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INTEGRAZIONE DEL PUNTO DI VISTA DI GENERE nel GREEN PAPER

Abbiamo evidenziato la necessità di fornire indicazioni e commenti al green paper per introdurre il punto di vista di genere. La mancanza di questo punto di vista potrebbe rendere non corretta o parziale “la strategia globale dell’UE a favore della salute mentale”.

Le nostre osservazioni sono indicazioni di massima: siamo ovviamente disponibili a collaborare con la Commissione su una elaborazione più ampia ed articolata dell’inclusione del punto di vista di genere nella strategia comunitaria per la promozione globale della salute mentale.

Le nostre osservazioni sono articolate in due documenti su file separati:

- 1. commenti nel corpo del green paper : “commenti al libro verde”**
- 2. riferimenti a supporto dei commenti: “riferimenti dei commenti al libro verde”**

Introduzione

Dal 2000 In Europa (Organizzazione Mondiale della Sanità – Regione europea) e precedentemente negli Stati Uniti (National Institute of Health) la salute comincia ad essere coniugata secondo il genere e l’appartenenza etnica oltre che secondo l’età e lo stato sociale.¹

I documenti che coinvolgono la salute dei cittadini devono quindi confrontarsi con queste indicazioni sulla integrazione del punto di vista di genere. In particolare il principio della integrazione del punto di vista di genere è un fatto assolutamente prioritario nella ricerca e nella prevenzione, là dove cioè è determinante per la salute l’individuazione dei fattori di rischio e di protezione, che sono indissolubilmente legati alle condizioni di vita, alla storia sociale, culturale e sessuale delle persone,

Finalizzata a questa operazione di inclusione del genere, che riprende una analoga operazione svolta dal WHO: “Operationalizing HEALTH21 for the health of

¹ U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES - National Institutes of Health
Outreach Notebook for the Inclusion, Recruitment and Retention of Women and Minority Subjects in
Clinical Research

women”², è la raccolta delle proposizioni più significative sul rapporto genere e salute e sul rapporto genere e salute mentale.

I paper citati in avanti indicano tutti concordemente che:

- esistono e sono tutte documentate le differenze di genere relativamente a: epidemiologia e diffusione delle patologie psichiche, decorso delle malattie, fattori di rischio e percorsi di prevenzione;
- le differenze di genere devono essere prese in considerazione nella ricerca e nei servizi. Ricerca e servizi devono cioè essere sempre “gender sensitive” ovvero capaci di differenziare per uomini e donne lungo il corso della vita, dati e casistiche, programmi di prevenzione, cure ed organizzazione di attività.

Prima di ogni cosa è necessario distinguere il genere dal sesso:

WHO, Gender Mainstreaming: *about Gender*

Gender is used to describe those characteristics of women and men which are socially constructed, and sex refers to those which are biologically determined.

Strategic Action Plan for the Health of Women in Europe, WHO 2001

Target 6 – Improving mental health

By the year 2020, people’s psychosocial wellbeing should be improved and better comprehensive services should be available to and accessible by people with mental health problems.

While patterns of morbidity in men and women and their significance are still a matter of debate, the excess of female psychosocial distress is undisputed. Women across the world have significantly higher presentations of mental health problems than men and the types of disorder generally differ. Women are more likely to be adversely affected by specific mental disorders, the most common being: depression and anxiety-related disorders; the effects of domestic violence; the effects of sexual abuse; and escalating rates of substance abuse. There is also a greater prevalence of parasuicidal behaviour in women. Addressing mental health needs in Member States requires appreciation of the differences in etiology, manifestation and duration of problems experienced by women. The preponderance of depression, for example, has been linked to the greater stresses experienced by women in poverty, which heightens their isolation and social exclusion. The double burden of motherhood and work has been identified as a contributory factor in the poor mental health of disadvantaged women. Much of the female excess in mental health problems is attributable to the pervasiveness of gender inequality, which includes direct and indirect discrimination and the cultural devaluation of the female. In relation to employment, for example, women experience discrimination in the workplace such as unequal pay, greater job insecurity, more part-time work and sexual harassment. Similarly, the endemic nature of violence against women across all

² **dipartimento Gender and Health della Organizzazione della salute mentale: In Strategic Action Plan for the Health of Women in Europe Endorsed at a WHO meeting Copenhagen, 5–7 February 2001**

societies also has a major impact on their mental health. Studies consistently demonstrate higher levels of psychosocial distress including 18 Strategic Action Plan for the Health of Women in Europe post-traumatic stress disorder (PTSD), eating disorders, self-mutilation and depression in women subjected to male violence.

The identification and implementation of measures to reduce gender inequality are thus prerequisites for sustainable improvements in women's mental health. In relation to health services, there has to be a shift in recognition of the above factors contributing to women's mental health problems, which will require training for mental health professionals to detect and respond appropriately to women's needs.

Integrating mental health promotion interventions into countries' policies, practice and mental health care system (the IMHPA Project)

I. Final Report to the European Commission DG SANCO/G October 25th, 2005

7.2 Future development: European Platform for Mental Health Promotion and Mental disorder prevention During the different brainstorm sessions and project meetings key areas that needed further development were identified by project partners. Long discussions were held around the lack of access to the evidence base, the lack of information at the country level of the situation of prevention and promotion that could identify the gaps and help build action; the lack of a trained workforce for prevention and promotion and the lack of information systems that would make the knowledge available across Europe. In order to continue and build forward on the products and synergies that had been created during the Imhpa project and with the intention to move the field forward and close the gaps between needs for action, a new project, the European Platform for Mental Health Promotion and Mental Disorder Prevention was outlined. This project aims to build on the Imhpa project and expand its work and partners to become the European Network for Promotion and Prevention in Mental Health. The aim of this network and new project development is to develop a comprehensive strategy to tackle prevention and promotion in mental health developing an integrated approach to information, intervention, training, policy and implementation, as identified during the IMHPA project.

The three main objectives include: 1. The creation of a European Platform for mental health promotion and mental disorder prevention; 2. The development and integration of indicators, interventions, training and policies for mental health promotion and mental disorder prevention; and 3. The development of capacity, dissemination and implementation of information and action across European Member States and applicant countries. The European Platform, with the collaboration of all its partners, will develop a comprehensive strategy for MHP and MDP, composed by the work and products developed under seven work packages: 1. An information system on available policies and infrastructures on MHP - MDP across Europe. Aims to assess and develop a monitoring system on available infrastructures and policies for mental health promotion and mental disorder prevention. This work package is linked to the HP-Source database for Health Promotion and builds on the work already started by the Imhpa project. Following the model initiated by Imhpa, country coalitions for mental health will be created in each country and the assessment of available infrastructures

and policies will be undertaken through consensus. A final country story will be prepared for every country, describing the infrastructural situation of mental health promotion and mental disorder prevention in each country. All country profiles will be published in a book which will accompany the EC green paper on mental health. 2. *An internet information system (database) on efficacious prevention programmes for depression, suicide and eating disorders.* To develop, coordinate and operate a mental health information system on available evidence based programmes and policies for mental health. *This builds on the IMPHA database. Priority areas for this new phase include suicide, depression and eating disorders prevention.* The aim on the long run is that every country can have its own web-site on programmes and policies. A country pilot with this purpose will be developed in Scotland, to assess systematically all available programmes and practices for children and adolescents. In addition an evidence committee will work on developing a set of guidelines to rate evidence and provide recommendations on which programmes have sufficient evidence base so that could be recommended for adoption across member states.

Gender Disparities In Mental Health World Health Organization Department Of Mental Health And Substance Dependence, WHO 2002

To address this mounting problem, a much improved understanding of the gender dimensions of mental health is mandatory. Evidence is available on some aspects of the problem but serious gaps remain. It is known that:

- Rates of depression vary markedly between countries suggesting the importance of macrosocial factors. Nevertheless, depression is almost always reported to be twice as common in women compared with men across diverse societies and social contexts.
 - Despite its high prevalence, less than half the patients with depression disorder are likely to be identified by their doctors in primary care settings. Gender differences in patterns of help seeking and gender stereotyping in diagnosis compound difficulties with identification and treatment. Female gender predicts being prescribed psychotropic drugs. Even when presenting with identical symptoms, women are more likely to be diagnosed as depressed than men and less likely to be diagnosed as having problems with alcohol.
 - Comorbidity is associated with mental illness of increased severity, higher levels of disability and higher utilization of services. Women have higher prevalence rates than men of both lifetime and 12 month comorbidity involving three or more disorders. Depression and anxiety are the most common comorbid disorders but concurrent disorders include many of those in which women predominate such as agoraphobia, panic disorder, somatoform disorders and post traumatic stress disorder.
 - Reducing the overrepresentation of women who are depressed must be tackled as a matter of urgency in order to lessen the global burden caused by mental and behavioural disorders by 2020. This requires a multi-level, intersectoral approach, gendered mental health policy with a public health focus and gender-specific risk factor reduction strategies, as well as gender sensitive services and equitable access to them.
- Gender acquired risks are multiple and interconnected. Many arise from women's greater exposure to poverty, discrimination and socioeconomic disadvantage. The social

gradient in health is heavily gendered, as women constitute around 70% of the world's poor and earn significantly less than men when in paid work.

- Low rank is a powerful predictor of depression. Women's subordinate social status is reinforced in the workplace as they are more likely to occupy insecure, low status jobs with no decision making authority. Those in such jobs experience higher levels of negative life events, insecure housing tenure, more chronic stressors and reduced social support. Traditional gender roles further increase susceptibility by stressing passivity, submission and dependence and impose a duty to take on the unremitting care of others and unpaid domestic and agricultural labour. Conversely, gains in gender development that improve women's status are likely to bring with them improvements in women's mental health.

Globalization has overseen a dramatic widening of inequality within and between countries including gender-based income disparities. For poor women in developing countries undergoing restructuring, rates of depression and anxiety have increased significantly.

Increased sexual trafficking of girls and women is another mental, physical, sexual health and human rights issue. The mental health costs of economic reforms need to be carefully monitored.

- Finally, the epidemic of gender based violence must be arrested. The severity and the duration of exposure to violence are highly predictive of the severity of mental health outcomes. Rates of depression in adult life are 3 to 4 fold higher in women exposed to childhood sexual abuse or physical partner violence in adult life. Following rape, nearly 1 in 3 women will develop PTSD compared with 1 in 20 non victims. Current levels of detection of violent victimization are poor and primary health care providers require better training to intervene successfully to arrest the compounding of mental health problems.

- Research needs to be conducted into the relationship of violence to comorbidity. Women are at significantly increased risk of violence from an intimate and are over represented amongst the population of highly comorbid people who carry the major burden of psychiatric disorder.

Equally, research is needed to understand better the sources of resilience and capacity for good mental health that the majority of women maintain, despite the experience of violence in their lives.

- Access to safe affordable housing is essential if women and children are to escape violent victimization and the cessation of violence is highly therapeutic in reducing depression.

Improved balance in gender roles and obligations, pay equity, poverty reduction and renewed attention to the maintenance of social capital would further redress the gender disparities in mental health.

1. Gender and Depression

Depression contributes most significantly to the global burden of disease and it is the most frequently encountered women's mental health problem (Piccinelli & Homen, 1997). Unipolar or major depression occurs approximately twice as often in women as in men (Murray & Lopez 1996). Any significant reduction in the overrepresentation of women who are depressed would make a significant contribution to reducing the global

burden of disease and disability. Depression and anxiety are the most common comorbid disorders and a significant gender difference exists in the rate of comorbidity (Linzer et al., 1996).

Comorbidity contributes significantly to the burden of disability caused by psychological disorders (Kessler et al, 1994; Üstün & Sartorius 1995, WHO & ICPE, 2000).

The gender difference in depression is one of the most robust findings in psychiatric epidemiology. A comprehensive review of almost all general population studies conducted to date in the United States of America, Puerto Rico, Canada, France, Iceland, Taiwan, Korea, Germany and Hong Kong, reported that women predominated over men in lifetime prevalence rates of major depression (Piccinelli & Homen, 1997). This difference is documented in clinical and community samples and across racial groups (Kessler et al., 1994; Gater et al., 1998, WHO & ICPE, 2000). Depression may also be more persistent in women (Bracke, 2000) and female gender is a significant predictor of relapse (Kuehner, 1999).

Gender analysis in health framework used for analysis of tools

Department of Gender and Women's Health, World Health Organization 2002

Specific Questions

Social determinants of health and illness

Does the document provide information about or ask questions to:

Identify the social, cultural, economic and political factors which make women sick; which make men sick? (e.g. that women are responsible for fetching water which is done in the morning when mosquitoes are around hence making them vulnerable to malaria?; that men are more likely to work in mines and be vulnerable to related lung disease);

Identify actions which the reader could take to address these;

Identify the relationship between these determinants (e.g. the interaction of gender inequality and poverty which makes more women poor, and leads women therefore into 'transactional sex' which makes them vulnerable to stis; that men are often migrant labourers and hence have sex outside of long-term relationships and are vulnerable to stis);

Identify actions which the reader could take to address these.

Identify the ways in which biological factors contribute to the health problem under consideration, and the way in which social construction of gender does.

Gender and Mental Health WHO, 2002

What research is needed?

It is important to go beyond documenting sex differences in rates of mental and neurological disorders.

There is a need to examine how gender differences influence women's and men's risk and vulnerability, their access to health services, and the social and economic consequences of mental illness, in different settings and social groups and at different

points in the life cycle. A public health approach to improve primary prevention, and address risk factors, many of which are gender-specific, is needed. This implies going beyond medicalising distress. If gender discrimination, gender based violence and gender-role stereotyping underlies at least some part of the distress, then these need to be addressed through legislation and specific policies, programmes and interventions. Training for building health providers' capacity to identify and to treat mental disorders in primary health care services needs to integrate a gender analysis. The training should also raise awareness about specific risk factors such as gender-based violence. Primary care and maternal health services that are responsive to psychosocial issues and are sensitive to gender differences are well placed to provide cost-effective mental health services. In this context, it maybe important to promote the concept of 'meaningful assistance' for mental health care needs, including psychosocial counselling and support to cope better with difficult life situations, and not just prescription of drugs. Provision of community-based care for chronic mental disorders should be organized to ensure that facilities meet the specific needs of women and men, and that the burden of caring does not fall disproportionately on women.

Decisione n. 1786/2002/CE del Parlamento europeo e del Consiglio, del 23 settembre 2002, che adotta un programma d'azione comunitario nel campo della sanità pubblica (2003-2008) - Dichiarazioni della Commissione

18. L'obiettivo complessivo del programma nel campo della sanità pubblica è di contribuire al conseguimento di un elevato livello di salute e benessere fisici e mentali, come pure di una maggiore parità in materia sanitaria nell'intera Comunità, impostando le azioni sul miglioramento della sanità pubblica, promuovendo la prevenzione dei disturbi e delle affezioni umane e eliminando le fonti di pericolo per la salute, nell'intento di lottare contro la morbilità e la mortalità precoce, *tenendo conto del sesso e dell'età*

(12) "È necessario raccogliere, elaborare e analizzare i dati a livello comunitario per realizzare un monitoraggio efficace del settore della sanità pubblica a livello comunitario e trarne informazioni oggettive, attendibili, compatibili e comparabili che si possano scambiare e che consentano alla Commissione e agli Stati membri di migliorare l'informazione del pubblico e di elaborare strategie, politiche ed azioni atte a raggiungere un elevato livello di tutela della salute umana. Tutte le relative statistiche dovrebbero essere analizzate e ripartite per sesso

Articolo 2

Finalità e obiettivi generali

1. Il programma, che integra le politiche nazionali, intende proteggere la salute umana e migliorare la sanità pubblica.
2. Gli obiettivi generali del programma sono i seguenti:
 - a) migliorare l'informazione e le conoscenze per lo sviluppo della sanità pubblica;
 - b) accrescere la capacità di reagire rapidamente e in modo coordinato alle minacce che incombono sulla salute;

c) promuovere la salute e prevenire le malattie affrontando i determinanti sanitari in tutte le politiche e le attività.

3. Il programma contribuisce così:

a) a garantire un alto livello di protezione della salute umana nella definizione e attuazione di tutte le politiche e attività comunitarie, promuovendo una strategia sanitaria integrata e intersettoriale;

b) a lottare contro le disparità nel settore della salute;

c) a incoraggiare la cooperazione tra Stati membri nei settori contemplati dall'articolo 152 del trattato.

AZIONI E MISURE DI SOSTEGNO

3. Promuovere la salute e prevenire le malattie agendo al tempo stesso sui fattori determinanti sanitari e a livello di tutte le politiche e attività comunitarie, in particolare mediante:

3.1. l'elaborazione e l'attuazione di strategie e misure, comprese quelle connesse alla sensibilizzazione del pubblico sui determinanti sanitari legati agli stili di vita, quali l'alimentazione, l'attività fisica, il tabacco, l'alcool, le droghe e altre sostanze, nonché sulla salute mentale, ivi incluse le misure da prendere in tutte le politiche comunitarie e le strategie comunitarie specifiche a seconda del sesso e dell'età;

3.2. l'analisi della situazione e l'elaborazione di strategie sui determinanti sanitari di ordine sociale ed economico, al fine, da un lato, di individuare e combattere le disuguaglianze per quanto riguarda la sanità e, dall'altro, di valutare l'incidenza dei fattori sociali ed economici sulla salute;

3.3. l'analisi della situazione e l'elaborazione di strategie sui fattori determinanti sanitari legati all'ambiente e il contributo all'individuazione e alla valutazione delle conseguenze dei fattori ambientali sulla salute;

WHO European Ministerial Conference on Mental Health - Facing the Challenges, Building Solutions - Helsinki, Finland, 12–15 January 2005

Member States are committed, through the Mental Health Declaration for Europe and this Action Plan, to face the challenges by moving towards the following milestones. Between 2005 and 2010 they should:

1. prepare policies and implement activities to counter stigma and discrimination and promote mental well-being, including in healthy schools and workplaces;
2. scrutinize the mental health impact of public policy;
3. include the prevention of mental health problems and suicide in national policies;
4. develop specialist services capable of addressing the specific challenges of the young and older people, *and gender-specific issues*;

Gender disparities and mental health WHO May 20, 2002

Gender is a critical determinant of mental health and mental illness. The morbidity associated with mental illness has received substantially more attention than the gender specific determinants and mechanisms that promote and protect mental health and foster resilience to stress and adversity.

Depression, anxiety, psychological distress, sexual violence, domestic violence and escalating rates of substance use affect women to a greater extent than men across different countries and different settings. Pressures created by their multiple roles,

gender discrimination and associated factors of poverty, hunger, malnutrition, overwork, domestic violence and sexual abuse, combine to account for women's poor mental health. There is a positive relationship between the frequency and severity of such social factors and the frequency and severity of mental health problems in women. Severe life events that cause a sense of loss, inferiority, humiliation or entrapment can predict depression.

WHO's Focus in Women's Mental Health

- Build evidence on the prevalence and causes of mental health problems in women as well as on the mediating and protective factors.
 - Promote the formulation and implementation of health policies that address women's needs and concerns from childhood to old age.
 - Enhance the competence of primary health care providers to recognize and treat mental health consequences of domestic violence, sexual abuse, and acute and chronic stress in women.
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Gender in mental health research

World Health Organization 2005

For many mental health disorders there are male:female differences in prevalence rates; in adults the differences are most apparent for alcohol use disorders (male excess), depression (female excess) and eating disorders (female excess).

In the case of the most commonly occurring mental health problems, namely depression and alcohol use disorders, gender variables play a significant role in explaining the difference in prevalence between men and women. Gender is also a powerful determinant of eating disorders.

Even for disorders without a significant male:female difference in prevalence, such as schizophrenia, gender plays a key role in shaping the outcome and impact of these disorders.

Conclusion

The present review of gender influences on mental health disorders indicates that there is a clear need for research in this area to move towards a more gender-sensitive model.

Research can be summarized as follows:

Research should include both men and women as subjects. If this is not the case, researchers need to explain the reasons for the exclusion of men or women.

Results should be reported disaggregated by sex; the influence of sex on participation, continuation and drop-out rates must also be reported.

Gender factors should be measured a priori on the basis of their hypothesized role in the causation, course, treatment-seeking patterns, attitudes towards, treatment effectiveness, impact and outcome of mental disorders.

The impact of other exposures, such as socioeconomic variables, on mental illness should be examined differentially for men and women, and should be critically analysed with a gendered perspective.

Researchers working in the other aspects of gender and health should acknowledge the influence of gender factors on the mental health of men and women, and include measures of mental health in their research.

Why does gender matter in Europe?

WHO – Gender and Health

The WHO gender policy adopted in March 2002 states the following:

“Gender roles and unequal gender relations interact with other social and economic variables, resulting in different and sometimes inequitable patterns of exposure to health risk, and in differential access to and utilization of health information, care and services. These differences, in turn have clear impact on health outcomes. Evidence documenting the multiple connections between gender and health is rapidly growing.”

The United Nations Development Programme Gender-related index (GDI)³ shows that Europe has some of the highest ranking countries in gender equality. Several health issues, however, are strongly affected by gender inequities, such as:

- gender-based violence
 - risk and protective health behaviours
 - mental health
 - sexually transmitted infections and HIV
 - adolescents' reproductive health
 - access to health services.
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Strategic Action Plan for the Health of Women in Europe, WHO 2001

The Strategic Action Plan for the Health of Women in Europe aims to assist national and local governments in their efforts to achieve greater gender equity in health and health care and thus to contribute to improving the status of women in society.

The Action Plan can help in countries' work to improve the health of all their people by pointing out ways to meet the need for both gender-specific and gender-sensitive programmes of disease prevention and treatment.

The Strategic Action Plan for the Health of Women in Europe aims to assist national and local governments in their efforts to achieve greater gender equity in health and

³ The GDI – gender-related development index – is a composite indicator that measures the average achievement of a population in the same dimensions as the HDI while adjusting for gender inequalities in the level of achievement in the three basic aspects of human development. It uses the same variables as the HDI, disaggregated by gender

health care and thus to contribute to improving the status of women in society. The Action Plan is intended to ensure that women's health issues are explicit in any strategies to address inequities in health across the WHO European Region.

Il libro verde si riferisce in particolare a due condizioni sulle quali occorre soffermarsi per l'elevato livello di impatto sul genere femminile: il lavoro e la violenza.

L'analisi del lavoro secondo il genere indica che le donne soffrono maggiormente di stress per le minori opportunità di carriera, per le peggiori condizioni di lavoro, e per la sovrapposizione dei ruoli (lavoro,casa). Sono anche vittime di violenza e molestie più degli uomini.

**Including gender issues in risk assessment
European Agency for Safety and Health at Work, 2003**

Continuous efforts are needed to improve the working conditions of both women and men. However, taking a 'gender-neutral' approach to risk assessment and prevention can result in risks to female workers being underestimated or even ignored altogether. When we think about hazards at work, we are more likely to think of men working in high accident risk areas such as a building site or a fishing vessel than of women working in health and social care or in new areas such as call centres. A careful examination of real work circumstances shows that both women and men can face significant risks at work. In addition, making jobs easier for women will make them easier for men too. So it is important to include gender issues in workplace risk assessments, and 'mainstreaming' gender issues into risk prevention is now an objective of the European Community ('Adapting to change in work and society: A new Community strategy on health and safety at work, 2002-06'. Communication from the European Commission, COM(2002) 118 final)

Molestie sul posto di lavoro

A5-0283/2001

**Risoluzione del Parlamento europeo sul mobbing sul posto di lavoro
(2001/2339(INI))**

D. considerando che dai dati provenienti da uno degli Stati membri risulta che i casi di mobbing sono di gran lunga più frequenti nelle professioni caratterizzate da un elevato livello di tensione, professioni esercitate più comunemente da donne che da uomini e che hanno conosciuto una grande espansione nel corso degli anni 90,

2. richiama l'attenzione sul fatto che il continuo aumento dei contratti a termine e della precarietà del lavoro, in particolare tra le donne, crea condizioni propizie alla pratica di varie forme di molestia;

4. richiama l'attenzione sul fatto che, secondo alcune inchieste, le donne sono più frequentemente vittime che non gli uomini dei fenomeni di mobbing, che si tratti di

molestie verticali: discendenti (dal superiore al subordinato) o ascendenti (dal subordinato al superiore), di molestie orizzontali (tra colleghi di pari livello) o di molestie miste;

**Gender issues in safety and health at work- A review
European Agency for Safety and Health at Work, 2003**

EXECUTIVESUMMARY

“Because of strong occupational gender segregation in the EU labour market, which remains high despite changes in the world of work, women and men are exposed to different workplace environments and different types of demands and stressors even when they are employed by the same sector and ply the same trade. There is strong segregation between sectors, between jobs in the same sector, and there can be segregation of tasks even when women and men have the same job title in the same workplace. There is also strong vertical segregation within workplaces, with men more likely to be employed in more senior positions.

Other gender differences in employment conditions also have an impact on occupational safety and health. More women are concentrated in low-paid, precarious work and this affects their working conditions and the risks they are exposed to. Gender inequality both inside and outside the workplace can affect women’s occupational safety and health and there are important links between wider discrimination issues and health.

Work-related stress

Key points

- Stress is a major work-related health problem in Europe for both women and men.
- Women report more work-related stress health complaints than men.
- There are known causes of work-related stress and these factors are present in many jobs typically done by women. Women are more exposed to some specific stressors because of: the type of work they do; their position in the hierarchy of organisations; discrimination; sexual harassment; their situation outside of work.
- The established safety and health risk-assessment and management approach can be applied to preventing the causes of workrelated stress.
- Both instruments used for research and risk assessment should cover work issues that affect women more, such as working conditions incompatible with family responsibilities, sexual harassment and discrimination.

Many studies find that employed women have higher levels of stress and distress than employed men (Williams and Umberson, 2000).

Responsibility to multiple supervisors, for example in clerical work, and unclear work expectations are stressors common in female-dominated industries, especially in the

service sector. Also, overtime work and unpredictable or inflexible scheduling are stressors that women with caring responsibilities suffer particularly.

Monotonous work and low control are characteristics typical of many female-dominated occupations. Miller et al. (2000) found little gender difference in sources of workstress among managers, but found that female managers experienced more distress. They hypothesise that the greater psychological and physical ill health reported by women is due to work/home overload and conflict. In a study of female and male managers, Davidson et al. (1995) found that female managers were under much more pressure than their male counterparts, for example stemming from 'organisational structure and climate' and discrimination and prejudice.

Box 14

Responses to the third European survey on working conditions suggest that, compared to men, women are:

- less likely to have planning responsibilities in their jobs;
- more exposed to monotonous tasks;
- less likely to work in jobs involving problem solving and learning;
- less able to choose when to take breaks;
- more likely to have their work interrupted to deal with unforeseen tasks;
- less likely to receive training.

What is more, women in professional jobs have lower work autonomy than male professionals.

Sources: Paoli and Merllié (2001); Fagan and Burchell (2002).

World Report on Violence and Health (2000, WHO)

Sexual violence occurs throughout the world. Although in most countries there has been little research conducted on the problem, available data suggest that in some countries nearly one in four women may experience sexual violence by an intimate partner, and up to one-third of adolescent girls report their first sexual experience as being forced. Sexual violence has a profound impact on physical and mental health. As well as causing physical injury, it is associated with an increased risk of a range of sexual and reproductive health problems, with both immediate and long-term consequences. Its impact on mental health can be as serious as its physical impact, and may be equally long lasting

One of the most common forms of violence against women is that performed by a husband or an intimate male partner. This is in stark contrast to the situation for men, who in general are much more likely to be attacked by a stranger or acquaintance than by someone within their close circle of relationships (1–5). The fact that women are often emotionally involved with and economically dependent on those who victimize them has major implications for both the dynamics of abuse and the approaches to dealing with it. Intimate partner violence occurs in all countries, irrespective of social, economic, religious or cultural group. Although women can be violent in relationships with men, and violence is also sometimes found in same-sex

partnerships, the overwhelming burden of partner violence is borne by women at the hands of men (6, 7). For that reason, this chapter will deal with the question of violence by men against their female partners. Women's organizations around the world have long drawn attention to violence against women, and to intimate partner violence in particular. Through their efforts, violence against women has now become an issue of international concern. Initially viewed largely as a human rights issue, partner violence is increasingly seen as an important public health problem.

Psychological and behavioural *Health consequences of intimate partner violence:*

Alcohol and drug abuse
Depression and anxiety
Eating and sleep disorders
Feelings of shame and guilt
Phobias and panic disorder
Physical inactivity
Poor self-esteem
Post-traumatic stress disorder
Psychosomatic disorders
Smoking
Suicidal behaviour and self-harm
Unsafe sexual behaviour

***American Medical Association
Diagnostic and Treatment Guidelines on Domestic Violence***

According to various studies, battered women may account for:

- 22% to 35% of women seeking care for any reason in emergency departments, the majority of whom are seen by medical or other nontrauma services
- 19% to 30% of injured women seen in emergency departments
- 14% of women seen in ambulatory-care internal medicine clinics (28% have been battered at some time)
- 25% of women who attempt suicide
- 25% of women utilizing a psychiatric emergency service
- 23% of pregnant women seeking prenatal care
- 45% to 59% of mothers of abused children
- 58% of women over 30 years old who have been raped

**Gender disparities in mental health 2002
WHO DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE DEPENDENCE**

If it is accepted that both women and men have a fundamental right to mental health, it

becomes impossible to examine the impact of gender on mental health without considering gender-based discrimination and gender-based violence. Consequently, a human rights framework is needed to interpret gender differences in mental health and to identify and redress the injustices that lead to poor mental health. Many of the negative experiences and exposures to mental health risk factors that lead to and maintain the psychological disorders in which women predominate involve serious violations of their rights as human beings including their sexual and reproductive rights. The 1999 Human Development Report, referring to the increase in organized crime related to globalization, noted an escalation in the trafficking of women and girls for sexual exploitation - some 500,000 girls and women trafficked to Western Europe alone - and described trafficking as one of the 'most heinous violations of human rights'. The multiple, severe mental health consequences of sexual violence and abuse are discussed below.

UNICEF

L'educazione delle donne: Tutte a scuola

: Sono 121 milioni i bambini nel mondo ai quali è negato il diritto allo studio, e 65 milioni, più della metà, sono femmine. Mandiamole TUTTE A SCUOLA. *nei Paesi dove il livello di educazione femminile è aumentato, c'è stata una parallela crescita economica ed è diminuita la mortalità infantile... La scuola per le bambine, oltre a essere un diritto fondamentale, è anche il presupposto necessario per migliorare l'educazione globale e lo sviluppo effettivo di un Paese. Per questo l'UNICEF lancia una campagna mondiale per mandare a scuola tutte le bambine*

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