WOMEN'S HEALTH IN NORWAY: A CASE STUDY OF A POLICY DRIVEN AGENDA

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Abstract

In this paper we try to present some policy issues that relate to women's health from a public health perspective. The entry point is lessons we learned from working on a recent government report on women's health in Norway (Department of Health and Social Affairs, 1999), and policy issues developed in this process. Some of these issues are indeed of a general nature, pertaining to women all over the world. Most aspects of women's living conditions relate to their health and use of available health care. Women in general differ from men regarding access to and use of health care, disease patterns and use of welfare schemes. Both biomedical and social gender differences contribute to these differences. The main message is that even if a gender equity framework is assumed and applied in a country, there are still vast inequities between men and women. Aims and efforts to reduce gender inequities should be assessed and included in all future policy making regarding health. Women's health is not only a reproductive health concern, but has to meet the needs of very diverse women in different ages, ethnic subgroups, and social strata.

Keywords*: Women's health policy, Health care for women, Government involvement, Gender equity in health, Norwegian Health Plans.*

Résumé

L'auteur expose quelques problèmes d'ordre politique liés à la santé des femmes dans une perspective de santé publique. Elle prend pour point de départ les leçons qu'elle a tirées de sa contribution à un récent rapport gouvernemental sur la santé des femmes en Norvège (Ministère de la santé et des affaires sociales, 1999) et les questions de nature politique qui ont surgi à cette occasion. Il est vrai que certaines de ces questions sont très générales et concernent toutes les femmes à travers le monde. La plupart des composantes du cadre de vie des femmes sont liées à leur santé et à l'emploi qu'elles font des services de santé existants. En général, il y a des différences entre hommes et femmes en matière d'accès et de recours aux services de santé, de types de maladies, et d'utilisation des systèmes de sécurité sociale. Ces différences entre sexes sont à la fois d'origine biomédicale et sociale. Le message central est que, même si un système d'égalité des sexes est adopté et mis en œuvre dans un pays, de grandes inégalités entre hommes et femmes subsistent. Il faut configurer et introduire dans tout projet de politique touchant à la santé des objectifs et des mesures destinés à réduire les inégalités entre les sexes. La santé des femmes ne se limite pas à la santé de la reproduction ; il s'agit de satisfaire les besoins de femmes qui se trouvent dans des situations très diverses en termes d'âge, d'appartenance ethnique et de catégorie sociale.

Mots-clés *: Politique de santé féminine, Soins de santé féminine, Action gouvernementale, Égalité des sexes en matière de santé, Planification de la santé, Norvège.*

1. Introduction

Many organisations working on health issues pay attention to women's health. There are women's health programs in the World Health Organisation, other UN agencies and the World Bank address the issue, and there are women's health NGOs and advocates in many countries. But so far, gender issues in health with a women's health entry point, have not become part of the mainstream policymaking. In this paper I will illustrate some core policy issues through a case report from my own country.

The need for a separate women's health issue was indeed acknowledged when the government of Norway, by the Ministry of Health and Social Affairs, in 1997, appointed a committee whose task

it was to produce an official or public report on the status of women's health in Norway. They realised that the issue had to be lifted to the forefront of public attention through a separate activity. The committee producing the report was headed by myself, and also consisted of another seven members: politicians, health professionals, social security administrators, and gender equality experts. The mandate was broad, and covered issues of women's diseases, living conditions, health care, social security, participation, ageing, use of health care, mental health, and also differences between groups of women. The more than 500-page report was submitted to the Minister of Health in January 1999 (Department of Health and Social Affairs, 1999).

It is important to have a very broad understanding of what encompasses women's health. There seems to be a clear distinction between a biological or bio-social approach to gender differences in illness, and the social approach to women's health issues that is currently more widely applied. Nevertheless, both biological and social gender differences apply both to a variety of diseases, and to the broad concept of health. The biomedical models to understanding women's health have been accused of being too deterministic, and to focus mainly on the reproductive function of the female body. Of course one of the main biological as well as social determinants in women's lives is their ability to become pregnant and bear children, an ability still exclusive to women. But this is not the only matter of concern for women's health. In biomedicine, it is now well known that there are some disease entities that are more frequent in women than in men, take a different natural course, have a different prognosis, different age of onset or have different risk factors. Other diseases, however, show no major gender disparity. Therefore, a detailed discussion of women's health cannot be completely separated from a review of the different diseases and their gender implications (Schei *et al.*, 1993). A lot of health care is very specialized and tries to handle or cure very specific ailments, and these approaches also need to become gendered.

There are two trends in the ongoing debate on women's health. The first trend is to discuss women's health as a separate political agenda, and to focus only on issues that are specific to women, and not always of relevance to the general debates on health. The other trend is to use a gender framework, and thus to emphasize the comparative aspect of women's health, using the male as a comparison, and sometimes demonstrating that male perspectives are also the normative

ones. The biological model often uses a 70-kg. male as the prototype of a human body, and handles deviations from this normative body as specific cases (i.e. children or women). Thus, anything that strikes men more than women (like cardiovascular disease or road traffic accidents) become neutral events, while problems that affect women (like anxiety disorders or osteoporosis) become gendered.

But gender is also identity, cultural symbols and structure. It is therefore important to demonstrate how all of these dimensions of gender increase the understanding of women's health and of how medical science, health systems and care units and welfare schemes meet female patients as users of their services.

2. A methodological approach based upon consensus

For women, user perspectives may be important, as less women than men have seats in formal decision making bodies. In producing a women's health policy, it may be of core importance to have several consultations with members of various women's groups, health lobbyist groups, patient groups, experts and researchers. In Norway, we also organized a lay-people's conference around one issue, namely chronic musculo-skeletal disorders in women. The aim of this broad process is to illicit issues of relevance for most women, as well as for different groups of women. Our mandate also asked us to create concrete and prioritized arguments for investments or changes that can improve women's health and living conditions. As is common in political processes in Norway, our document had afterwards to go through an extensive hearing process. Some of the organizations that gave inputs were also on the hearing list. Many of the commission's members were in addition asked to give presentations to a variety of organizations during the hearing process. The end result of the process is still open, but several of the recommendations have already been implemented by various government agencies.

To illustrate and document as many aspects of women's health as possible, it is important to make it an interdisciplinary effort. Thus experts in demography, women's health, disease management, health care or sociology/anthropology may be asked to submit core texts on issues of relevance to a broad understanding of women's health. In our case, an expert panel was appointed, and the texts were revised by the secre-

tariat and the committee jointly, until an agreed upon structure and content was secured. The full document (in Norwegian language) is available on the Internet (http://www.odin.dep.no/nou/1999-13/), and a short summary is also printed in English (Department of Health and Social Affairs, 1999).

3. Points of entry into women's health

Our point of entry was that in general, women's health in most parts of Europe is good. On average, women in Europe and other industrialized parts of the world expect long lives, longer than that of their male counterparts. Even in most developing countries, men live shorter than women. Because of this, many women seem to live as elderly citizens with some disabilities or diseases that are not life threatening, but reduce the quality of life and demand health care attention. Women are health care consumers, especially in primary care, more than men are, and elderly women are sometimes seen as a "burden" for care services. As a comment to this, the response we got from lay women is that care providers often do not take women's complaints seriously. So even if a relative longevity is a fact, the burden of disease, the living conditions of elderly women, and their health care needs demand attention.

Another point of entry was a cohort and fertility perspective. While a large proportion of women in all cohorts in Norway and other European countries have been employed wage earners, the majority of those women who are now near pension age entered the workforce only after their completion of childbirth and child care. Thus they have fairly short work careers, and have earned substantially fewer pension points than their male age-mates (Skrede, 1999).

For the 1950 and 1960 cohorts and onward, as in other similar countries, there has been a steady increase in the median age of first births in Norway, and the fertility is now very low (TFR 1.7-1.9). The current generation of mothers or mothers to be have completed an increasingly longer education and started working even before the birth of their first child, and seem to struggle to keep their attachment with the workforce at the same time as they pay a lot of attention to the role of motherhood. The outcomes of maternity are good. Maternal mortality has virtually been eliminated, and infant mortality, which was just

over 150 per 1000 births around 1860, is now almost the lowest in the world. Perinatal mortality is equally low. Norway and the other Scandinavian countries have, as opposed to some similar countries like the U.K. and U.S.A., almost eliminated teenage childbirth. The reasons for this are not fully understood. Good contraceptive coverage, high employment rates, long educational attainments for girls, and widely distributed sex education are contributing factors. Most of the pregnancies that occur in teenagers end in induced abortions. Norway, Sweden and Denmark grant legal access to abortions before 12 (16 in Sweden) weeks of pregnancy. Most of the births and abortions in Norway, however, are in the 20-29 year age group. Some 98% give birth in institutions with maternity services, and of those who don't, most of them are accidental transport deliveries, due to long distances (Medical Birth Registry of Norway, 1997).

In Scandinavia, antenatal care and maternity care have been and remain free of charge, and almost always delivered as part of the government health service. There are some 60,000 babies born in Norway each year, around half of them to mothers who are married, and 40% to mothers who live with a partner. Only around 10% are truly single. These shifts away from formal to more individualized unions have caused some turmoil in standard setting for childcare, social security and other social services that take into account women's social positions. On the other hand, the stillbirth and infant mortality rates do show a social gradient as well, and are slightly higher for young, uneducated single mothers (Arntzen, 1996). Infertility is low, about 3-4% end their reproductive career involuntarily without children, and half of those eventually adopt (Sundby, 1994). Contraceptive prevalence rates are high, and while young women use the oral contraceptive and to some extent the condom, the Intrauterine Device and surgical sterilization are common in women past 35 years of age.

4. Motherhood - and recent social reforms

The importance placed on responsible parent- and motherhood has already lead to several social reforms. These reforms vary somewhat within Europe, even within Scandinavia, but in general the trend goes towards longer maternity leave and better protection of the work environment of pregnant women. Norway enjoys good and well struc-

tured maternal as well as paternal benefits. The mother is entitled to a restructuring of her workday if the pregnancy makes it difficult to work as usual, and if this is impossible, she is entitled to "pregnancy money" which is supposed to be a compensation for lost earnings due to problems at the workplace. Very few use this opportunity, and we experience that more than 50% of the pregnant women actually are on medically certified sick leave during pregnancy. This has to be justified as a disease that is added on to the pregnancy state in itself. Thus unspecific diagnoses like "girdle instability" or pelvic pain are the most common diagnoses used. The central issue here is the relative balance between two norms. The first one is a workforce gender equality norm that pays no attention to the biological changes that occur in the female body during stages of pregnancy, and claims that a pregnant woman should have no special protection. The second is a more biology-based norm that may eventually claim that men and women are fundamentally different, and that women should have an inferior role in the workplace because of their (more vulnerable, pregnancy-ridden) body and their reproductive role (Schei *et al.*, 1993).

For the last three weeks of the pregnancy, a woman is entitled to take leave by use of her maternity leave period. In addition to these weeks, the woman has the exclusive right to a two-three month maternity leave after childbirth. The entire maternity leave is either 12 months with reduced salary or somewhat less (10 months) with full pay. Unique to Norway is the fact that the father of the child has the exclusive right to four weeks of leave at any time during the child's first year of life - as paid leave. All mothers make use of their rights, and some 80% of the fathers. Most often it is the woman who takes long leave, but there is an increasing proportion of young fathers that take their share. Breastfeeding is very popular among Norwegian women, and a large proportion continue to breastfeed as a supplement into the second year of life; and then they are entitled to an hour off work daily.

Most women do go back to work after one year, and public and private child care has become fairly accessible. However, the dual/triple role of motherhood, partnership and employee seems to increase levels of stress in mothers of small children. For a fraction of the mothers, especially from members of the workforce with less education and more routine types of jobs, part time jobs, use of periods of sick leave, and even the new state compensation of a sum of money paid to parents of children between one and two years of age seem to

be factors that make young women somewhat less tied up with the work force. There has also been an increasing number of young women who are on lengthy sick leave or even disability pension for psychiatric conditions, namely anxiety disorders and depressions. One study indicates that 2/3 of the prescribed psychotropic drugs in the Norwegian market are consumed by women (Mouland *et al.*, 1998).

On the other hand, the legal restrictions toward alternative maternal roles like assisted reproduction or adoption have a different view on motherhood. Until recently, adoption has been restricted to married couples where the mother is not past 45 years of age, and Norway has the most restrictive legal framework for artificial fertilization in the world. The normative and religious influences toward a traditional motherhood are obvious (Bioteknologinemda, 1999). These issues are still debated heavily.

5. Women are not equal to one another

In some respects, women live rather different lives from men in modern societies. On the other hand, there are great variations between women. Socioeconomic status seems to predict life expectancy for both women and men (Rognerud and Stensrud, 1997). In the capital Oslo, people living in the affluent West end have a much higher life expectancy than people living in the more average East end or the even poorer inner city. Women in East end and men in West end have approximately the same life expectancy. We see the same socioeconomic pattern in the abortion rates. In those municipalities within the city where average income is low, the abortion rates are higher than in the more affluent parts. Even if it is difficult to classify the woman's social status according to her own income, because she will also be classified according to the total family income if she is married, on a more aggregate level there are vast differences also between groups of women.

One challenge in dealing with health issues for women in Norway, is the fact that women smoke more than before; now both 33% of men and women are daily smokers (Engeland, 1996). As a result of this, we have had a 500% increase in lung cancer rates for women. Women also smoke during pregnancy, even if they reduce the number of cigarettes smoked. Women of all social strata smoke, but smoking is higher and smoking cessation during pregnancy seems to be even more

difficult among women from lower social classes. In Norway, the percentage of pregnant women who smoke is among the highest in the world. Women in Norway who smoke have a 3-4 times higher likelihood of mortality from stroke than non-smokers. The trend is alarming, more young women than men seem to take up smoking before age 18. Low self esteem, social pressure and a need for revolt and protest seem to be associated with early debut as a smoker (Hafstad, 1997).

Another issue that is of concern, is how women's participation in the work force influence their health in general. One Norwegian study shows a positive relationship between important goals for health and participation in marriage, motherhood and employment (Elstad, 1996). Married women with children and a full-time job have the fewest measurable or self reported health problems. There are some exemptions. For most women paid work is a good thing; for some the workplace is detrimental to health. For example, women who work in routine low pay jobs in care giving in the public sector, seem to suffer from more long-term diseases in the joints, bones and muscles. They also suffer from stress and psychological problems related to their jobs. For many, having a family is beneficial to health; for some, where sexual violence or abuse is involved, marriage is a direct hazard to health. There is no difference in the mental and physical health for the children of working or non-working women.

6. Femininity - healthy or dangerous

The Norwegian woman is internationally often pictured as very modern, very independent and maybe somewhat less traditionally feminine than the rest of their European sisters. Norway has a very cold climate, and for this reason, it may sometimes be difficult for Norwegian women to dress up in a typical modern way. Norwegian women seem to trade off media made feminine norms against a more functional one. If a woman's workday is going to contain getting up in the dark, to rush yourself and two children to the kindergarten by public bus; when it is snowing heavily and the temperature is minus six degrees, the best way to dress is in long under-pants, jeans, a parka and boots with a rubber sole. The workplace dress code is pretty tolerant to this. But nevertheless, the international norms for dress codes for women do reach the Norwegian consumers, too, and many girls com-

promise between risking to catch a cold and wanting to wear thin stockings and high-heeled shoes.

This leads on to a discussion of what aspects of the codes for femininity are potentially good and what is potentially bad for health in different arenas in women's lives. Norwegian girls are, as in other countries, taught to be attentive and caring towards other people and to understand themselves in relation to other people. Health benefits can be found in good close relationships and networks. Women respond more often than men that they have intimate friends other than their spouse to share emotional problems with. Women also more often than men seem to seek care for minor psychiatric problems at an early stage, thus accessing help before the problems get to be overwhelming. Beauty and aesthetics are important projects for many women. Women are great consumers of all kinds of beauty products, also in the new health care arena of plastic body shaping surgery, nutrition supplementation, diets and skin cosmetics. The health benefits lie inherent in caring for oneself and looking after one's appearance. The negative side effects are a preoccupation with appearance, unhealthy dieting, eating disorders like anorexia and overeating disorders, low self esteem or exposure to dangerous medical practices like extensive removal of fatty tissue, implant surgery, over-consumption of drugs that regulate bowel movements, diuretics or nerve pills. There has been an increase in the number of young women who suffer from bulimic or anorexic eating disorders also in Norway, and researchers view this, more than anything else, as diseases in the crossroad between modern culture and exaggerated femininity conflicts (Skårderud, 1999).

Women increasingly suffer from chronic diseases like osteoporosis in older ages, and as a result of that and a few other environmental problems in Norway that we do not fully understand, there is an epidemic of hip bone fractures and forearm fractures in the Norwegian female population. Regular exercise as well as diet are important prevention measures for this, but the medical society is also concerned about prevention through partly subsidized hormonal drugs. Young women in Norway often participate in sports, but often in less competitive sports than men, and often they quit earlier. On the other hand it seems as if women more than men enjoy skiing, hiking or tour walking. Exercise is also important for the prevention of cardiovascular diseases and late onset diabetes due to overweight, both of which are quite prevalent in Norway. Young women often complain that they

find no time for exercise for themselves when they are in the workforce and have small children at the same time.

7. Many women's lives - different health conditions

It is demonstrated internationally that single mothers who have given birth at a young age, who have a shorter than average education, weak ties with the labour market and little contact with the child's father, are in particular danger of finding themselves in financial trouble, of being disregarded for a long time by the labour market and wearing themselves out because they have been left alone with caring responsibilities. Many of them feel a distaste at being dependent on benefits from the social welfare office. This kind of situation entails a health risk for both mother and children. Women living in informal unions seem to have somewhat less stable relationships than those who are formally married, but living together and having children may also lead into marriage at a later stage. While living together was a way of organizing the family only for an educated elite some two centuries ago, it has now entered all classes of society. This may imply anything from just sharing small apartment for a short time to lengthy marriage-like contracts involving the purchase of a house, a vehicle and family ties. The state has had to revise its marriage and property ownership laws to protect women and children in these types of unions. Another public report was just submitted to the government regarding new patterns of living together and policy implications (Department of Family Affairs, 1999).

In Norway, a woman's right to make decisions concerning her own body is a major, guiding principle. Her exclusive right to make decisions regarding abortion in the first trimester of pregnancy, and the state's limited right to take any action against a pregnant woman is underlying these principles. The legal age for sexual intercourse is age 16, but a sexually active girl under that age may nevertheless be given contraceptives if she needs it. Norwegian women have easy access to reproductive health information and services, including sex education in schools, and there have been improvements in the enforcement of legal actions against sexual exploitation, incest and rape. The HIV epidemic is very limited in the Norwegian heterosexual population, and other types of sexually transmitted diseases have also got a very limited prevalence. We do test all pregnant women for HIV (voluntary testing)

but very few cases of infection not already known are found. STD control programs are an integral part of all MCH and FP programs, in a "matter of fact" way. The prevalence of syphilis in pregnant women is so low that the compulsory screening may be abandoned. The major concern is a still somewhat high prevalence of chlamydia in young girls.

On the other hand, there are some remaining problems, like inequities in access to basic care and services due to health service infrastructure being difficult to maintain in remote areas, and a lack of political willingness to open up for issues like easy access to emergency contraception, medical abortion or sex education in some local communities. There is a lively debate going on about these matters, especially because it is an imperative to reduce the number of unwanted pregnancies and abortions.

8. Diseases

In order to carefully review the impact of disease on women's health, there is a need to give particular importance to diseases that almost exclusively affect women, or affect women more often or earlier than men. Diseases that affect both sexes, but where the prevalence, course, outcome or consequences are different for men and women and the diseases that statistically affect many women, although they also affect many men, are also important to account for. But for policy makers, it is often the conditions which society regards as problematic that receive public attention and are gendered. Research into illness in women has to make room for newer understanding of women's biology and at the same time integrate to a greater extent knowledge about women as individuals in society. As long as a lot of the disease statistics are not broken down on men and women separately, a lot of information is lost (Halsteinli, 1997). In Norway, we are concerned with violent people with psychiatric diseases. Almost all of those are men, but this is not addressed in the statistical review of number of assaults done by these patients. Another issue is the gender perspective of health service facilities and their use. Why are so many encounters between women and the health service described as problematic? What is needed before women regard services and meeting their needs in a good way?

Women's more frequent contact with the health service applies in the first instance to consultations with general practitioners, in old people's homes and rehabilitation institutions. If we look at consultations in hospitals' out-patient departments, the gender difference is almost eliminated and the same applies to admission to hospital, if we exclude admission due to childbirth and pregnancy. Most women have few visits to the doctor each year, while a small minority have many. This small group of women (5-8 per cent), who have ten or more contacts with the doctor each year, excluding those who go for antenatal care services, suffer from problems that are difficult to diagnose accurately, and thus hard to help. This group may also include women with chronic diseases who need close, special monitoring (Kalseth *et al.*, 1997).

Many of the chronic and complex ailments that groups of women suffer from have a low status in the hierarchy of diseases. This applies to musculo-skeletal disorders, mental disorders and geriatric complaints. Some vague complaints and chronic pain syndromes are difficult for the health service to offer good care for (Malterud, 1990). Typically, these disease groups have

- low prestige within the medical community;
- poorly developed and badly integrated research-based knowledge;
- too little expertise among general practitioners - with subsequent inadequate uncovering of the problem, help and referral;
- communication with and interpretation of the women characterized by poorly founded presentations and prejudices;
- conflict in relation to the traditional ideal that the doctor will "sort things out": make a diagnosis and prescribe treatment;
- inability to understand complaints in the light of the individual woman's life situation, resources and ability to cope;
- too little capacity and expertise in the specialist health services.

9. Women and welfare

The intention of most welfare policies, including the Norwegian National Insurance Act, is to provide security against a major loss of income or major expenses incurred through illness. Through the social security and welfare schemes, a distribution of different resources are handled. In Norway, we have a general health insurance that covers all individuals living in the country, and the payment is directly deducted

from the wages of the wage-earners, while self employed people pay according to other schemes. Even non-working citizens are provided for, but receive less benefit, as one is entitled to a certain fraction of the earned salary as a basic benefit. The systems also offers benefits for pregnant mothers and caretakers of newborn babies. Most of the schemes are described as formally gender neutral programs. The basic requirement of being employed means that working women have the same possibilities as men to earn rights, but no consideration is given to the fact that women's and men's participation in the workforce is not equal. Women work more part-time than men, and women usually have a shorter total time in the work force before retirement (Brage, 1998).

Social security benefits were originally introduced to give men compensation for loss of income resulting from unemployment, illness, disability, occupational injury, etc. When women entered the workforce, they were still first and foremost seen as secondary supplementary family income earners. The first benefits that were brought in for women were based on loss of support and provided compensation for loss of a family supporter or for lack of support. Now women's ties to the family are more varied. Many divorced men who are legally supposed to pay child care maintenance fail to do this. The mother will then receive a sum from the government to help her support the children. Many men and women live together in less stable unions; the number of households with one adult has grown, and adult women are less dependent on men as family supporters. The benefit schemes are intended to motivate people to work. It seems as work motivation, or ties to the workforce, are different for women and men. Women score higher on short term and long term sick leave as well as on disability pensions. On the other hand, given their lower levels of income, they are cheaper to keep on benefits, as they seldom reach the higher level of benefit payments. The goal of high employment also includes people who are poorly qualified to meet the competition on the labour market. The challenge is to provide social security benefits that serve as safety nets for people who lose their income from employment, but they must be designed to ensure that employment is the first choice.

However, women who have few ties with the workplace and a low education may be more difficult to return to or retrain for employment. In the second place, all jobs will not necessarily lead to self-respect, integration and financial independence. Many female workplaces especially in the public care services and in ware trade, pay

badly, have poor working conditions and little right of self-determination. The fact that a number of women have had their claims for a disability pension refused and have been referred to the social welfare office or private support shows that the work approach does not work as intended. They have not returned to work and they have not been granted social security. If the work approach is to succeed, these women must be given a concrete offer of training, qualifying or suitable work. If such work is not available and there are no opportunities for them, then social security must be an alternative for them as it is for other people (Malterud and Hollnagel, 1997).

Social security rights depend on the definition of the term disease in the regulations and in social security service practice. The national insurance scheme's concept of disease is based on a medical science and practice based formulation. Specific requirements are often made of the illness with regard to diagnosis, type of symptoms or consequences. When women's illnesses are given less priority than typical men's illnesses, this may be reflected in who is entitled to social security benefits and the understanding one is met with in the social security system. So far, more women seek disability pension than men, and at an earlier age. On the other hand, a higher proportion of women's applications are turned down. We do not really know what happens to these women in the long run.

10. Recommendations

Different women's health reports contain a series of different recommendations. One global recommendation is of course to increase the knowledge base on the relationships between women's lives and women's health, and to gain more knowledge about women's diseases. We do emphasize that this does not come automatically from mainstream research centers, but may have to get special legal and grant frameworks as is also recommended in other countries (Haseltine *et al.*, 1999). In some institutions, like major teaching units, it may be important to set up women's health chairs or units, and to earmark grant money to women's health research. Of core importance is also a reshaping of health services to better meet the needs of female clients, and emphasize the need for multi-specialist centers for some of the main problems that affect women (Doyal, 1998), and to put a better

gendered understanding of central care issues into plans and treatment strategies for mental health services. We also reinforce that all health statistics should be broken down to separate reporting for men and women. Finally it may be relevant to request all levels of health care management to review various methodologies for involving women users in health care decision making, both in individual cases and in larger policy issues.

An example of this is a project launched by Norwegian board of health, which together with the National Research Council organized a lay women's conference and an expert conference on maternity services in Norway in late 1999. The two conferences events challenged the mainstream expert recommendation that maternity services, for the sake of perinatal survival, should be even more centralized. While experts were mainly concerned with minor gains in perinatal mortality figures, the laywomen mentioned two types of needed safety. They wanted biomedical safety in the background, in case it was needed. They also requested another, more human safety measure that has to do with being seen and treated as an autonomous woman even when in labor pain with an increased risk of dangerous outcome for the baby. Sometimes these two types of concerns are in conflict, but the women's solution would not always be the more centralized one if that would imply not being treated as a patient in her own right (National Research Council and Norwegian Board of Health, 2000). Other organizations have also launched different methods for assessing women's and users' perspectives on health issues. The best documented effort is the gender advisory panel that gives advice to the Reproductive Health Research Program (HRP) in the World Health Organization. This is a body that reviews research policy and priority within a large, multilateral research organization (Hardon and Hayes, 1997). The way they have been able to influence decision making is a nice illustration to the point that if some women's voices are listened to seriously, things may change for the better for many women.

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