

Dialogue workshop:

Networking for women's health across regional diversity in Europe



Osnabrück, Germany (university and cloister Börstel)
30th of March to 2nd of April 2000

Thematic focus:

Work and motherhood – Risks and resources for women's health

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1. Introduction

On the 31st of March 2000 sixteen European experts, invited in the context of the *European Women's Health Network*¹, came together in Osnabrück for three days discussion on "Work and motherhood – risks and resources for women's health". The thematic focus of the dialogue workshop was intentionally very broad and was chosen to include a wide range of viewpoints.

This dialogue workshop, moderated by Carol Hagemann-White, was the first meeting within the *European Women's Health Network* to include experts from Italy, Spain and Portugal²; its aim was to initiate a broader transnational dialogue on women's health as an issue for gender equality policy. Accordingly, experts were sought from projects and organizations with an interest in promoting women's health. The workshop format was chosen in order to identify issues and strategic frameworks that would be useful to further common understandings as well as constructive controversy. One specific goal was to identify issues on which political energies could be usefully focused in order to profile women's health as a European priority for the future.

In a first introductory round during a public welcoming ceremony at the university on Thursday evening all of the participants presented themselves and the work and objectives of their organizations. This gave a first impression of the diversity of issues involved in health promotion of women. The workshop itself took place in the cloister Börstel near Osnabrück, situated in a rural and lovely environment surrounded by historical sites. Its setting offered the group a peaceful and intensive working atmosphere.

On Friday morning the group began by focusing discussion on selected topics relevant to the practice of participating projects. This gave the group an opportunity to identify important issues within the field of women's health and at the same time to present their work in more detail. Short presentations initiated each session.

2. Mental Health

In her opening contribution to the first session Patrizia Giffoni described the objectives and current work of her organization, the *Centro Prevenzione Salute Mentale per la Donna* (Center for Women's Mental Health Prevention) in Naples, Italy.

The center was created in the context of critical social movements in the 1970s, in particular feminism and the anti-psychiatry movement. In psychiatric institutions women were given twice as much medication as men, and feminists concluded that women patients were not taken as seriously as their male counterparts. Instead they were often just classified as innately depressed or crazy. The challenge to unnecessary and harmful medicalization of

¹ Since 1997, the network EWHNET has laid the foundation for a multifaceted and continuing transnational interchange among women's health groups, networks and associations. Most participants conceptualise women's health broadly in the context of women's lives and share an orientation towards women's self-help in the feminist tradition. Based on a commitment to empowering women, they incline to be sceptical of "high-tech" medicine and criticise existing health care systems for failing to meet women's needs.

² For a list of participating persons and their organisations see appendix below

women led to re-interpreting symptoms such as fatigue and depression. These were no longer seen as derived from women's biology but as rooted in the contradictions of women's daily lives.

The center emerged after a community mental health policy was established, closing down all psychiatric hospitals and transferring mental health care into local responsibility. It is now based in the local unit of health prevention in Naples. Its guiding philosophy maintains that most mental disorders of women - but also, for example, hypertension and breast cancer - are related to oppression and isolation, to work overload and stress, either from multiple and seemingly limitless caring responsibilities or from a double burden of housework and employment. Women's caring is not even recognized as work; instead, women are seen as natural carers, moreover as weak and dependent.

Patrizia Giffoni suggested that the "burnout syndrome" in women results from accumulated stress, in many cases caused by multiple work loads, such as employment outside the house, caring for children, husbands and the elder family members, and organization of the household. The reproductive work can be managed up to a certain limit, but when her energies/resources are exhausted, the woman breaks down. This burnout syndrome seems most likely to occur after certain critical life events such as the menarche, marriage or pregnancy, when women take on additional and essential responsibilities, and the menopause.

The *Women's Mental Health Center* in Naples offers counseling, therapy and prevention. Its clinical work addresses women who have developed symptoms of mental illness, but also women who are not yet acutely affected. For this preventive work the center "attempts to prevent specific distress situations; the goal of this counseling service is to reduce the damage caused by subordination and violence in every-day women's life. It brings their life problems into focus and promotes abilities, awareness and skills to find a solution."³

In other words cure as well as prevention entails encouraging women to recognize that:

- women are confronted with multiple work loads;
- women can and have the right to set limits to their care work - although at the same time, there are tasks they cannot simply refuse, such as seeing to the child's urgent needs;
- women can delegate work to other members of the family;
- most central however is the recognition of women's work, and of the plurality of their reproductive work, by themselves and by others.

However continuing questions arise in connection to this awareness. How can women use this knowledge? Should women for instance educate their husbands to take over responsibilities or should they rather look after themselves first and see to their own needs? Can double shifts of work be seen as resources for wider fulfillment? Can women learn to appreciate their skills, the care work they do and at the same time recognize their limits? And does this combination help them towards self-care and self-esteem?

The debates showed that there are diverse ways to deal with the high and multiple expectations towards women. It became clear that counseling and therapy need to be complemented by broader political demands. There should be a redistribution of caring work, which should be shared by all, men and women alike. When women refuse to do care work

³ Support groups are initiated within the centre which help women to address certain typical problems: work interruptions for pregnancy and child care; difficulties in social relationships; difficulties in either housework or external work, abuse and violence inside and outside of the family; drug abuse.

this should be accepted, because women are not natural carers, there is no justified expectation towards women. Altogether stereotypes of women need to be invalidated, those which describe women as weak, sexually passive, unintelligent and in need of protection by men. Health professionals could give important impulses in that direction.

Another approach calls for rethinking images of work. Redistribution of paid work between men and women, restructuring working hours to be more flexible in response to the demands of personal life, would enable men and women to balance employment and private life.

Finally, as Lucia Mazarassa (Spain) pointed out, there should be recognition of women's (and men's) specific socio-economic situations and class differences, which may impact on their burden of responsibilities and their health status.

3. Pregnancy and Birth

Lola Ruiz Berdun opened this session reporting on her experience as a midwife working in the *Health Primary Care Center* of the Health National Institute in Spain; she has carried out research on 100 women attending maternity classes. Her contribution pointed to how women's very personal health and well-being interrelate with their social and economic position. Based on her clients' reports she interpreted the massive decline of the birth rate in Spain as related to the rising unemployment of women and their fear of discrimination.

Lola Ruiz Berdun learnt from her clients that it is very difficult for most women to have children and at the same time to find or maintain employment. Women fear to lose their jobs in case of pregnancy, because employers believe working mothers to be less capable to cope with the work load than women without children. This comparison is never made between fathers and men without children, for it is still women who are supposed to take full responsibility for the family and do the caring work. There are no initiatives towards changing this situation in sight. Childcare continues to be scarce. Moreover there are no adequate political responses to the increase of female unemployment.

Since the responsibility remains with women they often tend to neglect their own health instead of risking losing their jobs, and as a consequence, fail to claim their legal rights. After delivery, for instance, they may do without maternity classes or medical consultation for themselves rather than missing time from their jobs. They thus put their own health and eventually their children's health at risk. This is particularly true in poorer families, which rely on women's additional income. Women who do not work outside the home tend to have more children and a better economic situation.

Recent legislation has aimed to involve men in parenthood, yet failed to show any effects. Although men are now allowed by law to attend birth preparatory classes with their wives and to be present during delivery itself, in fact they are not accepted in most birth clinics. This is a consequence and also a symptom of persistent beliefs among women and men that pregnancy, birth and the care of children are women's responsibilities exclusively. Thus, pregnant women continue to be supported by female family members and friends in all matters related to pregnancy and birth and men remain excluded. Persistent beliefs and stereotypical thinking among men and women alike resist changing gender roles.

Along with the ascribed role for women as mothers and declining birth rates in Southern Europe goes the wish for a perfect baby. The latter was suggested as one explanation for the extremely high rate of caesareans. With 25% of all births in the public system, and 30-40% in private clinics by caesarean section, Spain's rate is one of the highest in Europe. There might be a lack of shared experiences and information between women. Most striking seems to be women's lack of self-confidence and trust in their own body and its capabilities. In the discussion it was remarked that there is no evidence that caesareans are safer than natural births; the mortality and morbidity rates of children are not lower.

Moreover Lola Ruiz Berdun criticized the lack of service in private clinics in Spain, which, in her opinion, respond even less to women's needs than the public system does. Because women are rarely given a choice of what kind of delivery they prefer, the overall development of medical care is one in which women lose authority over their own bodies.

Patrizia Prospero (Italy) of *Il Melograno*, an information center for motherhood and birth working in the field of active birth, raised three points for discussion with respect to the situation in Italy:

1. Where does prenatal care take place?
2. What kind of assistance is given?
3. Who is entitled to attend delivery?

ad 1. In Italy there is a growing interest in maternity houses. The complex of services these houses offer can be seen as a combination of services previously offered by the public medical system and simple birth houses. *Il Melograno* researched and developed a guide to places for giving birth and thus contributed to more widespread awareness of their service character, raising expectations.

ad 2. The high percentage of caesareans in Italy (30%) underlines the increasing professionalization and medicalization of the process of delivery. There is a tendency for clinics to develop into profit-oriented service centers, led by managers who imitate *Il Melograno* as a well-functioning, attractive model, but without its concern for women's empowerment.

ad 3. At present the role of midwives is decreasing, their work is taken over by clinics. Interest has shifted towards the physical health of mothers, and away from their emotional health. Apart from medical professionals, gynecologists and obstetricians, men are not involved in the delivery of babies. In Italy as well, fathers are usually not present in preparatory classes or during birth.

In sum, declining birth rates, rising percentages of caesareans and a declining role of midwives seem to be the tendency in Southern European countries. This was confirmed by Marguerida Sim-Sim and Maria de Lurdes Santos Rosa from Portugal, where the fertility rate is now 1,4, which is below the level of generational renewal (2,2). Moreover in Portugal, there are no plans to open midwives' training courses (specific academic training in maternal care) in the coming year. The subject of maternity care will be integrated into the training of general nurses, which is insufficient. This can be seen as a trend to disempower women in a very central area of health care.

Strategies to change the situation were discussed. On a professional level, the role and

competence of midwives should be given more weight in order to help women to re-appropriate their bodies. Information such as that given out by *Il Melograno* contributes to a more critical awareness of, and attention to women's well-being. Links to critically oriented gynecologists can support this. Maternal education should be focused on parenthood, not only on delivery itself. Special courses for fathers can inform them about the physical and emotional needs of mothers after birth.

All these strategies entail political demands for empowerment of women both in the professional field (midwives, nurses and also women gynecologists) and for women in pregnancy and birth. More information and more power and support has to be shared among women in order to achieve more self-confidence and thus enable a better health situation, not only emotionally but physically.

4. Gender Equality, Work Organization and Well-Being

In Scandinavia there are higher proportions of women in parliament than in most other EU-countries; this has helped to place relevant issues in the lives of women on the political agenda. It is said that women created the Scandinavian welfare state. Kaisa Kauppinen pointed out that in Finland, the economic activity rate of women has traditionally been high and is currently identical with that of men. But women still face problems in job advancement (the “glass ceiling“), and they are still overwhelmingly responsible for the family and domestic work.

Kaisa Kauppinen described her research on **gender and working conditions in the European Union**; it found great differences in how women combine work and family, and diversity in women's working hours. In the Netherlands, 83% of women with one child, but nearly everyone with two or more children work part-time. But in Finland and Portugal low percentages of employed women with children have part-time work. In most countries long working hours for employed women with children are linked to higher stress and lower job satisfaction, while short working hours are associated with better job satisfaction and lower stress. Men's working hours are more rigid and hardly respond to their family situation.⁴

Kaisa Kauppinen emphasized that sexual harassment and workplace violence are a major problem for women working in health care and social services. They affect women in the workplace across the EU. Also about 4% of women say that they have been subjected to sexual discrimination; as a result they report health disorders, fatigue, headaches and stress.

In Finland burnout is currently a hot topic. It is defined as a serious syndrome that develops at work. According to Kaisa Kauppinen three elements of burnout have been identified and studied in Finnish working life: feeling tired or exhausted, cynicism, and poor professional self-esteem. Especially women in care work are very vulnerable to burnout because they do more client- and patient-related work than men, and empathy is a job requirement.

The group discussed how selflessness and “being a good girl“ are risk factors for burnout. There is a great need for women to look at their own interests and recognize their own limits. Anna Bexell mentioned that the term burnout is not liked in Sweden because it suggests being final. There is a need to re-conceptualize burnout to allow for regeneration.

⁴ Kauppinen, Kaisa & Kandolin, Irja, 1996: Gender and Working Conditions in the European Union

Leonore Nicolai reported that in the Netherlands the first gender specific research study has been done in occupational health. It showed that women in the health care professions often use drugs and run a relatively high risk of addiction.

Lea den Broeder stressed that most of the women in the Netherlands who leave employment for health reasons do so because they have psychological or psychosomatic complaints or complaints that are interpreted as such. Chronic fatigue is one example. Although it is progress that these problems are now seen from a gender specific perspective, somatic illness and physical occupational health issues are being neglected, e.g. toxicology, ergonomics, and noise. Gender has been missing in occupational health reports.

The group discussed measures of prevention. It would be important to educate medicine professionals to recognize that “fake complaints“ of women are real signals. Another issue was the everyday balance of stress (good and bad stress) and resources of women. In one program in the Netherlands medical professionals are trained to help women to find their resources and to avoid bad stress to achieve balance. They are trained to ask about all life conditions, i.e. families, children, homework, work places, relationship etc.

Kaisa Kauppinen emphasized the need for both family-friendly workplaces and organizational justice. Workplaces have to be changed to make jobs attractive for women and men. She described a research and development project - in which she participated - set up by the central labor market agency. The project combines three different measures:

1. It conducts research, develops evaluation criteria on gender equality, and promotes equality planning in work organizations.
2. It encourages innovative work time arrangements to enable people to combine work and family life, and promotes social auditing at workplaces.
3. It carries out research on the emerging cultural diversity at work as well as on attitudes towards ageing and ageism.

The study showed that women suffer much more than men from inequality at work. Women, not men, mainly cited disturbances in well being, poor and tense atmosphere, and conflicts at work. Members of the project created a self-assessment system that could generate ways and means of evaluating the state of equality at workplaces. The goal was to see gender equality not merely as an ethical norm, but as an economic factor contributing to well being, profitability and public image.

In this frame of reference, equality is not understood as referring to gender only, it refers also to different age groups, ethnic groups, and persons with a differing cultural backgrounds. The new term is *diversity*. It is important not to treat women and men as homogenous groups. Thus, it is not enough to seek numerical equality between women and men, since this might mean, for example, rewarding women for fitting into the same narrow and rigid pattern of competitive behavior that has traditionally been demanded of men.

5. Hot Topics

After discussing three areas in depth, the group collected ideas about “hot topics“ that have the potential to become major women’s health issues.⁵ Only some of these could be discussed. One such hot topic was sexual education. Marguerida Sim-Sim (Portugal) reported that in

⁵ For the list of all collected topics see appendix below

Portugal there is a high level of teenage pregnancy. Although the government mandates sex education there is little implementation in schools. Girls might have one class session about contraception and other issues but there is no continuity and often they don't use the information given.

Differences between the South and North of Europe were suggested. In the Southern European countries, for example, sexual education is primarily focused on the prevention of sexually transmitted diseases. It hardly allows for talking about pleasure, much less fantasies. While in the Northern European countries sexual education is implemented in schools and perhaps more liberal, there is little preventive work on aggressive or violent sexuality.

Goals of sexual education might be to give information and talk about pleasure, contraception, and responsibility. One approach offered by Marguerida Sim-Sim centers on recognizing a plurality of sexualities. To overcome stereotypical thinking she teaches students the concept of a "continuum between hetero- and homosexuality", which allows everybody to move on and to occupy different spaces.

Anna Bexell (Sweden) described her experience counseling university students on psychological and health issues. She recognized that young people today have strong conviction of their right as humans, but there seems to be a widespread devaluation or even perhaps hatred of the feminine. The number of girls with eating disorders is continually increasing. Girls are very open to speaking about sexuality but many are insecure about what is expected of them in practice. Anna Bexell sees a denial of the female body, which the girls want to control but can't feel. It was mentioned that in Scandinavia and the Netherlands a lot of cosmetic surgery is done.

6. Differences and Questions for Future Co-operation

After having defined and discussed some key issues in health promotion for women, the group was asked to think about differences in how women's health needs are perceived (and responded to) in their respective countries. As explained by Ute Sonntag (Germany) identifying differences and defining common research questions are a primary interest of the European Women's Health Network.⁶ Differences deriving from cultural backgrounds, philosophies and health systems (theories and structures) - if understood and identified - could be used constructively in promoting women's health. Common strategies could be found.

In order to trace differences the participants tried to identify important women's health issues that have been neglected in the respective countries, and that need to be put on the political agenda. One important aspect raised by Leonore Nicolai (the Netherlands) was the overemphasis on mental health and on psychosomatic complaints of women, both in the medical system and in everyday thinking.

Regina Stolzenberg (Germany) reported that, while women's health centers in Germany do give attention to women's bodies and somatic problems, medical health professions also seem

⁶ These differences could be taken up and further discussed in future working groups developed within the European Health Network. Further aims of the European Health Network consist of (i) strengthening national networks, (ii) collecting models of good practice (iii) identifying issues to be put on the political agenda, (iv) influencing policy sectors nationally and EU-wide and (v) developing common European standards;

to focus increasingly on psychosomatic and mental health problems of women, such as eating disorders or depression. This may indicate a trend towards psychologizing women's health, drawing attention away from real physical diseases of women. However, she is also concerned that emphasizing the body has been characteristic of an individualistic approach in the women's movement.

The women's health movement in Germany as well as *Aletta* in the Netherlands have addressed this neglect. They have tried to foster a more holistic approach and also put women's bodies and the social dimension of health more into the center of attention. More recent developments however – *Aletta* has been closed and the women's health centers in Germany have never been institutionally integrated in the public health systems – show that there is still a general lack of attention to bodily health of women in the medical system. With the exception of gynecology and obstetrics, neither money nor effort is invested in research on gender related courses of chronic diseases such as rheumatism, MS, cardiovascular or respiratory diseases. There is not sufficient knowledge and there are few experts who further a gender perspective in medicine.

As further areas needing gender sensitive-approaches and research toxicology and epidemiology were named. According to Kaisa Kauppinen there is excellent toxicological research being done in her country, also at the work place, but it lacks a gender sensitive approach.

The emphasis on mental disorders and gynecological problems has an additional implication for women's lives. As Kaisa Kauppinen stressed, employers tend to believe that women constitute risk factors due to their biology. Young women fall pregnant, elder women may “suffer“ from menopause. If women are also described as prone to psychosomatic disorders, this thinking could be reinforced. Employers often lack awareness that women are neither a homogenous nor a risk group.

In sum: in the northern European countries there seems to be a one-sided approach to women's health – focusing on mental health and gynecology while neglecting physical health. The effects of widespread medicalization of women seem to be ambiguous. On the one hand women express the need for optimal services, information and security. On the other hand they delegate the authority and control over their own bodies to medicine and thus contribute to their own disempowerment. Current debate in the women's health movement seeks ways to retain what has been gained while counteracting the imbalances that have emerged.

The focus of discussion in the Southern European countries as analyzed by the participants from Italy, Spain and Portugal were women's roles in day-to-day caring, in the health professions, and in the political arena. Patrizia Prospero (Italy) raised the question of how to effect changes in the health system so that women's needs are more effectively met, to achieve a system that takes better care of women. As an example she pointed to the need to include a gender perspective in the education of all health professionals, such as doctors, midwives and nurses.

The recent (1999) law in the Netherlands that gender issues should be included in the curricula of all health professions has no parallel in Italy or in the other European countries yet. In order to integrate a gender perspective and to achieve a women-friendly health care system quite a few steps have to be taken. Research needs to be done and the gender perspective clearly defined, sensibly balancing the dimensions of difference and similarity.

Moreover detailed proposals have to be elaborated of how to include the necessary knowledge in training programs and curricula. Most of all a common understanding among professionals, politicians and teachers in the health professions of the necessity of this perspective is needed.

Furthermore, Patrizia Proserpi criticized that reproductive health services in her country do not meet the needs of women. Only very few clinics follow the example of *Il Melograno* and offer all possible services. Moreover in Italy midwives have far less power than gynecologists. This takes us back to the question of who determines those services; the political participation and leadership of women are crucial to bringing about change. Should women continue to work within informal networks, lobbying and trying to find allies at the decision making level, or is more presence of women in professional organizations and in politics required? Which approach to leadership of women should be developed?

In Portugal, as Marguerida Sim-Sim reported, the failure of reproductive health services to meet the needs of women does not derive from an absence of good laws, but from the cultural and religious tradition of the country and the health system's philosophy. Recurring to the biblical words on women's suffering while giving birth, pain is seen as natural and even necessary. Women's well-being is not a concern. Thus, there is a need for more women researchers and also more political participation of women who publicly reject the model of pain and suffering and promote the concept of women's well-being.

Another issue raised by Marguerida Sim-Sim and Maria de Lurdes Santos Rosa is the need for a more open model of sexuality and better information and education of the population. Cultural and religious traditions continue to inhibit public discussion of such issues as sexual orientation, contraception, and sexually transmitted diseases, HIV etc. These are not sufficiently addressed in schools or in other educational institutions.

Altogether, both women's well-being and the responses of the health and educational system in Portugal are affected by a culturally shaped belief system. Organizations such as *Family Planning Association* as well as individuals emphasize the need to integrate a gender perspective in the health system and to support the work of women researchers. It was noted that the Portuguese - as well as the Spanish - health movement does not work through women-only organizations in the health movement, but within mixed-sex health organizations.

All participants stressed the need for more health promotion for women in their countries and stronger integration of a gender perspective in research as well as in education. In the Northern countries resistance to this development seems to be more subtle whereas in Southern countries cultural beliefs are more likely to obstruct changes in the health system directly.

7. Organizations and Strategies for Change

Given the different historical and political background in the countries of Europe, one goal of the workshop was to identify organizations and collective actors that might be important allies in promoting women's health issues. Strategic alliances can help to mobilize political energy to reach such goals as more leadership and presence of women or lobbying in the field of women's health.

In this session, a number of types of organization were mentioned, including international and national medical women's associations, the associations of women in health professions, women's NGO's, schools of public health, family planning centers, motherhood centers and of course women's health organizations that work on specific issues. Mixed federations in the health professions, trade unions, labor organizations and university departments, especially centers for women's studies might also be important allies as well as patient's associations (general or specific, e.g. women suffering from breast cancer) and self-help groups.

These organizations differ substantially from country to country with respect to the power they have in the field of women's health and their openness to gender issues. For example, in Scandinavia the trade union and labor organizations in the health sector are the umbrella organizations for the midwives' and the nurses' associations, which are quite strong. In Italy and Spain these associations are linked to the associations of women in health professions and seem to have less influence. The weak position of women's health professions was illustrated in Portugal in 1999, when the schools for midwives were closed. In Italy an influential appointed commission of the ministry of equality works on women's health issues and is linked to a network of women in the public health area.

After collecting organizations and actors which might be important allies (at least potentially), discussion turned to strategies for dissemination of information and the implementation of gender perspectives in the field of health. One approach is to find key persons within the organization who could act as multipliers for a gender sensitive approach to health issues; it might be useful to win influential individuals for an "advisory board". Another strategy would be a systematic effort to reach the media, using them to bring concerns, demands and information to the public. There is a need to learn how to "feed" the media in the interest of women.

In the Netherlands the *School of Public Health* has had good experience with cooperation between commercial firms and health promotion. In a project on girl's lives and health promotion they cooperated with the "body shop". This turned out as a very successful project with many publications in the media.

8. Issues and Controversies

In the last session the participants sought to identify common issues that might be considered worthwhile for future transnational collaboration. At the same time, some sharp differences of opinion were brought to light and successfully aired, although they could not be discussed in depth. The session was focused on the overall theme of the workshop: the combination of motherhood and work and related health implications. European cooperation was seen as all the more necessary because employers' organizations are lobbying on an EU-level, seeking to restrict maternal protection at work.

The issue of women's double work load can be framed in different ways. In the session on mental health, emphasis was on the dilemma women face when having to cope with double work loads while their socialization makes it difficult for them to set limits, so that they are vulnerable to burn-out syndrome. This issue generated heated discussion and different interpretations around the image of strained working mothers. The focus should be on the

strengths and social competence of women, their ability to cope. The so-called double shift could also be interpreted as double resources. In contrast to most men, women might consider a fulfilling family life and housework as compensating for a stressful time at work – or vice versa. Nonetheless, health implications of a gendered division of labor should not be ignored.

Continued disadvantages and discrimination at work, combined with the risk of losing the job altogether, cannot be good for women's health. Inequality damages women's health indirectly when they lack job satisfaction, are more prone to frustration and develop symptoms of stress. Combined with a monotonous or unsatisfying job, housework can compound this frustration. The burden of care work may then be perceived as heavy and unbearable, whereas if there is satisfaction at the work place, it can be a resource. However there is still far too little research on women in specific job situations and health consequences.

In addition to looking at specific situations of women one also has to consider that women are not a homogeneous group and that they might experience double shift of work in different ways. Some are more affected than others by stressful situations and women have different coping strategies. This certainly has to do with their environment, with the economic and political structure of the respective country or region and of course with their own economic background and social situation.

As Carol Hagemann-White suggested, it is important to develop an exact analysis of the realities of women's lives in their concrete social and cultural situations. The question is: for whom is the "second shift" or "role overload" a problem? When there is overload, where does it come from? The problem should be taken apart and different experiences and styles of combining employment and motherhood looked at.

A further controversial issue was the approach to changing the gender division of labor. Should women educate husbands to take over responsibilities? This might be one way for women to get relief from work and to make life easier. From the therapist's point of view however, working with women showing severe symptoms of burnout, the approach is that women should look after themselves first, before they think about educating others. At some stage they have to see to their own needs, if they do not want to break down. Different views were voiced about the choice of some professional health projects to educate men (or fathers).

Lea den Broder and Leonore Nicolai (the Netherlands) pointed also to the danger of overemphasizing stress and exhaustion. If working mothers are perceived as overloaded and stressed and likely to develop a burnout syndrome, potential employers will not be interested in hiring them.

Regina Stolzenberg (Germany), thinking of the Swedish model of parental leave, spoke of the need for laws that would provide a better protection for mothers while at the same time encouraging men to take paternal leave and take over household and family care duties. But in Sweden, as Anna Bexell reported, the situation is far from ideal. 60% of all pregnant working women do not carry on working until delivery, but take sick leave and stop working about two months before. The frequency of back and pelvic girdle pain has gone up in recent years, underlining the physical and emotional strain accompanying pregnancy.

Some European countries have responded to specific work place related health risks for pregnant women, such as toxicological substances or cigarette smoke. Finland passed a law prescribing pregnant workers' protection; all work places – with a few exceptions – are non-

smoking, and if they are not, employers have to remove women in case of a pregnancy. Such exceptions again make it less attractive for employers to employ women.⁷ The tensions between meeting women's health needs and eliminating discrimination remains unresolved, and some controversies result from the practical commitment to one or the other choice among strategies which are all, in some extent, unsatisfactory.

Overall the final session showed that the two-day process of sharing experience and seeking to understand other perspectives on common issues had created a foundation on which pointed controversy could be enjoyed.

9. Reflection

The dialogue workshop was a first step towards broadening the **European Women's Health Network** by involving organizations and experts from Southern European countries. The working atmosphere was very constructive and friendly throughout, supported by the lovely rural surroundings of the cloister Börstel.

All participants were very open to hearing about the working situation, approaches, strategies as well as organizational problems in the different countries. There was a lively interest in learning about projects and activities in other countries, in gaining deeper understanding of their approaches, and identifying levels of commonality as well as differences in this field, including differences in social, economic and cultural backgrounds. After a basis of mutual understanding had been laid, it was possible to begin debate on controversies and differing opinions on specific issues; the participants entered into this part of dialogue with enthusiasm as well. Many important issues in the field of women's health were discussed, giving a first insight into the backgrounds of different organizations and countries. However, a more extended awareness of the many dimensions of diversity is needed, and their in-depth discussion was not possible within the time frame of one such meeting.

Often, the relevance and importance of specific issues seem to be specific to a region or country. In Spain, for example, the declining birth rate and the rising unemployment of women were seen as interrelated symptoms of a major problem, and similar trends were described in Portugal and Italy. By contrast, in the Northern European countries the central concerns related to women's employment status were questions of women's identity, self-esteem and balancing of roles and burdens. A transnational dialogue thus must expect to encounter different priorities in the women's health organizations from different countries. There also needs to be sensitivity to the different ways of framing apparently similar issues.

Many differences in points of view or priorities appear to grow out of the concrete practical work in which participants are involved. Each organization has an underlying philosophy or basic approach, each develops its focus from working with specific groups of women or with local cooperation partners, and on this foundation develops a unique perspective on more general problems. Had the workshop invited participants from all of the same countries, but from quite different organizations – perhaps midwives from Scandinavia and occupational health researchers from Spain and Portugal – we might have seen other patterns of difference and agreement. It would be rash to assume that each participant spoke for her country or

⁷ As a matter of fact the protection of pregnant women at the workplace is regulated under the European directive 90/679/CEE. However the member states of the EU have been hesitant and slow in implementing this regulation through their national laws.

culture as a whole.

Nonetheless, the course of discussion over three days does suggest that certain accents, implicit assumptions and ways of framing issues and questions might be more typical of how women's health is thought of and worked on in the European regions. This closing reflection is a place to sketch what such differences in perspective might be.

The contributions from the Southern European region, although they included a marked difference of opinion among them on the desirability of investing women's energy towards changing men, shared an underlying theme of women's caring and care work. Valuing and recognizing women's commitment to caring and the responsibilities they carry in this sphere pointed, on the one hand, to the ensuing problems of overload, stress, lack of respect and rewards, difficulty of setting limits, and burnout, with negative effects on both mental and physical health. Contradictions within women's ways of coping with the demands on their caring and its simultaneous devaluation in society were discussed: For example, the low birth rate and an emotional investment in the one "perfect" child can make women accomplices in their own disempowerment (over-medicalization of birth, neglect of their own health). However, the underlying theme of women's caring also offers an approach to seeing women's real and potential power, and in fact, it was most often from this context that the question of increasing women's political involvement, furthering women's leadership and actively seeking political power for women was brought into the workshop discussions.

Women's health organizations in the Northern European countries seem more preoccupied with achieving equality in the sphere of work, and move from there towards issues of political influence and shaping policy. The recurring theme in these discussions might be understood as the paradoxes and ambivalences of apparently successful emancipation. Care work, in this perspective, is framed as a choice, so that there was debate on part-time employment as a solution for women who balance paid work and family involvement, on the implicit assumption that individual women could choose the mix best suited to their wishes. Many topics coming out of more Northern regions represented in the workshop pointed to a persistent and baffling dilemma: as long as the devaluation of women or of the feminine permeates our culture, every progress hides a backlash. Liberalizing sexual norms and overcoming the old double standard also places girls under pressure to comply with new sexual demands; awareness and understanding for the psychosomatic and mental health problems deriving from the typical pressures and indeed violations in women's lives leads to ignoring very real dangers to women's physical health; giving legitimacy to women's combining employment with family and care work gives employers new reasons to discriminate against them, more subtly than before. The search for solutions to these dilemmas tended to focus on structural measures and mainstreaming, demanding that women's health - or the twofold goal of gender equality and gender-sensitive health promotion - be defined as a priority everywhere, at work, in education, in politics.

All participants pointed to the lack of gender-sensitive research and the lack of integration of a gender perspective as obstacles to achieving a women-friendly health care system. One step forward was recently taken in the Netherlands where a law was passed requiring the curricula of all health professions to include gender issues. Thus far no parallel was found in other European countries. There is a need for (comparative) research as well as for clearer definitions of the meanings of a gender perspective, which might profit from awareness of the regionally and culturally differing frameworks and underlying assumptions that this workshop could only begin to illuminate.

In the feed-back session it became evident, on the one hand, that all participants see a need for a transnational exchange network and see such interchange as empowering and enriching. Personal contact was seen as very helpful, offering possibilities in finding partnerships and networks for future cooperation. On the other hand however, the participants recognized that difficulties and problems within their own organizations often require their full attention and working capacity and saw this as a possible problem for commitment to a transnational exchange network. Evidently, the cooperation process needs to be shaped in a way that gives its participants additional resources for their local practical work. One way to achieve this might be to focus on strategies capable of transfer or adaptation to another context. Thus, it would be helpful to exchange strategies (even if they are not applicable to all countries) that empower practitioners and activists and motivate them in their respective working arenas. A continuing productive dialogue gains its „European surplus value“ from this process.

Appendix

1. Issues that need further discussion:

- Power of women - empowerment and mainstreaming
- What have been the changes (gains and losses) in women's lives over the last 20 years?
Who has been promoting them?
- Strategies and ideas for women to enter in political life and to put women's health issues on the political agenda
- The role of the NGO's and networks of women in order to get more political influence
- Female images in society
- Maternity image in audiovisual media and effects in women
- Indicators on well-being and quality of life
- Women as victims or actors?
- Ethnicity, gender and health
- Health promotion
- Reproductive technology
- Medical curricula/training
- Causes and effects of violence on health
- Child care facilities (state of affairs of policy) in the different EU-countries
- Age(ing) and women
- Sexuality
- Mammography – Screening
 - experiences
 - challenges
 - dangerous aspects
 - cultural changes through technique
- Vaginism
- Biological/somatic health issues:
 - menopause
 - osteoporosis
 - rheumatoid arthrosis
 - eating disorders
 - multiple sclerosis
 - thyroid diseases
 - breast cancer
 - gynecological complaints
 - incontinence

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3. Introduction to the organizations

The **Netherlands School of Public Health** has its mission to promote public health by providing postgraduate training and supportive programmes, and by carrying out research in the field of public health.

It has a role as

- The national school of public health of the Netherlands
- The meeting place of academic and practical public health
- National and international centre of excellence in the field of postgraduate training in public health

The **NSPH** views a gender specific approach towards public health as a way to raise quality in the field of public health. Therefore the **Unit Gender & Health** was grounded in the year

2000. This is even more important since the largest organization in women's health care, **Aletta** was closed down at the end of 1998, leaving a large gap in gender specific health care. Part of this gap will now be filled up by other organizations, including the **NSPH**. Activities of the unit include training, projects and (in the future) research.

The **WHO Europe** started a **Women's and Reproductive Health (WRH)** Programme. It focuses on implementing seven areas of work recommended at the Cairo International Conference on Population and Development (ICPD) and the Beijing Women's Conference.

The evidence base is:

1. Current publication development

➤ *Family Planning and Reproductive Health in the CCEE/CIS*

This document outlines the profound and rapid changes that have taken place in the recent years in the countries of central and eastern Europe (CCEE) and the Commonwealth of Independent States (CIS), and reveals a particularly disadvantaged group in these countries: women. The new edition has just been completed

➤ *Women's Health Profiles*

Each profile outlines many of the social, political, economic and medical characteristics and experiences of women in the Region's Member States. Profiles for 39 EURO Member States were produced in 1997. An additional six countries joined the survey in 1999 and will be added to the 1999 update Profiles

2. Current research activities

➤ National surveys are currently being conducted in reproductive health in cooperation with other United Nations agencies.

➤ *East-West Scientific Working Group*

This group examines how Western Europe can assist the East with surveys and other research projects. The group supports national research initiatives on reproductive health in cooperation with **WHO** Headquarters.

The **Finnish Institute of Occupational Health** as a specialist organization with six regional institutes and a staff of 500, this Institute conducts appropriate research and helps solving problems associated with work places.

Research (39% of time, 180 on-going projects), advisory services (42% of time), training (150 courses annually), and dissemination of information (periodicals, newsletters, online information and library services through the Information Service Centre) are the core activities.

Anna Bexell is in the University of Lund (Sweden) responsible for the advisory of students in health care issues.

The Italian **Centre For Women's Mental Health Prevention** has its activities in following areas:

➤ Research about women's stress, adolescence and risks of psychopathology and connection between depression and violent events.

➤ Prevention activities in three areas:

1. female adolescence, body image and risks of anorexia/bulimia
2. female stress connected to an overload of family life caring
3. women and their dependence in situations of violence

➤ Counselling activities

➤ Organizing different seminars, conferences and meetings dealing with women's health issues

- Training projects
- Networking

Il Melograno, Information Centre for motherhood and birth, is an association with several centres in Italy that works in the field of active birth. The Roman centre was created in 1983 with the following goals:

- To promote the application of the recommendations formulated by the WHO (“Technology appropriate for birth “ May 1985)
- To support women in experiencing motherhood and birth as protagonist for, with respect for their own choices, individuality, culture, wishes and needs
- To promote culture of birth respectful of the physiological rhythm of birth, intimacy, emotions, affective needs of the couple and the baby
- To guarantee a continuity of assistance during the complete period from pregnancy to birth, to puerperium to the beginning of the child’s life
- To encourage women to share the experience of motherhood and not to feel alone.

The **National School of Public Health** is the eldest institution in the field of education and training in Public Health in Spain. It has three basis functions deeply related in the field of Public Health: teaching, research and assessment and evaluation of health related matters. The main teaching objective of the School is postgraduate training.

After the Fourth Conference of Women in Beijing, the **NSPH** began to build up a strategy to incorporate gender perspective in its activities. Since 1996 they have had a Collaboration Agreement with the Women’s institute, a body dedicated to gender equality in Spain.

The objectives of this agreement are:

- To share information between these two institutions, whose aims are to adapt training and research to the needs of women so as to avoid gender bias.
- To develop training programs for the health professions involved in health assistance programs for women.
- To support the development of didactic materials to facilitate health education activities addressed to women.
- To promote research that contributes to the illumination of health differences between men and women.

The **Federación de Panificación de Espana (FPFE)** is a Non Governmental Organization specialized in all areas related to family planning and reproductive and sexual health within their widest context.

FPFE provides services, counselling, research, information and training to professionals, institutions and individuals in the various areas of sexual and reproductive health and rights, pregnancy, family planning, youth, sex education, sexually transmitted diseases or HIV/AIDS, among others, working at both national and international level.

Founded in 1987, **FPFE** relies on member organizations from several autonomous communities throughout Spain. **FPFE** is member of the International Planned Parenthood Federation (IPPF).

The Portuguese **Family Planning Association (APF)** was founded in 1967, it’s a NGO, federated in the IPPF.

APF develops programmes and activities concerning family planning, sexual violence, abortion, prevention of sexually transmitted diseases and HIV/AIDS, school sex education, counselling, information/educational materials, training and training trainers and networking with other organizations and service providers.

The working groups from **APF** are constituted by volunteers and professionals from different backgrounds: Health, Education, Human Sciences, Justice, Psychology, Social Work and others.

Since 1996, after the improvement of the IPPF Charter of Sexual and Reproductive Rights, the **APF** has been very active in improving the dialog with the government and other NGO's to shift the emphasis from family planning and sex education to the much broader issue of sexual and reproductive health and rights.

In **University of Osnabrück** the chair of EDUCATIONAL THEORY AND WOMEN'S STUDIES is represented by **Prof. Dr. Carol Hagemann-White**.

In this unit following areas of research are presented (also in projects):

One of them is the **Socialization and the construction of gender: interactional and structural processes and constraints**. The ongoing empirical project studies the *Interaction of nurses and physicians in hospital wards: The construction of gender, hierarchy and professional socialization*.

The second major research area is **Violence against women & sexual violence: strategies for intervention, prevention and social change**. In this area empirical studies have been completed on *Peace practice against everyday violence – Preconditions for inter-agency cooperation on violence against women* and a related study of *national and nationalist orientations among women*. The most important current project is the *Evaluation research on community responses to domestic violence in Germany*.

A third research area concerns **Women and Health; working in health professions, networking for gender-sensitive health promotion and health care**. The Osnabrück group participated as one of five institutes in a comprehensive report on the *Health situation of women in the Federal Republic of Germany*, contributing an empirical study of women-friendly health care practices. Another ongoing part in this area is the project evaluation of the *European Women's Health Network*.

The fourth working area is **Women, power and the politics of emancipation / equality**, including consultations for the Council of Europe and the European Women's Lobby.

The **Landesvereinigung für Gesundheit Niedersachsen e.V. (Association for Health Promotion in Lower Saxony)** is an independent association for health promotion, health education and prevention. They collect and review health related information and train professionals active in the fields of health, social work and education in regard to the topics related to health.

They initiate and accompany health related networks and working groups. They plan and realize practical projects in their fields of activity.

They promote the cooperation of different disciplines.

The activities of the **Landesvereinigung** are based on a widely defined concept of health according to that of the WHO. The concept assumes that health consists of physical, mental, social and ecological aspects and is influenced by everyday life conditions.

The **Landesvereinigung** is the coordinating institution of the **European Women's Health Network (EWHNET)**.

The **Internationales Zentrum für Frauen Gesundheit IZFG (International Centre for Women's Health)** in Germany is a newly founded health centre. One of its goals is to introduce the results of international research on women's health and of practice in this field into the German Health Care System, and to raise public awareness for them. Another objective is to approach women's health with a broader definition promoted by the Ottawa

Charta of the WHO. It means to take social differences as much into account as biological ones.

Together with the **Arbeitskreis Frauengesundheit in Medizin, Psychotherapie und Gesellschaft (AKF)**, an association of health professionals psychotherapists and researchers, lobbying for women's health interests, the **IZFG** is planning a conference in September 2000. Health activists and professionals from different European countries are invited in order to learn about models of good practice in other countries and to discuss relevant questions and possible strategies to promote women's health on a European level.