of joint projects which would approach problematic areas internationally.
 4. Working out common standards and demands.
 5. The planning of a joint lobby and the agreement on possible methods of mutual support.
- IV. Women's health at the municipal level. The workshop's objectives and the main features of co-operation

During this workshop we have the possibility to work at various levels. In general, we will be concerned with local approaches to improve women's health within individual countries. This workshop can be a first step towards discussing possibilities of transnational co-operation. The results of this workshop will be summarized in a booklet that will present the main materials and discussions. After the meeting, some of us will reflect on how to formulate standards for work within the field of women's health at the local level.

I have gathered some questions and points to stimulate our discussion:

- How can we create a positive atmosphere for the work on municipal women's health issues? Is it possible to work transnationally in this area?
- We can attract attention by publishing the results of this workshop - how can this attention be used?
- I believe that the visibility of strategies, projects and achievements is of great importance. How do we achieve a proper visibility? This includes the characterization of models of good practice in order to indicate a direction of development.
- Are there possibilities to work out a "positive list" of local women's health projects that could be used both nationally and internationally?
- What possibilities of co-operation are there for local approaches within the field of women's health? Which projects, regions or problems can be identified?
- Which forms of co-operation are there? Maybe these suggest topics for further workshops or meetings. Which forms of international exchange of experiences are possible? Which forms can be organized?

We do not have to answer all these questions. But we have here today experts from various fields of work. Their experiences might allow us to find some solutions, to clarify some problems and to work out new approaches.

5. Mainstreaming - strategies in the context of women's health

Sabine Overkämping, European Commission, Brussels

- I. Introduction
- II. Mainstreaming
- III. Mainstreaming in health policy
- IV. Conclusions

I. Introduction

First of all, I would like to thank you most sincerely for your invitation to the workshop on "Municipal strategies for women's health - women's health in municipalities" here in Bregenz. The project which is responsible for organising this workshop is being funded under the Medium-term Community action Programme on equal opportunities for women and men. As you know, Commission officials are more actively engaged in project support than before, because the contract with ANIMA, the technical office, has not been extended. Although I am not the person responsible in the "Equal opportunities for women and matters regarding families and children" unit, which manages the fourth action programme in DG V (employment, industrial relations and social affairs), I have discussed the project in depth with my colleague Gisela Lange, the official responsible, and am both very keen to hear about what you are doing and very happy to be here.

First of all, I will describe mainstreaming at the European level in general and then I will explain how this approach is implemented in European health policy. Before going any further, I would like to point out that women and health was recently a key issue at a United Nations meeting in New York on the implementation of the Beijing Action Platform.

II. Mainstreaming

The resolutions of the fourth Women's World Conference made a contribution not only to the "Women and Health" issue but also to consolidating mainstreaming at all levels.

What is happening at the European level?

The German speakers amongst you will not be keen on the Anglicism "gender mainstreaming" which is used in this context. And you are right to point out that an across-the-board approach to women's policy covers this area quite satisfactorily. But as so often happens, the European dimension has developed its own momentum and ultimately can be of benefit even to the most expert in this field.

When I come back to mainstreaming later, we should not forget that specific measures for women, e.g. "positive action", are of course still necessary, at least until women and men really do have equal opportunities, and not only at the European level. In Europe we say that a twin strategy is necessary, combining mainstreaming with special measures for women. This is not a cause for concern; nothing is going to be replaced. On the contrary, specific women's measures which have been introduced so far have proven to be inadequate, which means that new strategies have to be developed to complement existing ones. And since the mainstreaming strategy is new, we naturally tend to talk about it more. However, we still need specific measures for women, in health policy as well.

The mainstreaming strategy is one of the newest equal opportunities issues at European level. The Commission has committed itself to this approach and has enshrined it as a key principle of the Medium-term Community action Programme on equal opportunities for women and men (1996 to 2000), both as a political objective and also as a strategy to bring about change in all the other areas of policy concerned.

I have now used the term mainstreaming so often that it is high time I define it. What do we mean when talk about mainstreaming at the European level?

What is behind it?

It is a key element in the Commission's equal opportunities policy.

The aim of mainstreaming is to get away from the traditional way of seeing equal opportunities issues as being separate from general policy issues, be they science, transport, finance or others. Effective gender mainstreaming leads to a commitment to examine every area of policy for its impact on women and to see equal opportunities as an integral part of every policy area. In other words, the equal opportunities implications of any policy are included, assessed and properly taken into consideration during planning, decision-making and implementation.

What is the Commission doing at European level to ensure that mainstreaming works in practice?

One of the key factors here is policy. A commitment at the highest level is needed to ensure that mainstreaming is put into practice. In February 1996, the European Commission adopted a Communication¹ on "Integrating equal opportunities into all Community policies and activities" which was the result of concerted action by various Commission departments, initiated by the Group of Commissioners on Equal Opportunities chaired by Mr Santer. In March 1998, the Commission adopted a follow-up report² describing progress on mainstreaming in the Commission. A further report is now being prepared.

In organizational terms, mainstreaming has now been firmly established by the appointment of officials in 29 Commission departments who are responsible for developing mainstreaming in their units. The individual directorates-general are responsible for incorporating equal opportunities into their policy areas and are supported by an inter-service group of officials. This new structure is intended to integrate equal opportunities systematically into all Community policy plans and activities.

Considerable political progress has been made, especially in the fields of employment policy and the Structural Funds, development cooperation and external relations, information and personal policy and general and vocational training and youth policy. The reform of the Structural Fund Regulations, for example, strongly reflects the mainstreaming approach. In research policy, too, considerable progress has been made in increasing input from women.

At the same time, however, the 1998 progress report also identifies policy areas where a greater effort needs to be made to integrate a gendered approach. These include the single currency, the accession of other countries and the information society. General problems which still persist are also identified: a lack of awareness of gender issues at decision-making level and of specialized knowledge on issues relevant to the sexes. The objective for the coming months and years is to overcome these problems and, in particular, to establish a procedure to

¹ COM (1996) 67 final of 21.02.1996

² COM (1998) 122 final of 04.03.1998

assess the gender impact of policies. Once a formal procedure has been established, the departments which are responsible for policy-making will have no alternative but to take up the challenge of equal opportunities.

The Medium-term Community action Programme on equal opportunities for women and men mentioned earlier will be useful. The Commission's mainstreaming strategy will be developed in the second half of this programme by a training and awareness-raising programme. In compliance with the new Article 3 of the Amsterdam Treaty, the Commission's procedures and regulations will be looked at carefully in order to improve the ratio between women and men in all its decision-making and advisory bodies and to ensure that all the Commission's proposals for legislation or other measures fulfil the obligation established by the Treaty to promote equal opportunities for women and men.

The Amsterdam Treaty is a key factor here, as it offers a guarantee that the objectives described will be met, and stresses in no uncertain terms the Community's obligation to implement a policy of equality. Articles 2 and 3 identify equality for men and women as a Community priority in all its activities, and the fact that these principles have been incorporated in the Treaty reflects both the effectiveness of mainstreaming and the obligation upon everyone in positions of political and social responsibility to put equal opportunities into practice. The Treaty's explicit pledge to promote equal opportunities in all Community policies forms a solid basis for actions to integrate equal opportunities at the European level.

III. Mainstreaming in health policy

What is the status as regards health policy?

First of all, we should point out that European institutions are actually entitled to take action in this field. Article 152 of the EU Treaty governs health-related activities at the European level. In its communication on the framework for action in the field of public health, the Commission proposed that it present a report on the health situation in the EU at regular intervals.³ In 1994 the first report⁴ was presented, giving an overview of the health situation. The second health report in 1997 concentrated on "Women and Health"⁵.

I would like to take a look at this latter report.

It gives an overview of the health of women in the European Community and highlights differences and similarities in and between the Member States. Morbidity is a case in point, as are individual and social factors which are intrinsic elements in demographic and social developments and affect women's health. The report identifies health problems mainly affecting women, such as eating disorders, breast cancer, osteoporosis, sexual abuse and the results of domestic violence. It also, of course, deals with problems which only women suffer from, such as those associated with reproductive behaviour, cervical and ovarian cancer and menopause. The comments on diseases such as cardiovascular disease and HIV/Aids, which produce different symptoms in women than in men, are of particular interest.

The report covers the 191 million women (51.2% of the population) living in the EU and draws its information from the WHO "Health for All" database, various Eurostat reports and data sets and a EU-wide Eurobarometer survey which was carried out at the beginning of 1996 with the support of DG V. The information available was not exhaustive, which restricted the topics

³ COM (1993) 559 final of 24.11.1993

⁴ COM (1995) 357 final

⁵ COM (1997) 224 final of 22.05.1997

selected and the age groups covered, but it did present an initial synopsis of the various facets of women's health.

Although nobody will be surprised to hear that women do enjoy good health, as reflected by their life expectancy (currently standing at 80), the report does reveal some problem areas. Almost one in four women in the EU suffers from functional disorders caused by chronic illness. The report highlights the unhealthy lifestyle of women who smoke, drink, take little exercise and do not have a healthy diet. Women clearly misjudge the risk of heart disease and do not appreciate the key risk factors. Inadequate medical care is also a matter of concern, for example when overweight women over 40, who run a higher risk of contracting Type-II diabetes, are not examined properly for this disease.

I have deliberately presented the women's health report in general terms and have not picked out individual conclusions underpinned by the data, as you probably know more about them than I do or have already analysed them.

As far as my presentation is concerned, it is the application of the mainstreaming approach to health policy which is relevant. The fact that there is a women's health report at all is because this approach is being implemented. It offers a separate assessment of the living conditions of women, which differ from those of men.

Responsibility for this at European level lies in the hands of Directorate General V, to which the "Equal opportunities for women and men and matters regarding families and children" unit belongs. The Directorate in question, just as the Commission as a whole, is committed to the mainstreaming approach, and equal opportunities have a real part to play here.

Together with the mainstreaming strategy, the gender dimension is an integral part of all activities, such as the planning of programmes, and all reports, such as the report on health.

The idea of applying the mainstreaming approach to health policy is not to give women's health priority over men's but, and this is the essential point, to recognize that women's health problems are different from men's for biological, social and other reasons.

What happens as a result of these findings?

The realization that women have specific health problems is the first step towards improving their situation. The women's health report clearly sets out approaches to improving health policy - a policy which must be designed differently for women than for men so that specific measures for women can take effect.

For example, the report presents the increasing incidence of osteoporosis as one of the greatest problems of elderly women, which is partly because they do not know what preventive measures and treatment are available. This problem has been looked at in more detail at the European level and the Commission is, for example, preparing a Council Recommendation on osteoporosis for mid-1999.

The findings of the women's health report are also taken up by existing programmes, although there are no plans for dedicated Community action programmes for women and health. The Community's action programme on AIDS (1996-2000) is a good example of this. Women are known to be more prone to HIV and AIDS, although they still account for a minority of AIDS sufferers. The women's health report emphasises that efforts to prevent this disease should also focus on women. The Community action programme on AIDS, under which a prevention

network for women from the Mediterranean states was initiated in 1998, responds to this problem.

Finally, I would like to mention a study financed under the Medium-term Community action Programme on equal opportunities for women and men. This study, which is entitled "Gender, power and changes in health institutions of the European Union", focuses on the participation of women and men in decision-making processes in health. The information it supplies is valuable but is not sufficient to enable useful comparisons to be made between the Member States. However, some general conclusions can be drawn. For example, it is interesting that at the government level there are far more women ministers responsible for health than for justice or finance. There are also more women in Member State parliamentary health committees than in other parliamentary committees. At the same time, the proportion of women in administrative positions of responsibility is lower than in the corresponding political bodies.

Although the results of the study are not entirely conclusive, I would like to present its main findings:

- Despite the fact that there is a high proportion of women in all medical occupations, the study emphasizes that there is a long way to go before there is equal access to decision-making positions in most European countries. Top jobs in hospitals, health insurance organisations, planning and advisory bodies, medical associations and trade unions are dominated by men. There is also a difference between the Northern and Southern countries within the Union.
- The representative survey on which the study was based and the interviews show clearly that there are far more male than female doctors. Conversely, the overwhelming majority of nurses and midwives are women who, although they are in much more direct contact with medical reality, have no decision-making powers.
- A particularly noteworthy finding of the study was that, in addition to the innovative working methods and management styles, women set different priorities on the health policy agenda than men. Preventive medicine, health promotion and care for the elderly, for example, are high on their list of priorities. Interviews also showed that women are clearly more interested in maternity and infant care problems. Men are more inclined to prescribe medication, whereas women appear to take a more long-term view and also consider low-prestige areas to be important.
- The innovative contributions by women to working methods, management styles and health policy decision-making mentioned above have led to changes in men's behaviour. This is emphasized in particular by the Swedish interviewees.
- Overall, the study concludes that gender-specific surveys and fair participation by women in the decision-making process in health are crucial factors.

We hope that the efforts made at the European level to promote a balanced participation of women and men in the decision-making process and the further pursuit of the mainstream approach in health policy will soon produce results.

IV. Conclusions

We cannot conclude the topic of this day - (gender) mainstreaming - without mentioning the United Nations' activities, which have paved the way for an increase in activity at the European level in this area, especially relating to women and health. The Beijing Action Platform in 1995 examined the issue of women's health comprehensively and, in compliance with the resolutions of the Fourth World Women's Conference, the March session of the United Nations Committee on the situation of women took a very close look at the issue of "women and

health", discussing the progress made and further action to be taken in this area. This in turn provides the impetus for further activities at the European levels as well.

Looking at the situation as a whole, the European Commission has developed a considerable array of institutional mechanisms to implement the Action Platform of the Fourth World Women's Conference in order to promote equality for women and men. The mainstreaming strategy of making equal opportunities for women and men an integral part of all Community policy and activities has been adopted throughout the Commission. Specific measures for women have been consolidated, either by making structural adjustments or by means of cooperation. The importance of a gender-specific approach has been recognized and is taken into account in an increasingly large number of Community policies, including health policy.

I am looking forward to the papers and discussions. I know how difficult it is to combine action at the European level with the municipal level, and I hope that we can join forces in a manner that will be mutually beneficial. Projects which are funded under the Medium-term Community action Programme for women and men must have a "European added value", and I am therefore confident that this joining of forces will prove successful.

6. What can we learn from Aletta⁶?

Lea den Broeder; Netherlands School of Public Health, Utrecht

I. Introduction

II. The Development of Aletta

III. Which factors can be identified that accounted for Aletta's success?

IV. Problems

V. Result

I. Introduction

The central theme of this workshop is communal strategies for women's health. As an example for possible strategies I will describe the founding, development and the closing down of Aletta, the Netherlands Centre for Women's Health Care.

Aletta was very successful in its 20 years of existence.

What was the reason for this success? How is it possible that despite such success, Aletta was liquidated? And how could other women's health organizations benefit from Aletta's example?

II. The Development of Aletta

I would like to take you back in time. We are writing the year 1980. A group of women in the municipality of Utrecht, Netherlands, are setting up a women's health group. They do so because they feel that regular health care does not meet women's needs and wishes. The group criticises the authoritarian way women are treated by doctors and other professionals, the medicalisation of women's lives, and the fact that women's experiences are not taken seriously by health professionals.

Two aims are central to the 'young Aletta':

- Implementing a women's health service that meets women's needs for empowerment, knowledge, and sharing of experiences.
- Developing a critical view of health care in general with a feminist perspective

In these early days the self-help approach was very important. Women's groups were practising self-examination of breasts and the vagina, and thus gained knowledge, as well as self-confidence and the capability to speak up for themselves. Thus Aletta was a grassroots organization, run completely by volunteers.

Aletta's initiative grew fast. More groups were set up, and health information for women was provided on a larger scale. The centre carried out group counselling and individual counselling. At this stage it became apparent that criticising the medical establishment was not sufficient. The 'good practices' developed by Aletta became more sophisticated, criteria for woman friendly health care were formulated and were communicated to the medical field.

⁶ The women's health centre was named after Aletta Jacobs (1854 - 1929) who was the first woman in the Netherlands to be a medical doctor. In 1880 she opened her practice in down-town Amsterdam. She treated mainly women and children. She spoke out in favour of contraception and was actively engaged in the women's suffrage movement.

In 1984 Aletta set up her own general medical practice. This required courage, for in the Netherlands it is uncommon that general medical practices are founded without the consent of surrounding practices. Still, the indignation of the other Utrecht general practices was short-lived, and Aletta's practice was well integrated into the municipality, taking part in all activities and in night and weekend calls.

Perhaps these first initiatives of Aletta were not community based in the strict sense of the word. But although the local community as a whole was not involved in the founding and development of Aletta, it was certainly a grassroots organization. The questions, problems and needs of women were starting points for the services provided.

At the same time, the experiences with women who came to Aletta were transferred to another level: the policy level.

Aletta's structure can be made clear by looking at its house:

On the ground floor was the grassroots level: A general practice and group and individual information and counselling services. Here one also found the library, the basis of knowledge that was needed for Aletta's work. The management as well as the administration was working on the first floor, and on the second floor projects and activities were conducted on the development of innovative views and methods. This was also the place where Aletta's health information booklets and other materials were developed. All levels were in touch with each other. Of course there were institutionalised consultative meetings, but the informal exchange played an important role as well. Aletta's women gathered in the kitchen during breaks and discussed their experiences, questions, and 'hot topics' in this friendly environment. Thus, Aletta's kitchen may be seen as a symbol of the mutual exchange between women working on different levels.

At some point in their development, many women's health organizations feel the need to move away from providing services and towards the policy level. This same development was seen in Aletta. The very successful group information meetings gradually became less frequent and were eventually stopped. Simultaneously, Aletta's function as an office for reporting sexual intimidation/harassment by care providers was transferred to the municipal health service. However, some services were kept. The general practice was continued for strategic and fundamental reasons:

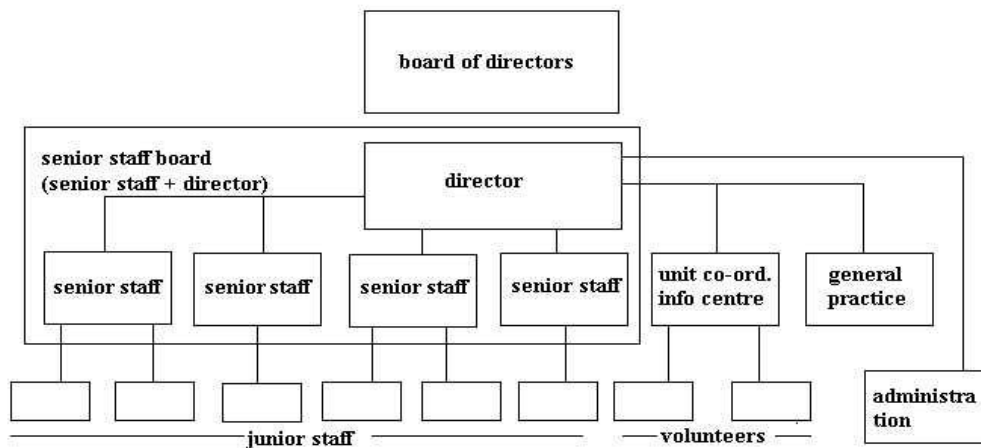
- to keep in touch with women's health problems and needs,
- to provide the necessary medical knowledge,
- to serve as an important example of good practice, and
- to provide a certain status for Aletta within the regular medical field.

More practical reasons were behind the continuation of other services. An example was the provision of self insemination kits (including sperm containers, cervical cups and instruction material). Women came from near and far to obtain this service, so it was felt that the service could not be discarded. Another example was a telephone service for women with health questions.

This development towards the policy level was mirrored in Aletta's change of name: whereas it was initially called Women's Health Centre, later on it carried the name: Netherlands Centre of Women's Health.

A large part of Aletta's work became focused on another part of the community: care providers. Successful projects included the training of general practitioners and gynaecologists. Projects were designed for the integration of gender specific health care in nursing. Aletta's plea for the integration of gender specific health care into all medical training programmes was also picked up by health professionals, training institutes, and the government.

Aletta's organisational Structure



In the mean time, the government, which had been financing Aletta, put a growing strain on Aletta by deciding to pull back (gradually). Aletta was expected to conform to a market economy. In the end, the pressure and the financial problems became too big for the organization. Aletta's board of directors decided to close the centre.

III. Which factors can be identified that accounted for Aletta's success?

- A very important factor was the professionalism of the staff members. Aletta's staff was multidisciplinary and consisted of highly qualified women from the nursing and medical professions, social sciences, and psychology.
- Especially the presence of medical doctors on Aletta's staff made the entrance into the regular medical field easier.
- The multidisciplinary also guaranteed a broad working field and a correspondingly large network.
- Communication with the regular field of health worked out well because Aletta sought the cooperation with regular health organizations, instead of mere confrontation. For instance, gynaecologists, nurses, and social workers from hospitals were involved in developing criteria for gender sensitive gynaecological care. Of course, it was important to cooperate

without losing a critical distance. This was exactly the reason why Aletta wished to remain an independent organization.

IV. Problems

The difficulties that Aletta encountered were partly linked to its success:

- The government's decision that Aletta should finance itself was based on the observation that Aletta was a successful and valued organization, ignoring for a long time the fact that the 'popular' services had been free of charge, or at least relatively cheap.
- The good integration of (some of) women's health views and methods into regular care might easily have led to the idea that women's health organizations, as critical observers of health care, health policy, and health research, were no longer necessary.
- The professionalisation of the organization necessitated the development of new organizational structures. Both finances and time provided little space for these changes.

Some other difficulties were independent of Aletta's accomplishments:

- Planning and ongoing development were often hindered by financial uncertainty.
- The financial strain also limited the networking abilities with other women's health organizations.
- It was sometimes difficult to charge an honorarium for the services provided to regular organizations, where women's health views were initially seen as strange or not applicable to existing practices.

V. Result

The last question is: what can other organizations learn from Aletta's example?

Most topics have already been mentioned such as interdisciplinarity, networking as communication-strategies, and internal communication from the services level up to the policy level (in formal ways as well as through the 'kitchen' model). Most important seems to be that the organization should be specifically aware of the 'disadvantages' of success.

Being successful means that it is time to look for new strategies, new structures of communication and possibly organization. One could say that by their nature, women's health organizations are 'learning organizations'. This was also true in the case of Aletta. However, the pressure from outside acted as a break on ongoing development. Nowadays, many women's health organizations struggle to survive. Many are highly dependent on governmental financing. Striving for financial independence could help to keep the 'good practices' going.

7. Dealing with women's health issues at the local level in Germany - background, experiences, difficulties and perspectives

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Vera Lasch, Institute Women and Society, gGmbH, Hanover

- I. Introduction**
- II. Political possibilities of women's health issues at the local level in Germany**
- III. Experiences – an overview**
- IV. The diversity of local women's health projects – an attempt at systematisation**
- V. Constellations of participants and bargaining processes at the municipal level**
- VI. Municipal settings as a place of success or failure of women's health policy and women's health projects**
- VII. Difficulties and perspectives for municipal work on women's health issues in Germany**
- VIII. Literature**

I. Introduction

It is not easy to describe the variety of municipal women's health projects in Germany. The demands for a municipal health policy in Germany began with the healthy-city movement. This was the first time that global demands were formulated that were to be carried out at the local level. The manifoldness of the existing project approaches is strongly related to the fact that these demands for a municipal health policy encounter, on the one hand, historically grown structures within the health system, with a differing understanding of what individuals or political institutions are able to do, on the other hand completely different possibilities of anchoring these demands. In addition, the general conditions of financing power and the institutional possibilities vary greatly at the local level.

This contribution endeavours to describe this variety, to illustrate the background of the development and to characterize approaches and strategies for action in women's health policy.

II. Political possibilities of women's health issues at the local level in Germany

When talking about the community⁷ as a place of women's health policy in Germany, one thinks foremost of the public health services (Öffentlicher Gesundheitsdienst)⁸, that is, the local public health departments.⁹ The community is the place where medical and health related social services are maintained. According to national and state law, the communities are required to carry out these services. In addition, because of their constitutional right of local self-government, the communities can pursue an independent local health policy.

⁷ The term „community“ embraces such regional administrative-political units as municipalities, cities, towns administered as districts in their own right and districts.

⁸ The public health service (Öffentlicher Gesundheitsdienst) are part of the German health care system (the most extensive term). Their main responsibilities are public and legal tasks within the area of health service as well as related examinations (cf. Beske et al., 1995, p. 46) There tasks are prevention and public health care.

⁹ “The local public health departments were established in all districts and towns administered as districts in their own right, in order to carry out health service and to pursue public-legal tasks within the health service area”(cf. Beske et al., p. 53). Note: There are about 520 public health departments in Germany.(Beske et al., p.54)

A locally oriented women's health policy encounters a deep-rooted collection of social and health policy structures and models. In order to understand the background of local woman's health projects in Germany, it is important to be acquainted with certain historical developments:

There are three mainstays of the health care system in Germany. Apart from out- and in-patient medical treatment, the public health services are often called the "third pillar" of the health system. Federal objectives such as cost reduction or the revision of social welfare legislation influence health care activities.

Historically, the public health services primarily dealt with social tasks and problems in the big cities. At that time, the statutory tasks of the urban and district doctors were medical care, health-policy and hygiene. However, this development came to a halt during fascism. Since then, the public health services were all but ignored by the local health administration in the former West Germany.¹⁰

Nowadays, the public health services tend to the public and legal tasks within the area of health service, including related examinations. The historical development still shapes its particular spectrum of tasks.

In addition, one has to distinguish between the public health services at the national, regional, district and local levels. The legislation that regulates the public health services in the different states is just as varied.¹¹

Accordingly, the public health services as an institution is represented differently in the different municipalities, either as independent local health departments (for example in some of the big cities), or as a local administrative division with differing staff composition. The following traditional tasks dominate wide parts of the public health services even today:

- supervision and observation of individuals and institutions working within the area of health service
- the prevention of and fight against infectious diseases
- the supervision of food, medicines and poisons
- health self-help (marriage counselling, health care in schools, mother and child advisory centres, care for patients with tuberculosis, venereal diseases, handicaps, addictions, or other groups in need of care)
- health education, information and advising
- promotion of body care and sports
- activities related to medical certificates, forensic medicine and work-related medical examiners¹²

Tight legal boundaries leave little room for manoeuvring and more far-reaching and independent local health politics. Communities and cities did not have a partner for issues of health policy on a local and everyday level.

¹⁰ The public health services played a different role in the former East Germany.

¹¹ States with public health services legislation: Baden-Württemberg (1994), Bavaria (1986), Berlin (1994), Brandenburg (1994), Bremen (1995), Mecklenburg-West Pomerania (1994), North Rhine-Westfalia (1997), Rhineland-Palatinate (1995), Saxony (1991), Saxony-Anhalt (1997), Schleswig-Holstein (1997). Regions without public health services legislation: Hamburg, Hesse, Lower Saxony, Saarland, Thuringia.

¹² Beske et al., p.54

At the end of the 80s there was a change of direction in the approach towards health policy guidelines. The Ottawa Charta of 1986 emphasized the local conditions of life as a vital basis for health conditions. With the development of a health supportive policy, local activities again become the focus of attention of health-political efforts. The community is declared responsible for creating healthier conditions of life and environment. To that effect, new policy tasks and responsibilities within the community were formulated: traffic, living and working conditions, education, political decisions concerning energy, clean air etc. Within the political system of Germany, these new tasks are now assigned to the – more or less unprepared – public health services.

According to the Ottawa Charta (1986), active, health supportive action requires:

- the development of a health supportive policy (i.e. health issues must be placed on the political agenda in all political sectors; politicians should be made aware of the health consequences of their decisions);
- the development of ways of life which are health supportive (municipal decisions influence work and leisure conditions, traffic, housing, education, political decisions concerning energy, etc.);
- the support of health related community activities (health support should be implemented within the context of concrete activities of citizens within their community; it should strengthen the autonomy and control over the health concerns of the individual);
- the development of personal competences (e.g. by passing on information, through formation and improvement of social competences and other practical skills);
- the re-orientation of health services (the participation of the public health services, as well as of other individuals and groups involved in medical health care is important in this context).¹³

These standards require global thinking. A broad spectrum of agents is called upon to participate. Thus, municipal health promotion demands, besides traditional agents (i.e. health care mainly oriented towards medicine and health security through doctors and health insurances and the public health services), also new agents from the municipal area (as for example individuals or organisations in the area of women's health). Above all, the public health services acquires a broader spectrum of duties.

This broader spectrum includes (without a claim to completeness), a description of health and social conditions of a community/city in form of **health reports** (as an instrument of control), the organization of **public involvement** or of participants outside the administration, but also the development of **new forms of co-operation at the administrative level (inter-sector activities)** in order to develop such an ambitious program. However, the increasing number of new tasks for the public health services (as well as for other agents involved) can be problematic because the administration has not yet sufficiently prepared this working field. The goal of **policy development** for an implementation of these tasks has not yet been reached. Implementation concepts are still missing!

¹³ WHO, The Ottawa-Charta (selected extracts) in: Trojan and Stumm. P.84-91.

III. Experiences – an overview

A brief historic outline of the development of the topic “Women’s Health“ since the beginning of the 70s

During the 70s, a sensitivity towards women’s health issues developed within the framework of the new women’s movement: Through the women’s health movement, on the one hand, developed topics such as the abortion law, self-examination, self-help groups, new forms of birth care and body self-determination, while, on the other hand, through the women’s shelter movement developed topics such as violence against women and battered women’s shelters. Women’s health research, aside from research on gender specific health behaviour and illness patterns, also initiated gender specific data collection (reporting) for health planning.

In the course of these developments a diversity of individual local, regional and national initiatives and projects were created which understood women’s health as a new area of work and action.¹⁴

In the last few years, many **national** associations concerning women’s health issues have been established (for example the AKF e.V., the FGZBV, battered women’s shelters association, as well as divisions within professional associations such as the DGTV, the DGS and the PPP). In addition, **regional** associations were founded (such as the Network Girls/Women and Health in Lower Saxony, Forum Frauengesundheit Bremen, networked working groups e.g. in Berlin, Bremen, Frankfurt, and Hamburg, women’s health centres with regional political influence, the birth-houses movement with their umbrella organization).

Since 1988, within the framework of the German “Healthy-Cities-Project“ of the WHO, women interested in health politics, as well as women’s groups and projects, have been taking part in the discussion on new municipal approaches and structures within the area of women’s health. These projects add to the variety of the projects currently in Germany. Thus the WHO was the initiator that placed women’s health issues on the agenda of local politics.

The women’s health movement succeeded in consolidating itself during that period. At the same time appeared a differentiated spectrum of work approaches and organisations. Some of the organizations managed to organize beyond the local level; in some places, renowned projects were implemented.¹⁵ In regions with an established women’s policy (e.g. women’s offices, equal rights offices; but especially in big cities or university towns) there are good prerequisites for a public discussion and thus also for a discussion of women’s health issues within local politics. Elsewhere, however, women’s health issues have been ignored in local politics.

¹⁴ Examples are the women’s health centres, which formed relatively early, or the more specialized self-help groups on bulimia or HIV, which developed later.

¹⁵ Nevertheless, some organisations still have financing and staff problems

IV. The diversity of local women's health projects – an attempt at systematisation

There is a wide range of topics within the different women's health projects with various approaches and diverse participants:

- Into one category fall the projects of a **“social“ character** that attempt to improve the social and economic situation of women. These include battered women's shelters, projects dealing with addiction, projects for single mothers or for unemployed women.
- In another category are the projects with an emphasis on **criticism of medical health care**, such as birth houses, changes in the organization of hospitals (e.g. through rooming-in), and projects with the goal of professionalising the nursing profession or new forms of lay medical care.
- Some projects work on the **image of women in medicine**. The prevailing aim of these projects is self-determination, overcoming the notion of women as beings with deficits. Classical examples are the early projects on self-examination. A more recent example is the International Centre for Women's health (Internationales Zentrum für Frauengesundheit, IZFG), that has developed new forms in the area of cure and post-treatment of illness. Concerning women-friendly treatment methods for some specific illness patterns, some clinical institutions developed concepts of treatment which originate from a social model or women-specific needs. In addition, organisations with similar interests reaching beyond one's field of specialty and occupation developed with the goal of discussing and presenting women friendly health care (for example the AKF e.V.).
- In a further category are projects in the area of **health policy planning** on a municipal level. The lack of corresponding data led to the attempt to describe first of all the health situation of women. Examples are the sporadic local health reports or working groups on specific topics (as for example in Berlin-Hohenschönhausen; in this category also belong the way health reports are created, e.g. organized out of administrative structures in working groups, as for example on the topic of mother's health in Hamburg).

Thus for the majority a spectrum of working approaches has developed in the area of women's health, which works locally or regionally mainly concentrated on specific issues, and does not have an explicit connection to local politics.

As good as never do these projects have a direct connection with municipal politics in order to improve local (regional) conditions in the field of women's health. A broad notion of health, which also includes social aspects, tends to be the exception. A network of projects that differ widely (as for example the Network of Women and Girls in Lower-Saxony) is rather rare. Quite a few projects think of themselves as autonomous, independent or feministically oriented and not as belonging to a general women's (health) movement. They are probably not very interested in common lobby work. Only some of the projects have an objective in municipal politics that goes beyond guaranteeing their own financing in the community.

We picked three projects out of the manifold spectrum in order to describe the approaches that work at the municipal policy level as well as the gamut of approaches:

Project: health support for women in a redevelopment area (a district project): Osterholz Tenever in Bremen as a project combining social and women's health interests; since 1989, ongoing

Description: The aim of the project is the improvement of housing, social and health conditions of women in a high-rise-building estate (a redevelopment area) in Bremen. Occupants, social workers, the construction firm, city council and the senator for health participated at various stages.

The project includes the following aspects: improvement through self-organisation of the health situation within the home and within the entire residential district, health consultation (e.g. nutrition and pregnancy), child care and child rearing. Once the project got started, the residents increasingly developed their own focal points and became active within their own district.

Project: birth house as a project of the women's health movement in Hamburg's district Altona, since 1992, ongoing

Description: The aim of the birth houses is to create a different experience concerning all aspects of birth and alternative care possibilities.

Participants are independently working midwives who are members of a registered association.

This project pursues the following health aspects: a holistic care before and after birth, public relations work (concerning life with children), as well as cure offers for parents. This changes not only the experience of birth and all the provisions around birth (all in one place), but also the work of the midwives.

Project: women's health report of the central office on health in the Berlin district Hohenschönhausen as a project of municipal planning of health policy; 1998, ongoing

Description: The aim of this project is to make health and social conditions of women the subject of discussion by means of a women-specific health report and to compile suggestions for organizing health support in the district.

Citizens, experts, members of associations and district authorities.

The project considered the following health aspects: employment/unemployment and health, women and addiction, town planning and women. In cooperation with the health support conference of Hohenschönhausen, they have already implemented essential parts of the tasks .

These projects alone show the diversity and breadth of women specific approaches at the municipal level, their various financing possibilities and the different constellations of participants within the local political context. It is also interesting that some of the municipal projects have objectives that do not refer explicitly to health, but rather work with an implicit health connection; that is to say, the respective political object is not health, nevertheless, their field of action (e.g. labour market policy, education, traffic) has consequences on health conditions which then are recognized as relevant especially for the life situations of women.

V. Constellations of participants¹⁶ and bargaining processes¹⁷ at the municipal level

When one wishes to place women's health policy issues onto the local agenda in Germany, one encounters the following constellations of participants, with only little networking up to now: The questioning of Northern German public health departments and equal rights offices, for example, showed the following constellations of participants¹⁸:

self-help institutions (associations, self-help groups, Pro Familia, centres for mothers, women's health groups)

institutions of medical health care (doctors, psycho-social medical care institutions)

political institutions (**political parties such as the SPD, the Green Party, the CDU, or the FDP**)

administrative institutions (**health administration, public health services, equal rights offices for women**)

educational institutions (adult education centres, universities)

welfare associations

institutions organized by churches (Caritas, Diakonie)

This spectrum shows not only the variety of participants but also the different institutional ties. Up to now, however, there is little networking between these participants and little political experience in co-operation. In addition, the answers of the local health departments to the question, which agents they know, show that they know especially the traditional agents of community cooperation such as adult education centres. Agents that traditionally work on women's health, such as women's health centres, are named rarely and appear farther down on the list. Turning this argument around, the results show how little the projects within the field of women's health understand themselves as actors in local politics. Their political strategies, if they exist, are not geared towards integration into local politics. (For some projects the demand for inclusion into local politics is probably not even understandable. For these, the Glasgow project of a women friendly "healthy city" can give an orientation.)

When evaluating the existing projects that have a focus on local politics, one finds that successful work in the field of women's health at the local level depends to a great extent on successful "constellations of participants", especially in Germany. Therefore, it is advisable for

¹⁶ This means a number of participants, with the same or similar interests and fields of action that develop strategies for solving political problems (cf. Lenhardt et al., 1996).

¹⁷ Bargaining processes include the processes of understanding and conflict among participants within the local political area. These take place at various levels (regular's tables in pubs can be important for decisions) and they can be carried out among fluctuating participant constellations.

¹⁸ These answers are from a questionnaire given to local health departments and equal rights offices in Northern Germany in the spring of 1998. According to the health departments questioned, the following groups were involved: individuals, women's representatives, administrations, initiatives, self-help groups, Pro Familia (a family planning organization), centres for mothers, municipal psychosocial institutions, women's centres, women's health groups, privates and public institutions of medical care, educational institutions, adult education centres, universities, charity organisations, institutions organized by churches and political institutions.

nearly all projects to carry out an analysis¹⁹ of these local constellations at the beginning or during the course of a project.

There is a classical spectrum of agents in Germany whose specific interests or possibilities of participation can be investigated locally. Another good strategy for discovering possible constellations of agents is questioning of existing projects on their experiences with certain agents:

- by discussing financing aspects with health insurance companies, doctors' organizations or other agencies of public responsibility,
- by seeking political support through discussions with politicians, women's representatives and through public relations work in the local press,
- by informing individual institutions of public health,
- by networking with other organizations within the women's health area for support.

Depending on the goals and the forms of implementation of the project, one must first establish municipal networks locally and then suitably weave them together. An exchange with already experienced projects is advisable (however, competition between established projects can be disruptive as well).

At the same time it can not be ignored that women's health issues are competing with traditional health-political topics such as cost saving, hospital beds or with other target groups such as children, senior citizens, addicts, disabled persons. That is why it is not easy for women related topics²⁰ to make it onto the agenda of local politics. The goal of municipal women's health politics should therefore be a thorough knowledge of the local political conditions and spheres of influence.

VI. Municipal settings as a place of success or failure of women's health policy and women's health projects

It is not easy to formulate or generalize criteria for the success or failure of such approaches within the setting of a community as a place for the implementation of women's health. This is especially true since there are still few experiences with cooperation in the community. In principle, one can differentiate between:

1. the goal to establish specific projects,
2. the goal to network participants in order to place women's health on the agenda of local politics, and
3. the goal to implement specific women's health interests into political planning.

In establishing specific projects in the field of women's health, priority should be given to financing, the development of work structures, the personnel and the organization of the necessary support.

¹⁹ A possible method for such a analysis can be the persual of local newspaper for active groups. To this can be added talks with relevant experts such as doctors, self-help groups, insurance companies, or actors within the local administration.

²⁰ As an example the topic violence against women, support of women specific self-help offers, etc.

Networking of agents in women's health has the goal to include and influence important local political structures and constellations of conditions in which decisions are made on women's health.

In the implementation of women's health issues into political planning, the level of activity is more strongly constrained by the local political processes and agents, for example by the health policy administration.

Let me present two examples that can be described as a mixture of networking goals and the goal of implementing women's health issues into the political agenda:

The **Network "Mädchen/Frauen und Gesundheit in Niedersachsen"** ("Girls/Women and Health in Lower Saxony"): This network has state-wide network structures with various participants working on "women's health": representatives from local equal rights posts, the Ministry of women, work and social affairs, and various women's organizations. Co-operation includes a wide range of topics. A general meeting defines and determines the common topics. Working groups carry out the preparation of events to specific topics. Out of these working groups, as well as among the participating agents, develop more stable working structures. Topics are migrants, girls, elderly women. Target groups are multipliers and women's equal rights posts. The aim of this network is the exchange of experiences and information and the development of political strategies on social and health-policy perspectives. The most important objective is to enhance the visibility of discrimination against women. Solidarity, co-operation and joint action need to be supported. The network is a service point for projects on women's health as well as a flywheel for ideas and their implementation. Some approaches exist for the education and training of multipliers and for starting relevant campaigns. These approaches are beginning to gain recognition, and there is a development of analysing and collecting know-how. A further part of the work is information policy (e.g. through the journal *impulse*). Such a network can be considered a base from which a positive influence on women's issues emanates onto the political climate; at the same time, it consolidates expert competences of the region.

The development of health support in local politics through the creation of a **local health report** (example: Hamburg, district Eimsbüttel): the city-state of Hamburg is one of the 16 German states and has a broadly-developed history of health reporting. In the district of Eimsbüttel, the local public health service is currently developing a local health report. When the district of Eimsbüttel processed the state data, they found that there is a special need for the treatment of patients having a stroke. On the other hand, the district had a surprisingly high occurrence of breast cancer in women. The data analysis could not show any causal connection for these phenomena. During the political-administrative debate of these results and the negotiation on resulting strategies it was decided either that the administration develops a project on breast cancer or to support a project on strokes. However, while there was an extensive number of experts (doctors, university projects, the medical field) supporting the project on strokes, there was no such support for the project on breast cancer. The final decision was made in favour of the stroke project and the topic of breast cancer was put aside.

Because of the special constellations in municipal politics, decisions at the administrative level are often the result of bargaining processes and of political constellations. If we want to anchor women's health policy at this level, then the knowledge of the local structures and the

intervention possibilities within these structures is indispensable. The local rules of the game need to be known in order to use them to one's advantage.

VII. Difficulties and perspectives for municipal work on women's health issues in Germany

At the local health policy level, women's health issues are first of all competing with all other topics of municipal health support. There are always "good reasons" to decide against women's health. Not the least of them are the efforts to modernize (foremost by reducing jobs) in the administrative area, which can be a reason for their lack of effort.

What conditions are necessary to place women's health issues on the local agenda?

In our experience, there are possibilities when:

- there are strong and stable groups of agents within and outside the administration that are geared towards longevity,
- there already exist networking structures which bring together loosely co-operating groups (from self-help groups to churches) and there is little competition (e.g. for financial support) among agents,
- the topic of women's health is put in the "proper" context (this includes that topics are recognized, that old topics are connected with new, etc.). It is necessary to approach the right topics at the right time: topics should be popular and politically flexible.
- the arguments are sound. In this context, scientific verification has gained importance (e.g.: How can the frequency of breast cancer be explained?).
- the participants carry out informational and public relations work and become aware of their goals in bargaining processes in order to implement their goals more successfully at the local level,
- the community is regarded as a space where constellations of agents act and thus open up or close down possibilities for women's health issues,
- the local agents improve their sensitivity and their understanding of political strategies and bargaining capacities in such processes,
- the quality criteria and evaluation patterns for work in women's health projects are applied and developed further,²¹ and
- the joint lobby of women within women's health policy has become a matter of course and thus, competition and co-operation are re-determined.

VIII. Literature

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Lenhardt, U., Rosenbrock, R., Elkeles, T., (1996) Bedingungs- und Akteurskonstellationen für Gesundheitsförderung im Betrieb, WZB, Arbeitsgruppe Public Health

WHO – Die Ottawa-Charta (vereinzelte Auszüge), in: Trojan, A., Stumm, B., Gesundheit fördern statt kontrollieren – Eine Absage an den Mustermenschen, Frankfurt, 1992, 84-91.

²¹ It is advisable within this highly ambivalent area not only to carry the evaluations called for nowadays, but also to strive towards joint impact control. This includes criteria for the effectiveness of women's health projects, possibilities for debate on working conditions, education and training of staff, as well as management structures (of hierarchical vs. egalitarian, or official vs. voluntary constellations) within projects (cf. Berg and Werth, 1997)

8. Implementation Strategies for a Health Policy for Women: Strategies, Concepts and Experiences Using the WOMEN'S HEALTH FORUM in Bremen as an Example.

Ulrike Hauffe, Ilse Scheinhardt

- I. Introduction**
- II. Reasons for a Health Policy Specifically for Women**
- III. The WOMEN'S HEALTH FORUM as an Example of Networking**
- IV. The Goals of a Women-friendly Health Policy**
- V. Summary**

I. Introduction

We present the implementation of women's health interests in form of the Bremen Central Office for the Realization of Equal Rights for Women (Bremische Zentralstelle für die Verwirklichung der Gleichberechtigung der Frau (ZGF)) and a municipal women's health policy which has existed in Bremen since 1981.

The provision of resources from the city-state of Bremen and the networking throughout the whole municipal area are exemplary.

A Regional Authority with the Task of Contributing towards Equality

In 1981, the Bremen Central Office for the Realization of Equal Rights for Women was set up by law as a regional authority. The Central Office has both a watchdog function as well as the task of taking active measures to ensure compliance with the constitutional law of equal rights for women in the work place, education and society. The title of the director of the ZGF is State Representative for Women.

Therefore, the ZGF has the right and the responsibility to

- advise individual women as well as whole social groups in cases of discrimination
- support disadvantaged women individually in the assertion of their interests
- check draft bills and resolutions at the local, state, and national level in order to counteract discrimination against women
- suggest measures and draft bills to support women
- promote equal rights for women by means of independent public relations and educational work

The main emphases of the specialist consultants are:

- Matters of general interest in feminist politics
- Legal matters
- Questions relating to women and work
- Promoting the advancement of women in the civil service and working with girls
- Education and science
- Violence against women
- Women and health

Women-oriented health promotion and health provisions – a traditional matter of concern for the women's movement – are prerequisites for equal rights and self-determination. Health is one of the basic rights of every person (World Health Organisation WHO 1981).

The work in the area of 'Women and Health' of the Bremen Central Office for the Realization of Equal Rights for Women agrees with the definition of the WHO: Health is "... one of the basic rights of every person" (1981).

Health "is the physical, mental, social, ecological and spiritual well-being. Well-being and indisposition up to the point of health and illness are closely linked to the environment in which we live. When this environment is characterized by plenty of possibilities for self-realization, for participation and determination of one's own circumstances, then these are health-promoting factors." (3rd International Conference on Health Promoting Spheres of Life, organized by the WHO, 1991, in Sundsvall, Sweden, final document)

Health – as is ascertained in this formulation – is maintained and developed in connection with the self-determination of people over the world in which they live. "*Health promotion* is primarily a task of the health and social areas and not a medical service" (WHO, 1981).

With this definition the WHO does *not* reduce health to the care of illness by medical disciplines, but refers to health-maintaining or health-damaging places and basic conditions of individual and social spheres of life and actions. Health promotion is the organization and preservation of health-promoting spaces in everyday life.

Health promotion is therefore a political term and thus a health policy for women is also the responsibility of feminist politics.

II. Reasons for a Health Policy Specifically for Women

Why is it necessary at all to demand explicitly a women-friendly medical science? Worldwide investigations have proven that cause, form, expressions, symptoms and the experience of health and illness differ in men and women. However, studies on illness referring to causes, diagnosis, therapy and success of treatment orient themselves mainly towards male biology, male life situations and male social positions.

The results of women's health research show that women react more sensitively and earlier to physical and psychological symptoms that can precede a health imbalance or an illness. Women use - of their own accord and in greater measure than men - early diagnostic tests, courses on maintaining health as well as rehabilitation possibilities to promote their health or to actively restore it.

Women are both healthy and ill in different ways from men. A woman's life passes in different rhythms from time to time. It consists of biologically defined physical and psychological phases such as puberty, pregnancy and menopause. All transitions and stages of life involve physical and mental changes, which become noticeable in feelings of uncertainty and experiences of endings and new beginnings.

During the last three decades gynaecology has interpreted these transitional phases as risky events and "treated" them accordingly. Eva Schindele on this subject: "Gynaecology today standardizes and pathologizes female sexuality, (...) turns the female (body) into an *object* which must be kept under control. Anything that differs from the *norm* is seen as needing treatment."²²

²² Schindele, 1993: Pfüsch an der Frau, Hamburg

There are well-known examples of this:

- In teenager consulting hours gynaecologists offer gynaecological *routine* examinations for girls to check on the “normal development” or to establish deviations from the norm. In this atmosphere of supposed pathology, the girls are informed about sexuality and hormones are prescribed to regulate their menstruation or for contraception.
- Gynaecologists use ultra-sound scans, laboratory tests and prenatal diagnosis – as prescribed in maternity guidelines and documented in the “Mother’s Passport” (a document given to expecting mothers in which details of the pregnancy are entered) – to define pregnancy and birth as highly risky pathological events, which should be controlled by medicalization and mechanization. The woman is regarded as a “foetal environment” and declared a risk for the child.
- Hormone replacement therapies are prescribed for menopause as an outside control against alleged inner “deficiency symptoms”.

This is shown clearly by the example of *menopause*: Societal ideas of both women and doctors, but also conveyed through the care structures of the health service, have an effect on how this stage in a woman’s life is dealt with:

Hormone changes occur in all women during menopause, but not all women suffer from them:

- One third of all women have no or few problems during menopause
- One third of all women complain of moderate problems
- One third of all women suffer from severe problems.

A study presented in England recently claims that in fact 75 percent of all women (in English-speaking countries) have *no* unpleasant symptoms.²³

Socio-cultural investigations have shown that psychological, social and cultural general conditions have an influence on when something is perceived as a symptom or when something is *felt* as an illness.

European and American women in particular mention hot flushes, for example, as an unpleasant symptom. Japanese women suffer above all from stiff shoulders, headaches and giddiness. North American scientists discovered recently that while bone density and the hormone level of Mexican-Indian and North American women are similar, Indian women nevertheless suffer rarely from menopause symptoms and not at all from fractures. It seems reasonable to conclude that it isn’t so much the missing hormones that are responsible for the state of health, but rather a physically active life, coupled with increasing social esteem. The social status of Mexican-Indian women is enhanced after their reproductive phase and they enjoy a defined increase in competence and power.²⁴

From the medical-biological point of view, the menopause of women in our culture is an unnatural, pathological condition with a high potential for jeopardizing health and well-being. Defined as a deficiency illness with alarming consequences (including osteoporosis and cardiovascular diseases), welfare demands – as a logical consequence – a permanent hormone replacement therapy for the benefit of the women.

²³ Barrett-Connor: 1998

²⁴ Love: 1997; Schindele: 1998

Judging one's own sexuality to be in need of control, one's own sexual organs to be potentially susceptible to illness, not trusting one's own body signals and therefore submitting oneself to the care of experts – these are not appropriate attributes or behaviours for organizing one's life as self-confidently, independently and healthily as possible.

A health policy which is mainly occupied with *illnesses* in statistics and with the *organization* of sick *care*, labours at the symptoms and does not improve the causes. A health policy which serves to maintain women's health must take into account their gender-specific interests and life conditions, such as the desire of many women to be *supported* in their own actions rather than be *treated*. A woman wants to be understood as a whole person – not within aspects of certain symptoms. Women – more so than men – have the need for *hearing* and *speaking* medicine – i.e. for *high touch* and *low tech* medicine rather than vice versa.

Fewer and fewer women are convinced that health can only be guaranteed by means of more numerous and more extensive medical techniques and medication. Women have recognised that well-being only flourishes under those psycho-social life conditions which leave them a framework in which to develop their own physical, emotional and social diversity of experiences: guarantors of health are not good conduct and conformity, but rather social safeguards, self-determination, creativity, self-esteem, courage and resistance.

To maintain and promote health, both women and men need places and times for a fundamental exchange of information and experience, in order to form their own viewpoints. For a long time now men have been organizing – successfully – alliances to form opinions and to network their interests: for mutual support and with the goal of exerting political influence. Women are also making more and more use of their contacts to enforce women's interests in health care.

III. The WOMEN'S HEALTH FORUM as an Example of Networking

One example of a regional platform of action for networking (female) experts from the Bremen health service area, for a *local, more women-oriented health policy*, is the WOMEN'S HEALTH FORUM (FORUM FRAUENGESUNDHEIT). It was initiated by the Bremen Central Office for the Realization of Equal Rights for Women (ZGF) in 1994, and meets every 3 months.

The FORUM is a plenum for interdisciplinary discussions on women's health questions with (female) representatives from women's projects, advice centres, educational institutions, midwives' practices, clinics, businesses, workers' associations and the administration – all of them from the fields of health, education, science and research. Experts take part in the FORUM as professionals in their respective fields, but also as women who are personally affected, consumers, patients and a "target group".

This specialist body discusses interdisciplinary aspects of women's health, and develops women-friendly alternatives which are passed on as guidelines for action and decisions – both as practical applications of health care and as advice for politicians. The professional interdisciplinary nature of the participants brings a new quality to the discussion of complex problems.

The WOMEN'S HEALTH FORUM takes up topics from a *woman's point of view* – topics which have hitherto received little attention in discussions on health policy, but which are of fundamental significance to the health care of women.

Here are some examples:

- Outpatient operations under the aspect of psycho-social advantages and disadvantages for women
- The development of specifically female standards for safeguarding quality within the framework of so-called quality management
- The effect of the health reform on women
- Women and addiction: explanation models, therapy comparisons and need-analyses
- “Inter-sexuality” and criticism of traditional methods of treatment
- The theory and practice of gender-specific care; the employment of male nurses on gynaecological wards
- Research results on women’s health.

The results of discussions in the WOMEN’S HEALTH FORUM are then, for example, passed on to the media as written statements, presented to a larger audience during public events or passed on in form of petitions to political decision-making bodies.

The plenum WOMEN’S HEALTH FORUM commissions its experts to explore questions developed in the FORUM, or to organise extensive events on pre-determined subjects.

The *study group* “**The treatment of women and girls who have experienced (sexual) violence**” conceived a four-part in-service training course for gynaecologists in the autumn of 1996, which was carried out in cooperation with the Bremen branch of the Professional Association of Gynaecologists (Berufsverband der Frauenärzte, Landesverband Bremen). This in-service training course was intended to sensitise specialists to the subject of (sexual) violence and its consequences on the mental and physical health of their patients. We currently strive for the institutionalisation of this topic within the regulations governing further education for all specialists by negotiating with the General Medical Council (Ärzttekammer) in Bremen.²⁵

The *study group* “**Women and addiction**” is a plenum of (female) employees from out- and inpatient institutions within the field of legal and illegal addiction, which takes care of women who are acutely addicted to drugs, women who substitute and clean women. The study-group is important as a forum for the exchange of information, for networking and cooperative further education. The group creates need-analyses, and develops concepts for the improved care of addicted women.

The *study group* “**Under different circumstances – becoming a Mother in *this* society**” organized a - nationwide acknowledged - specialist conference in September of 1996 :

In lectures, seminars and workshops, experts from the fields of gynaecology, sociology and the social sciences, psychology and cultural studies gave talks on

- The historical derivation and a cultural-comparative analysis of societal attitudes towards fertility;
- Prenatal diagnosis as a prenatal mechanism of selection;
- The stigmatisation of pregnant women as a highly risky “foetal environment” in need of control; and
- A European comparison of birth assistance.

The particular significance of this conference lay in the analysis of the connections between the societal shaping of public opinion, a focus on family and health policies, corresponding medical procedures and their influence on female experience and learning. A documentation-volume⁵

²⁵ Bremische Zentralstelle für die Verwirklichung der Gleichberechtigung der Frau: 1999

describes the alternative socio-medical views and practices developed using the examples of pregnancy, birth and motherhood, such as the structural rededication of the care of pregnant women towards the midwives' field of activity.

A plenum such as the WOMEN'S HEALTH FORUM is a **place of knowledge**. Such places link together the realities of different living and working worlds through information and the exchange of experiences. Out of this develop demands for a *more women-friendly* health policy. A women's forum is a "pool of wisdom", in which experts work with the intention of exerting political influence and with the potential for resistance.²⁶

A short definition of the term *resistance*, which makes sense from both the medical as well as the political viewpoint.

Here is a shortened account of a statement by Beate Blättner of the State Association of Adult Education Centres in Lower Saxony (Landesverband der Volkshochschulen Niedersachsen e.V.): if it is true that social conditions make women ill, then *resistance* against these conditions is a very central element of a health policy for women. Resistance and being resistant are central emancipatory political concepts. However, they are also terms used in medicine to describe the ability of the body to resist those conditions and influences which can cause illnesses. This power of resistance can be weakened by too many demands from the outside – or by disturbances within one's own immune system. Resistance can then lose its protective function, become too intensive or be directed against itself and lead to self-destruction. The causes of such illnesses are always manifold. We know, though, that this power of resistance can be positively influenced and strengthened through imagination exercises, such as the development of alternative perspectives.²⁷

This definition of the term *resistance* clearly shows how healthy it is to be resistant. The demands that women place on a women-friendly health-policy exceed individual demands for successful operations, or the prescription of low-cost medicines that work well and have no side effects. Women's health demands aim at the preservation of health and the prevention of illness, for example by means of preventive measures and rehabilitation.

IV. The Goals of a Women-friendly Health Policy

In order to make laws more women-oriented - here in the field of health - women should conquer the political platforms on which laws are developed and approved. We need networks as platforms of action on which competences of women are focused in order to exert purposeful and concrete influence.

Various associations and "free" initiatives have been working together successfully for years in regional and national networks.

Some examples are:

- Women's health and therapy centres, health shops, health initiatives, Pro Familia (a family planning organization)
- The study-group Women's Health in Medicine, Psychotherapy and Society (Frauengesundheit in Medizin, Psychotherapie und Gesellschaft e.V. (AKF))
- The network against selection by means of prenatal diagnosis
- Professional associations such as:

²⁶ Bremische Zentralstelle für die Verwirklichung der Gleichberechtigung der Frau: 1999

²⁷ Blätter: 1993

- The German Association of (female) Doctors (Deutscher Ärztinnenbund (DÄB))
- The German Association of Freelance Midwives (Bund freiberufl. Hebammen Deutschlands (DfHD)) and the Association of German Midwives (Bund deutscher Hebammen (BDH))
- The Society for Birth Preparation (Gesellschaft für Geburtsvorbereitung (GFG))
- The German Society for Psychosomatic Birth Assistance and Gynaecology (Deutsche Gesellschaft für Psychosomatische Geburtshilfe und Gynäkologie (DGPGG))
- Charitable Organisations and
- Consumer Protection Councils.

Together, these initiatives, professional associations and interest groups, with their knowledge and findings, can exert political influence on the health system, using information exchange, specialist cooperation and the formulation of women-friendly demands.

Here are some examples:

– *At the municipal level*

- with health reports and health departments
- with specialist divisions on “women’s health”
- with equal rights offices / girls’ and women’s representatives
- by means of institutional networking of the public health services
- through political work in expert committees and in the self-administration of municipal health insurance companies
- in women’s health forums, health shops, women’s health and women’s therapy centres
- within the framework of Agenda 21.

– *At the state and national level*

- by means of political work in the self-administration of health insurance companies
- by exerting influence on school legislation in order to develop a “health education”
- by applying to the Committee of Health Ministers (Gesundheitsministerkonferenz (GMK))
- by applying to the State Committee of Ministers and Senators for Equal Rights and Women (Konferenz der Gleichstellungs- und Frauenministerinnen, -minister; -senatorinnen und -senatoren (GFMK) der Länder)
- through critical statements on the Public Health Services Law (Öffentlicher Gesundheitsdienstgesetz (ÖGDG)) and on training regulations for health professions
- through statements and experts’ reports on health reform, family and social legislation
- by applying to the Federal Ministry for Education, Science, Research and Technology (Bundesministerium für Bildung, Wissenschaft, Forschung und Technik (BMBWF)), to the Federal Ministry for Health (Bundesministerium für Gesundheit (BMG)) and to the Federal Ministry for Family, Senior Citizens, Women and Youth (Bundesministerium für Familie, Senioren, Frauen, und Jugend (BMFSFJ))
- by means of an exchange of opinions and resolutions at the German Convention of Municipal Authorities (Deutscher Städtetag), (for instance to the Committee for Women’s Affairs and Equal Rights (Ausschuß für Frauen- und Gleichstellungs-angelegenheiten)), and by means of information at the consumer’s level, e.g. within the framework of the Foundation for Testing Goods (Stiftung Warentest).

From a women’s point of view, target groups for criticisms, demands and suggestions for improvement are political representatives from the municipalities and politicians at the state and national level, representatives of professional associations and interest groups, health insurance companies, sponsor organizations for the allocation of research money, universities, General

Medical Councils, associations and lobby groups – that is to say, all those who pass laws concerning health legislation, award research money, enact training regulations and school legislation, decide on regulations for the protection of expectant and nursing mothers, or influence public opinion fundamentally.

- During the 11th Meeting (on 6.2.1998) of the committee for “Women’s Affairs and Equal Rights” and at the 115th Meeting (on 18.6.1998) of the Health Committee, both at the German Convention of Municipal Authorities, the members passed a resolution to set up *forums* and *round tables* at the municipal level for political consulting on the subject of *women and health*.
- In the state of Bremen, the *Advisory Commission on Human Genetics*, set up by the Health Senator, together with participants from the Protestant Church, clinics, human genetics scientists, political parties, the public health department, the human genetics advisory centre CARA e.V. Bremen, as well as a journalist as a representative of women, worked out a statement to improve the advisory situation **before** prenatal diagnostic examinations.

V. Summary

Women – both as those treating others and as those being treated – want to influence decision-making processes of society in favour of more women-friendly laws. **Women are looking for new organizational forms in order to obtain more power. Women want to help develop those ways of life that grant them a greater variety of roles, more possibilities for development, competence and responsibility in all spheres of decision-making of society. For this reason women are uniting and establishing regional networks.**

It is more interesting, more fun, more informative, productive, purposeful and encouraging to tread new ground together with other women. Because of their different professional and personal experiences, each woman has a different understanding, a different logic, different explanation patterns, and also different sensory and emotional access to occurrences in society. We can use our various reaction patterns, but also our individual limits and levels of resistance, because in the diversity of opinion also lies the encouragement to find one’s own strengths. This applies to individual women as well as to small and larger groups.

There are many paths leading to emancipation.

Taking these paths means acquiring power: through increased knowledge, through the study and practice of health-related abilities to criticise and through the goal-oriented exertion of influence.

Thus our achievements are twofold: For a heightened sense of self-esteem, purposefulness, orientation toward health and the future, as well as access to social networks, delight in social contacts, a thirst for knowledge and the ability to learn are considered to be **the** health-maintaining and health-promoting elements.

A gain in intellectual clarity and stability ultimately also results in considerable pleasure, which can be the driving force for further competence, resistance, creativity and the desire to conquer new fields of action.

9. Fields of action – political strategies in the local authority district. Experiences and success within the frame of the Healthy – City – Project in Glasgow

Ann Hamilton, Glasgow City Council

- I. Introduction**
- II. Background**
- III. Glasgow's approach to women's health**
- IV. Centre for Women's Health**
- V. Violence against women**
- VI. Strengths, weaknesses, opprtunities and threats**
- VII. Weaknesses**
- VIII. Threats**
- IX. Opportunities**
- X. A networking opportunity**

I. Introduction

Today I'd like to set the context for how we view women's health and tell you a little about Glasgow, outline the Glasgow model, and highlight some of the elements which have been helpful in taking the work forward. I'm not going to cover any aspect in detail but would be happy to provide additional information in response to

II. Background

I am Principal Equality Policy Officer employed by Glasgow City Council and I've been involved in the development of the work on women's health over the past 15 years or so. I am one of a number of women employed by public agencies in Glasgow working together to promote gender equality and action on women's health in the city of Glasgow.

In the UK local government is responsible for Education, Housing, Social services, Environmental and cleansing services, leisure and culture, physical planning and the roads system. There is also a role in terms of policing, fire services. The local authority is democratically elected and accountable – elections every 4 years. Health care and medical services are commissioned through specific Health Boards and provided through Health Trusts. Health services including health screening are primarily free - there are prescription and dental charges for those in employment.

It is essential to place women's health within a broad social model of health. The World Health Organisation's definition is based on the understanding that health is not an outcome of medical intervention but is an ongoing 'state' in which emotional and mental well-being and environment contribute to health status. It implies that health is about having something which is positively good, rather than not having something which is bad.

We know that women live longer than men but experience a greater amount of ill-health during their lives. Factors such as poverty, poor environment, sexual abuse, caring responsibilities, sex discrimination and domestic violence have significant impact on women's lives and women's health.

Scotland has a total population of just over 5 million people. The city of Glasgow, with a population of approximately 620,000 has the highest level of areas of deprivation in Scotland, 78% of the worst districts defined as being deprived.

- Lone parents head 28% of all families in Glasgow - Scottish average 15%
- 18% of population with long term limiting illness - 13% Scottish wide
- 24% of households have no earner - UK 10%
- Life expectancy for Glaswegians is around 6 years shorter than affluent areas (UK)

The social model of intervention which we espouse demands an integrated response, which takes account of the needs and responsibilities of the individual but is also targeted at reducing the experience and impact of poor housing, poverty etc. Factors affecting health status include gender, age, ethnicity, domestic situation, disability, sexuality, social and economic status, location and environment.

III. Glasgow's approach to women's health

Gender health inequalities are derived from the generally low status of women legally, economically and socially; from the imbalance of power in relationships which limits women's choices and ability to protect and promote their own health; and the level of male violence and abuse experienced by women.

Women live longer than men however they experience a greater amount of ill-health during their lives.

The work on women's health in Glasgow is particularly well-developed and has been ongoing since 1983. The World Health Organization had declared 1982 to be a year focussing on women's health and held a major international conference in Scotland. Many professionals were invited but women and women's organizations were excluded. This concerned women and in 1983 a major women's health fair was arranged in Glasgow and attracted hundreds of women. The response to the event took even the organisers by surprise. Following on from this event there were women's health fairs held in local areas all over Glasgow.

I was working in a small deprived area at that time, and we organised a local women's health fair but generally there were many other women doing the same things: involving women and talking to women about their health.

Thereafter the Clydeside Women's Health Campaign was established which lobbied for public agencies to develop a commitment to women's health and the creation of a centre for women's health. In 1990 Glasgow became a WHO Healthy city and after some pressure it was agreed that women's health would be a particular element of the WHO Glasgow Healthy City Initiative. A Healthy City Women's Health Working Group was established and started to organise a range of activities. For the first time Glasgow also had a female Provost (Mayor) and she agreed to chair the Women's Health Working Group – status at last!

At the same time a number of key public organisations had put in place structures to address gender inequality and women's issues and so there was a small group of women who were in positions of influence within the key agencies in the city. A consultant in public health with responsibility for women's health was appointed. This was of great importance because we now had a woman in the health service who was arguing for women's health to be taken seriously and across a range of issues and not to be confined to obstetrics and gynaecology.

In 1989, after much political and community pressure, a women's unit was established in the local authority with a remit to promote women's equality and to tackle gender inequality.

In 1992 we developed the first women's health policy through a dynamic and participative process involving statutory agencies, voluntary organisations and individual women. The policy was adopted by all Healthy City partners, including Regional and City Councils, Health Board, Universities, voluntary and community organisations. Over 70 organisations, statutory and non-governmental, became involved. Phase 2 of the Glasgow Women's Health policy was produced in 1996 and reviewed earlier this year. A further consultation on Phase 3 is now underway.

At the end of last year we celebrated 15 years of our activity on women's health with a programme of events and projects held in various venues across the city.

In 1996 when involved in some work for WHO Europe advising other Healthy cities on women's health strategies we did some work on analysing our approach in Glasgow, and came up with a Glasgow model, comprising the following five key elements,

Investing in women's health

The Glasgow model recognises the need to make women's health a priority, because of the effects of disadvantage which women experience.

Social model of health

The model highlights the social, economic and environmental determinants of health as they apply to women. The model further recognises the heterogeneity of the female population and the needs of women further disadvantaged by race, disability or sexuality.

Consultation and participation

The Glasgow model recognises the sovereignty of women's views but also the limited access that women have to decision-making and the lack of opportunities that they may have to define their health needs.

Interagency and organisational development

The Glasgow model recognises the need for an integrated approach to women's health which requires organisational recognition of gender sensitivity and gender specificity as prerequisites for the effective planning and delivery of all services which have an impact on health.

Strategic framework

It follows from the above that a strategic framework is required –

- women's community development to help articulate health concerns
- intersectoral forum for women's health which brings together statutory agencies, voluntary organisations and community groups to identify priorities
- women's health policy development and implementation
- organisational structures and systems to raise awareness, facilitate data collection by gender, gender monitoring and gender sensitive planning
- the Centre for Women's Health, a demonstration project, which tests and evaluates new methods for responding effectively to women's unmet health needs
- research and development of indicators of women's well-being

The work undertaken in Glasgow is unique in Britain and has recently been awarded WHO Collaborating Centre status.

There is a recognition that much progress has been made in developing policy, establishment of a number of pilots and examples of good practice and a substantial library of reports and studies. There is however a concern that the priority must be to move further from the margin to the mainstream. The aim is now to influence more effectively the priorities, policies, and services of major organisations including local authorities, health and medical services, universities and colleges.

IV. Centre for Women's Health

The Centre for women's health has been particularly important in promoting our approach – providing direct services to women, particularly on unmet needs, testing and evaluating new methods and developing best practice. One service which the Centre for Women's Health has established is the only Lesbian Health Service in Scotland. This service was established after consultation with lesbians, discussion with those who were providing health care. The result is a quality service, sensitive to the particular needs of this group of women who are often marginalised and ignored. We have also developed a similar model in regard to disabled women and we are about to develop a black women's health project as well. Some work on it has been already done.

Through the work on women's health a range of information is made available to women. Partner agencies provide training, support and resources to those involved in working with women, on women's health or with issues that have been identified as being of interest to women's health. One of the initiatives has been the development of a handbook called Action for women's health. This publication provides women and men working on women's health rationale, support, guidance and examples of good practice on progressing women's health.

We have been looking at doing some work on developing indicators of women's well-being. How do we know when women are well? What would be the indicators of it? Number of friends and level of support available? Involvement in social or educational activities? Levels of energy? We would like to see work on indicators of women's health which could be used on a European level.

V. Violence against women

We have developed programmes of action on particular aspects which were of interest to women. One of the first topics was male violence against women. There was a public awareness and education campaign on violence against women developed in Edinburgh, another Scottish city, which the local authority ran in Glasgow with a range of partners including Women's organisations, Health Services, Police, Trade Unions, Universities and Colleges.

The public awareness campaign was designed to promote discussion in work places, in public arenas etc. The impact of the Zero Tolerance campaign has been significant

- playing a key role in putting the issue of violence against women and children on the public and political agenda
- influenced policy and practice at a local and national level
- succeeded in breaking some of the silence and stigma surrounding the issues of domestic violence, rape and sexual assault and child sexual abuse

The Zero Tolerance campaign has so far addressed the prevalence and nature of violence against women, made the links between the different forms of violence and highlighted the failure of the justice system to protect women. The current campaign was informed by research carried out in

Glasgow, Manchester and Fife in 1997 by the Zero Tolerance Charitable Trust which indicated the need for work targeted at young people on the issue of violence against women. The research study involved over 2,000 young people aged between 14 and 21 years and found that -

- 1 in 2 young men and 1 in 3 young women thought that it was ok to hit a woman or force her to have sex in certain circumstances. The circumstances included if she was 'nagging' or if she was 'his wife'
- Forced sex was more acceptable than hitting to both young men and young women
- A significant minority of young men (36%) thought that they might personally hit a woman or force her to have sex
- Over 50% of the respondents knew someone who had been hit by a male partner
- 50% of the respondents knew someone who had been sexually abused
- Young men and young women involved in the focus group element of the research study commented positively on the opportunity to discuss sex, relationships and violence during the research process and stressed the need for help in this area of their lives
- The attitudes and actions of adults (including parents and teachers) and mass media messages were also key factors in determining young people's attitudes to violence against women

Posters and postcards have been displayed in public toilets, libraries, pubs and other venues which young people use. Text includes 'Kiss is just a kiss', 'Lipstick does not mean sex, kissing does not mean sex', 'Give respect, ensure consent'.

A range of other initiatives have been undertaken to tackle violence against women and to provide improved services to women and children experiencing male violence. These include

- Development of protocols for Accident and Emergency Health Service staff
- Production of a handbook providing advice and guidance to those supporting women who have been raped or sexually assaulted
- Awareness training for staff
- Production of a leaflet outlining services for women experiencing violence
- Development of protocols for housing staff

VI. Strengths, weaknesses, opportunities and threats

I've been asked today to identify the strengths and weaknesses of our work and the opportunities and threats facing us in the future. The particular tactics which have been useful in Glasgow and which we intend to pursue further include

- promotion of the broad social model – everybody's responsibility!
- use of champions – politicians, Senior Officers, media reps
- exploiting existing planning and consultation mechanisms
- provision of good quality, well presented information
- being opportunistic and prepared to take risks
- developing partnerships and creating strategic alliances
- securing wide funding base
- mainstreaming and targeting work with large services which have considerable budgets rather than confining activity to pilots and development budgets
- supporting women's organisations/services who will in turn promote women's health activity with politicians etc

VII. Weaknesses

- Women's health is still viewed as peripheral to the real issues, e.g. although it is accepted that poor housing has an effect on women's health there is still more concern about poor housing than about its impact on women's health
- Women's health is also viewed as women's responsibility. We need to more effectively influence those who are in positions to make decisions and allocate resources – often not women.
- Women's health is still perceived to be about opinions and attitudes and I suggest the same is true about gender equality and gender inequality. You are to believe in women's health, you do not need to learn anything about it. But we all know that there is a body of knowledge. There is an expertise there, which is not recognized by scientists.
- We have got a network of about 70 organizations but normally meetings are attended by 35 women. However a small group of women dominate the discussion because of their experience and knowledge of the work. We are actively pursuing new ways of maximising women's involvement and participation.
- The level of understanding of the social model and our approach to women's health varies.

VIII. Threats

- diminishing resources, in terms of time, in terms of money and staff; we have to be careful of when and how we consult;
- competing demands such as anti racism, male unemployment, homophobic harassment

IX. Opportunities

- There is undoubtedly a general commitment to mainstreaming equality within most of the organizations within Glasgow. The commitment to gender mainstreaming is an important vehicle that can be used to our advantage.
- Another opportunity arises through the commitment to improving public services by developing a customer/citizen focus. It means that when you are providing a service you must think about to whom you are providing it. This is to do with 'added value', with accountability of local government and other public services but can be a means of promoting gender equality.
- There are more and more women engaged in politics in Scotland. The new Scottish Parliament will soon be established and we are expecting almost 50% of women to be elected. There are of course women who are not interested in women's issues but this is something we can work on. There are also more women in management posts.
- There is a new European Healthy City programme and Glasgow will be part of this.
- The UK Government has identified social inclusion as a key priority within its programmes. Within this framework we are trying to ensure that inequality and discrimination are included.

X. A networking opportunity

There is an ongoing discussion about how to use the media and certainly we have tried to take use of it. There is an exciting project called the "World Women Project". It was started about three years ago in Scotland. We have a newspaper called the "Scotsman" and the woman who was the Depute Editor suggested that on International Women's Day that a "Scotswoman" be produced instead. This project was very popular and a major commercial success. It was wholly written by women, developed by women and contained women's analyses of the major issues. It has been done once since then but the plan now is to produce a women's newspaper to celebrate the new millenium and encourage women from different parts of the world to write about the issues that matter to them. The plan is to use the internet to develop the project. Such a project might offer an opportunity for EWHNET to establish contacts with other women who are working on women's health and inequality.

10. Political strategies in the field of women's health. How do national and international strategies meet?

Carol Hagemann-White, University of Osnabrück

- I. Problem
- II. Which Europe?
- III. Which Network ?

I. Problem

At our meeting here we have discussed the need to raise awareness that women's health means a great deal more than - and in fact something very different from - morbidity and mortality equal with those of men. We were concerned that gender mainstreaming in the area of health might even become a boomerang if not linked to an understanding of the circumstances and conditions of women's lives, the specific risks to which women are exposed and the resources which they have and which they need to maintain health in the broad sense defined by the WHO. Furthermore, we agreed that health promotion is inseparable from empowerment of women, and that it requires processes of social change so that women have genuine choices in all areas of their lives.

On the other hand, we have seen that the new enthusiasm of national governments for mainstreaming, which derive in a large part from European-level policy debates and international agreements, sometimes serve as a lever or as an excuse for closing down, or reducing support for women's health projects, even when these are widely recognized and praised for their excellent work. And we have also seen that the seemingly successful introduction of a gender perspective into health promotion or data collection (e.g. in Healthy City programs, European women's health survey) can nonetheless be almost automatically and without second thought perceived and treated in terms of the familiar medical model. If we go beyond the sphere where women's health activists practise continuing awareness-raising in their work, when we look at the field of international organizations or more distant levels of government, the social model of women's health seems to be lost from sight rather easily, and the habit of referring to medical experts as the sole and final authorities on health returns to haunt us.

These observations suggest that we need to think more about how we can take the strategies and approaches that we have developed in local practices and agreed on in national networks, and „translate“ them into the language and policy debates on a European level. How can we create a „voice“ in transnational discussions which could intervene effectively, clarify how to collect truly useful and informative data, and set standards for what may go by the name of women's health promotion?

Note that there are two sides to this need to act transnationally. The European level is an opportunity: there has been success in giving issues of gender equality the status of a political imperative for all countries (for example, when they agree to produce reports on their progress, or when legal norms are established). And European integration is a threat: if we ignore this level of politics - because it is so far away - other groups' definitions of health promotion, social welfare and mainstreaming will fall upon us from above as fait accompli, and it can then be too late to intervene.

Linking our local and national activities with European political strategies is a challenge. I would like to suggest that we begin by giving some thought to „which Europe“ is the most

promising arena for moving towards strategic goals. For the purposes of an overview I have made a diagram comparing the Council of Europe and the European Union. In general, it has been customary to emphasize that these two structures of European cooperation are totally distinct with no overlap between their areas of activity. In reality, this has been changing, and both gender equality and health have emerged as fields in which similar or even identical issues are on the agenda of both the CoE and the EU.

II. Which Europe?

Council of Europe	European Union
40 members	15 members
focus on democracy, human rights, justice, social coherence	core concerns: economy and employment; social issues secondary
awareness-raising; can establish and supervise conventions	dynamic process of TREATIES → pressure to change
politics has higher profile than administration	wields economic power politics by way of administration
has been cutting edge on issues of equality	growing power of parliament → more intervention
health, gender equality and human rights each have primary status in steering committees, conventions, etc.	health is traditionally low-status issue secondary to employment; this can change (as in the case of violence against women)
external influences on policy:	
NGO's and experts	lobbies of interest groups

The differing characteristics of the two Europes suggest ways in which one or the other might prove a better arena for women's health network activity, depending on the goals that we set for such transnational work. Do we aim for direct involvement in the bewildering jungle of regulations, legal agreements and administrative procedures, knowing that these often have decisive influence on what becomes possible or impossible? Or do we aim at creating a political consciousness, to define the issues and the terms in which they are negotiated (e.g. gender-sensitive health promotion as women's human right)?

A second question which needs to be thought through realistically asks about the kind of network that we are able or willing to build. A little consideration soon shows that the choice of political arena and decisions about the organizational structure of the network are mutually dependent or at least interact. The following diagram, to be expanded on in discussion, shows some basic network types with their structural strengths and weaknesses; they are arranged more or less along a line of increasing formal organizational structure as we read down the page.

III. Which Network ?

TYPE	10.1 EXAMPLE	10.2 STRENGTH	10.3 WEAKNESS
individuals	new women's movement; research network	flexible; builds personal trust; furthers self-development	short-lived; needs recruiting; no formal recognition
grass-roots organization	„umbrella“ organisations of women's shelters (e.g. in Germany) WAVE (Women Against Violence Europe)	burdens can rotate; linked to empowerment; secures interchange on local practice; profits from diversity	changing participants; consensus at the price of exclusion; conflict of priorities and resources
network of networks	women's worlds conferences; WISE (Women's International Studies Europe); WHNET in the first year	wide scope for organizing and potential funding; combines continuity and change	depends on good coordinators; national problems often take priority; needs infrastructure
formal council or assembly	10.3.1. European Women's Lobby	established; if funded, can lobby over the long term	no direct „grass roots“; often hampered by diversity

To sum up this brief overview, we see that there are three basic „decisions“ which any network must make in the struggle to emerge as a „voice“ on the transnational level: on the goals that it will pursue as a priority, on the primary arena of activity, and on the type of organization or network it wishes to become. In pondering which path should be taken, it is important to realize that the three are often mutually interdependent (for example, a network of individuals cannot establish a lobby in Brussels unless one or more of them is very rich; thus networks of feminist experts, such as research networks, will probably find the Council of Europe a more adequate arena). The important thing is to decide which (if any) of the three decisions is the highest commitment, to which the others would be adapted if necessary.

11. How to build up a European Network for Women's Health - Experiences from the Women's/Girls' Health Promotion Network in Lower Saxony

Ute Sonntag, Association for Health Promotion in Lower Saxony

Ingrid Helbrecht-Jordan, Institute Women and Society gGmbH, Hanover

I. Introduction

II. The Women's/Girls' Health Promotion Network in Lower Saxony

III. General remarks on networking

IV. How to build a European-wide network

V. Literature

I. Introduction

This paper will describe our approach in setting up a network concerning women's and girls' health promotion in Lower Saxony. In the second part we will make some general remarks on networking. The third part will show the advantages of these considerations for a European-wide network.

II. The Women's/Girls' Health Promotion Network in Lower Saxony

Lower Saxony is one of the northern states of the Federal Republic of Germany. It is also one of the largest states with a mainly rural structure. The capital of Lower Saxony is Hanover, where in the year 2000 the World Exhibition EXPO will open its doors.

How to set up and develop a network?

The idea of a network developed during the every-day-work of the Association for Health Promotion in Lower Saxony (Landesvereinigung für Gesundheit Niedersachsen), which is a state-wide non-governmental organization, coordinating and initiating health promotion in Lower Saxony.

A newsletter on health named „impulse“ is being published quarterly by the Association for Health Promotion in Lower Saxony. The issue with the focus „women and health“ was sent to multipliers in all of Lower Saxony with an offer to cooperate. Thus it initiated a new field of cooperation. The response to this issue of the newsletter was large and very positive. Multipliers in the field of health promotion for women requested an exchange of experience, and advice on political strategies in order to implement health promotion for women and girls in the community. The women's equal opportunity officers (Frauenbeauftragten) were found to be a very important target group, working in local administrations and promoting women's interests.

Based on the good response, the Association for Health Promotion in Lower Saxony looked for institutions which would support these interests. Three institutions joined forces to focus the formulated demands by founding and supporting a network for Lower Saxony: the Association for Health in Lower Saxony, the Ministry of Women in Lower Saxony (which is now called Ministry of Women, Work and Social Affairs), and the Research Institute Women in Society in Hanover.

Which requirements do the supporting institutions have to meet in order to support such a network?

The institutional level: The institutions should expect a benefit for themselves. The network has to fit into the whole profile of the institution. The contents must have or receive high priority in the institution during the process of support. Characteristic for the identification with the network is the readiness to assume some of the costs.

The personal level: Dedicated people within the institution are vital. Women and health promotion has to be personally important to the supporters of the network. The desire to control, which any institution develops in such a network, must be absorbed constructively into one's own institution. One of the main tasks of the contact person should be mediation work between the network and the internal demands of the institution.

The intermediary level: The various institutions should keep their own profile. The identity of the institution has to remain clear. Our own experiences showed that similar profiles of institutions lead to an unfavourable situation. In that case, there will be some sort of rivalry between the institutions. In our case the profiles of the three organizations supporting the network complement each another. The Ministry of Women, Work and Social Affairs sets priorities in the field of politics. The Research Institute provides the scientific support of the network, and the Association for Health perceives the network as part of its role of coordinating measures in the field of health promotion.

Potentials of resources: As a result of these different profiles, the three organizations provide different resources. Money and the time spent by the contact person are the most important resources given by all three organisations. In addition, the Association for Health provides its infrastructure for public relations, including the mail and organizational requirements. The Ministry of Women, Work and Social Affairs provides its political connections. The Research Institute supplies its scientific overview of the women's research literature and its capacity for evaluation, which is carried out in cooperation with the Association for Health.

A network is efficient when there are structural elements of participation

The network in Lower Saxony is an alliance of active multipliers who want to improve health promotion for women and girls in the communities. The aims of the network are:

- developing the competencies of the multipliers,
- strengthening their own initiative,
- initiating empowerment-processes, and
- initiating health promotion activities at the local level.

Successful instruments are conferences, a newsletter and an offer to participate in one of four groups. Initially, the "organizational group" was established with members of the three institutions and women of the network. This was a place where the network members provided their resources and competencies. During the period from 1995 until 1999 this structure has differentiated. Now four groups exist:

- the conference planning groups, in which the next event is discussed and planned;
- the organizational group, which discusses wider perspectives of the network, as well as some aspects of the every-day work (for example, the mail or organizational requirements) and prepares the public relations work;
- the editorial group for the newsletter, published twice a year as an instrument of communication;
- the evaluation group, which carries out a process evaluation once a year.

These structures result in the active participation of 35-40 women from different fields every year.

Up to now, nine conferences took place. Three main dimensions can be distinguished:

1. Some conferences looked at *structural conditions* in the field of women and health. Examples are: „Communication and self-determination of women as clients in the health services“, „Prenatal diagnostics and its consequences“, or: „Which programs are useful for finding partners on a regional level in order to build up intersectoral coalitions for women’s health?“.
2. Some conferences looked at *the connections between the living conditions and women’s health*, for instance „Psychological disorders and health promotion for women in the community“, or: „Female migrants and health promotion“.
3. Some conferences looked at *the connections between phases of life and health*. Examples are: „Girls, their lifestyle and health promotion“, „Pregnancy“, or: „Elderly women“.

The structure of the conferences is as follows: To begin with, there are introductory lectures on the subject. Then, activities and projects which can be reproduced by the multipliers are presented in working groups. The aim of the conferences is to encourage the multipliers to start their own activities and to establish local alliances in health promotion. At the end of each conference a network plenum gets together to discuss questions concerning the whole network.

Between the conferences, the Association for Health publishes a newsletter with information *from members for members*, which contains important dates, job announcements, and suggestions for events. Apart from the conferences, the newsletter is the second instrument of communication within the network. Here is an example of one of the activities, propagated by the newsletter: At the conference on migration we showed a film, called „warrior marks“, concerning the circumcision of women, which was only available in English. Since it was a very good film on this subject, we requested the network members to write to the film distributor asking for the film in German. Right after the newsletter with this suggestion went out, the film distributor received many inquiries. Because of this demand, the distributor produced the translation.

Evaluation is a very important instrument in order to ensure that the needs of the users are met

The network was founded at the end of 1995. We shall now present the results of the process evaluation. In 1996 and 1997 a survey was carried out. The questionnaire included network members as well as users who were not members. In 1997, 240 women were sent a questionnaire, of which 40,8 % participated. In 1998, telephone interviews were conducted with a sample.

Who currently participates in the network?

The network was established as a multisectoral cooperation. At the end of 1998, 114 women were members. They were working in the communities as women’s equal opportunities officers (27 %), in the health services (21 %), in education (4 %), in politics (4 %) in the scientific sector (10 %), in initiatives or projects (11 %) and in non-profit organisations (4 %). 19 % were interested individuals, such as students. Thus we can conclude that the network reaches multipliers from a broad spectrum of fields.

The network aims to support regional efforts in order to implement health promotion in the communities. According to the regional distribution of the 1997 survey, half of the users specify rural areas or small towns as their field of operation (rural areas 30,4 %; small towns 19,6 %). 29,3 % are working in big cities, while 20,7 % say that they work in all of Lower Saxony.

These distributions are a good prerequisite for putting different environments on the agenda of the network and for having an effect in different regions and fields of work. We are very proud of these results, because the rural areas are difficult to access. The evaluation of the first year showed that the big cities were over-represented. We therefore made efforts to contact rural areas more intensively. For example, we held a conference in a rural region in order to receive more input.

The network is not only used by members, but by many women who are not members as well. This emphasises the openness of the network. In 1997 and 1998, 240 and 250 women respectively contacted the network, all of them regional multipliers. This does not include the individual contacts seeking more less intensive advice concerning strategies to implement health promotion for women and girls in the community.

What do members expect from the network?

The following expectations crystallized in the telephone interviews:

- to keep up-to-date in the field of health promotion for women and girls;
- to get ideas and support for their own practical work;
- to broaden their own perspective through interdisciplinary cooperation and exchange.

The interviewed women said that, for the most part, their expectations were met.

On which levels are suggestions made?

In the first year of the evaluation we evaluated three conferences directly. We asked the following question: "Did the conference encourage you to start new activities?" At the first conference, 45 % answered yes, at the second conference even 87 %, and at the third one 55 % answered yes. The qualitative answers showed two main points: First of all, the new impulses for regional activities came from the theoretical and practical knowledge the women received at the conferences, and secondly the conferences encouraged networks at a regional level.

How is networking in general assessed?

In the 1997 survey the users were asked about the general costs and benefits they see in networking. The question was: „The idea of networking is popular - in women's issues as well. But there are different opinions about the benefits of networking. How do you personally judge the following statements?“ Then six statements were listed, referring to the following aspects:

- the cost of networking, i.e. the organizational work;
- the benefits, i.e. gaining knowledge and receiving mutual support;
- the transfer-qualities of networking, i.e. the question whether networking is done as an end in itself or serves to build up women-friendly structures.

The answers very clearly stressed the opportunities and benefits. More than two thirds of the women we asked stressed the potential gain of qualification through networking. The majority considered networking to contribute towards building up women-friendly structures that are in the interest of local women and girls. Other written comments were: *Political demands of women's issues receive more attention through networking.* or: *Networking makes it possible to put one's own activities into a greater context.* Contacting other women who hold the same views is especially motivating. Another comment was: *Only through networking can one occupy public space.*

III. General remarks on networking

The general characteristics of a network

The general characteristics of the initial stage are as follows:

1. There has to be a demand. In our example the Association for Health tested the demand through its newsletter "impulse".
2. A network needs an occasion in order to establish itself. The founding must be prepared.
3. One has to reach a minimal consensus on the target. In our example, the aims of the network were formulated and passed at the foundation meeting.

Further characteristics are:

4. Networking needs active participation. Many people with possibly different viewpoints should participate. This is successful when there is large transparency on the professional identities, the institutional interests, the personal motives, and the cost-benefit-calculation of each person.
5. Renouncing dominance is very important in order to strengthen empowerment processes.
6. Networking means initiating exchange processes. All members agree to give as well as receive.
7. Networking produces external effects and gives ideas for activities and for transferring activities into one's own environment. In our example, other German states are interested in setting up a similar network in the field of health promotion and ask for our advice.

The secrets of successful networking

In 1996, the fourth Annual Conference of the Regions for Health Network, one of the newest WHO-networks, worked out some general guidelines on networking, based on the experiences of five WHO networks: Healthy Cities, Health Promoting Schools, Health Promoting Hospitals, Baby-friendly Hospitals, and CINDI (countrywide integrated non-communicable disease intervention programme). In general the conference proceedings point out: „Effective networking requires first and foremost a basic knowledge of potential partners, their goals and objectives and methods of working.“ (p. 5)

In discussion groups the participants of the conference explored the questions: Who are the key players and what makes them effective? What are supportive conditions and obstacles to networking? What are successful forms and methods of networking? Some of the results are as follows.

Concerning the question: „Who are the key players and what makes them effective?“ the participants stressed that all relevant groups must be involved (*comprehensiveness*), and that the network should try to involve even those people who did not initially cooperate (*enrolment*). Furthermore *maintenance* is important, i.e. one needs people who can assure the continuity of the network. Other reasons for the effectiveness are: *common interests*, i.e. that everyone gains at least as much as the effort or resources they put into the partnership. A very important point is *accepting equality*. This means that differing ideas, perceptions, interests and contributions are recognized and accepted. No network can be successful without the *willingness* of its members to be active participants. That means that all partners are willing to contribute time and effort towards the common goal. To install *self-confidence*, the participants have to define and agree upon the values and purpose of the network.

The proceedings mention, among others, the following conditions supportive of networking: *solidarity* between network members, *internal autonomy* of the agents at all levels within the network, and a *flat hierarchy*, i.e. a decentralization of control, resources, and communication structures.

Obstacles to networking listed were, among others: the *overcentralization* of resources, control, and policy-making. Also very important are *inappropriate benefits* of participation. These occur when agents participate for reasons that are external to the network's purpose and objectives and which do not benefit the networking process.

IV. How to build a European-wide network

A European-wide network aims to install a European voice for women's and girls' health. That means producing visibility at the political level, integrating the EU-nations into a certain structure, and securing more permanent ways of communication.

With this in mind, we shall now list some points that could be relevant for building a European-wide network:

The following aspects are central to the beginning of the process:

- defining the users;
- testing the demand;
- attracting potential participants of cooperation;
- finding a consensus on the target and the goals;
- identifying contact institutions in the participating countries. These institutions have to build up ways of communication within their country or determine existing networks.
- In order to increase the acceptance of the network and the access to different target groups, one should identify several bridge-building institutions that support the work and guarantee the financing.
- Participative structures are necessary to secure the practical relevance of the work.
- Evaluation is necessary, especially regarding effects on politics.

V. Literature

World Health Organization: Networking for Health. Report of the Fourth Annual Conference of the Regions for Health Network 1996, Copenhagen, 1997.