

ELVIRA REALE*

New perspective for women's health studies in Italy

GUIDE TO WOMEN'S HEALTH

by

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2001 Health designed for the woman

2003 Guide to women's health Mind, hearth, arms and. Searching for a medical science for women

Putting together knowledge and promoting women's health against prejudices

Introduction

In September 1999 a new work group «Medicine, Women, Health» was formally constituted at the Italian Ministry of Equal Opportunities with the objective: *to design a health for women*. The work group – coordinated by the psychologist Elvira Reale – includes women from different medical, health and social professions whose clinical practice and research in part address specific gender aspects of health. The women are: psychologist, psychiatrist, oncologist, cardiologist, gastroenterologist, epidemiologist, pharmacologist, experts in labour and legal medicine, sociologists, endocrinologists, gynaecologist, general practitioners.

The General Aims of the research-group are: to create a unified field of observation of the most common diseases affecting women; to point out research biases against women; and to propose guidelines of intervention for a women-friendly healthcare system.

The Specific Aims of the group are:

- i. to present women's health problems with an integrated approach which looks besides women's biological cycles
- ii. to find out inequalities in the treatment of men and women for what concerns relevant pathologies in population, in particular mental, cardiovascular, tumoral and gastroenterological disorders, and stress and violence related pathologies.
- iii. to point out the lack of attention paid to gender difference, to the fact that the male gender plays the main role in researches, particularly in procedures and methods that concern:
 - collection of statistical and epidemiological data;
 - evaluation of etiological and risks factors;
 - treatments experimentation and clinical trials;
- iv. to observe etiological and risk factors in male and female population and measure how much gender prejudice influences the evaluation of some of them compared to others;

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- v. to point out that medical organization about services and planning do not take in adequate consideration all women's health needs, but just the ones related to their reproductive function;
- vi. to evaluate the lack of research planning able to highlight, in all medical fields, specific differences between man and women;
- vii. to plan procedures apt to improve research and action programmes and provide guidelines apt to modify the approach of institutions and researchers to gender difference and equity of treatment.

The group has collected the results of its research-work in a *Report on women's health* and in a *Guide for women and their health providers*. The results of its three years work have shown the same transversal deficiencies, lack of attention and of adequate answers, under-evaluation of problems, in all medical sectors which have been observed.

The group has published, under the auspices of the Italian Ministry of Equal Opportunities first and of the National Commission on Equal Opportunities among Man and Woman then, a Report on *Health designed for the woman* (October 2001) and a *Guide to women's health* (September 2003), underlining a number of relevant problems and prejudices that limit research and clinical work in behalf of women's health. The most relevant subjects are: the new risk factors, such as environment, violence, work; and relevant pathologies such as Cardiovascular Diseases, Mental Illness (depression and schizophrenia), Tumours of the Uterus and Breast Cancer, Gastrointestinal and Liver Diseases, Osteoporosis, Thyroid Disorders, Stress related Pathologies, HIV, etc.

Health research and data collection

The **lack of gender-specific health data** is the first problem to be mentioned.

It is well known that women have longer life expectancy than men in similar socio-economic positions. Nevertheless, they suffer from poorer overall health because of age, biological factors, specific risk factors, poverty and loneliness. According to the data of the National Statistical Institute (ISTAT, 2000a; ISTAT, 2001) in Italy life expectancy is 82 years for women and 75.8 for men. This gap between women and men decreases if we consider life expectancy after age 65 and life expectancy free from disability. At age 65, life expectancy is 20 years for women and 16 for men, that is a gap of 4 years, but if we consider life expectancy free from disability this gap is reduced to one year only (15 years of life expectancy at 65 for women, 14 years for men). At age 75 the difference in life expectancy between women and men free from disability is irrelevant: only 0.3 years (Ministero della Sanità, 2000). Moreover, compared to men, women report more illnesses and diseases (particularly arthritis, osteoporosis, hypertension, depression): survey data on self reported state of health show that a wider share of women than men report at least one chronic disease, and in 23 out of 28 categories of diseases, the prevalence is greater among women (ISTAT, 2000a; ISTAT, 2000b).

The report of our work group provides data on male and female **prevalence** and **incidence rates** for several diseases. Where national official data were not available, the experts of the group have drawn from international data or from data originating from their own research and clinical work.

More men die for lung cancer but in Italy during the years 1984-1994 women's mortality rate for this cause increased by 18%, while the men's rate decreased by 4%. The World Health Organization estimates lung cancer (together with tumours of the trachea and bronchus) represents the third cause for death in the European population. Moreover, a lung cancer emergency for women is foreseen for the coming decade. (Ballard and Corradi, 2001; World Health Report, 2000). Mortality among women for AIDS has reached the male rate: indeed, AIDS constitutes the main cause for death among women in the age bracket 15-44 and in this age bracket their mortality rate is higher than men's (Corradi, 2001, 2003; World Health Report, 2000).

As the World Health Report shows, all types of mental disorders, except for alcohol and drug abuse, are increasing and are more common among women; in particular, unipolar depression ranks 4th for women and 8th for men in terms of the main causes of disease burden at the world level. Depression is 2-3 times more common among women compared to men and is the main cause for disability among women in the age bracket 15 and 44. In Italy, a recent study demonstrated that the prevalence rate for all psychiatric disorders is higher among women and that the peak incidence for depression occurs in the age bracket 35-44. Despite the fact that depression is more common among women, there are no gender-oriented research and intervention programmes for its prevention and treatment in our country (Reale, 2001 and 2003). Until recently Schizophrenia was more commonly diagnosed among men, but the most recent data show a slightly higher incidence among women, although among them this mental disorder shows less socially undesirable traits than in men. (Boidi, 2001, 2003; World Health Report, 2000).

Today also the rate of death for cardiovascular diseases is higher for women than for men. According to the World Health Report, they represent among women the first cause of death in all western countries and, in recent years, also in developing countries. In Italy, according to data of the National Statistical Institute, in 1991 cardiovascular diseases was the cause of death in 48% of adult women and in 39% of adult men. Hypertension, the most important risk factor, is more frequent in males up to the age of 45, while in females it is more frequent from the age of 50. A recent research on women of the age bracket 45-60 of the Province of Modena shows that 38.2% suffer hypertension; however it is striking that only 34% receive adequate treatment. There is much evidence in the medical literature of a general under-evaluation in the diagnosis of ischemic cardiovascular disease in women. (MODENA, 2001, 2003).

In spite of the fact that there are striking differences by gender for important diseases, in Italy a structured national system capable of monitoring social differences in health is not available; more specifically, aside from mortality and cancer incidence, data and research on gender difference are lacking and health data are not systematically collected and disaggregated by sex. The information provided by hospitals and local health units is incomplete, not divided by sex and often unreliable. There are no clear national norms for including gender as a basic variable in all data collection (VINAY, 2001, 2003).

It is self evident that gender sensitive research and data collection are very important to promote women's health. A Technical Paper of the Department of Women's Health of the World Health Organization (2000) emphasized this matter with these words:

«First and more importantly, it is essential that the situation of women is more accurately reflected in routinely collected health statistics. It has been a frequent complaint of policy makers that most statistics are not disaggregated by sex. This makes it difficult to understand the specific situation of women (or men) and to plan in ways that take these differences into account (i.e. making projects gender sensitive). If this is to be remedied, special care is needed both in the collection of data and also in its analysis and presentation. If the diversity of women's needs is to be acknowledged it is particularly important to have data that is disaggregated by sex and age as well as social class.»

Gender sensitive research on risk factors

Another important problem underlined in the report is **the lack of gender sensitive research on occupational and environmental risk factors**. Little attention has been given to these risk factors for depression, ischemic heart disease, breast and uterine cancer, since these diseases have been up to now considered to have mainly hormonal aetiology. Let us make some examples.

Tobacco smoking is the main risk factor for lung cancer. Women start smoking earlier than men and have more difficulty quitting. However, primary prevention of tobacco smoking is gender-blind, that is, aside for the period of pregnancy, specific messages aimed at girls and women are lacking. Instead, an effective primary prevention should investigate gender and socio-cultural factors associated with smoking initiation and cessation.

In the field of mental health, research on etiological and risk factors are mainly oriented toward the evaluation of biological-hormonal factors, generally omitting for females (but not for males) the investigation of psycho-social and work factors. There seems to be gender bias in psychiatry that underlies the consideration of hormonal variations as the major risk factor for depression and other psychiatric disorders in women. As in general medicine where there has been an improper process of medicalization of the physiological stages of a woman's life, also in psychiatry there has been a process of psychiatrization of female physiology: this is particularly true for depression. Among women there has been a clear under-evaluation of environmental and psycho-social factors as well as the impact of every day life on their mental health. Moreover, in studying etiological and risk factors for mental disorders in women, specific targets in the National Health Programme have not been foreseen (Reale, 2001 and 2003).

In the research on risk factors for ischemic heart diseases, for women there seems to be an over-evaluation of biological and hormonal factors and an under-evaluation of environmental and stress factors; stress is considered the main risk factor for ischemic heart disease only for men (REALE ET AL. 1998; MODENA, 2001, 2003).

Occupational health remains an area where we lack knowledge about occupational hazards and their effects on women's health: often this type of data is not disaggregated by sex or there is insufficient detail on women. However, in many occupations that may be considered «female» hazards are very high: in the health sector 54% of accidents involve women. As more women work, occupational injuries are increasing among women (+ 8.4% from 1994 to 1997) while decreasing among men (- 9.8% during the same time period). More

studies are needed to investigate whether occupational exposures have different effects on female workers than on male workers. One example is heavy physical work, which is less well tolerated by women. This is partly due to the fact that work organization is based on standard measures designed for male workers. Italian women suffer more frequently musculoskeletal disorders, compared to men, even in the same work environment. This is because women are given repetitive tasks in fixed and inadequate ergonomic positions which put excessive pressure on their smaller and more vulnerable muscles (FIGÀ TALAMANCA, 2001, 2003).

In studying risk factors for cancer, the type of work is always considered for men while the same emphasis on work has not always been taken into account for women. However, some recent studies have shown the correlation between some forms of tumour (kidney, lung, leukaemia, lymphoma) and exposure to solvents and hydrocarbon among female workers. Thus, also in the field of occupational health, information is lacking, the model of reference is the standard male worker and (except for pregnancy) there are no guidelines to measure work hazards for women (FIGÀ TALAMANCA, 2001, SALERNO, 2003).

As we know, a very important risk factor for women is the **stress and strain linked to the multiple work** load for the family and for the labour market. Our work group has underlined that in medical research and clinical practice, great importance is given to **work** as a major risk factor in the analysis, prevention and treatment of diseases in men, but for women little attention is given to this factor or to other life conditions. In particular, little or no attention is given to the coexistence for women of a plurality of roles, responsibilities and tasks linked to their professional and family life. The risk of physical and psychological burn-out is neglected and parameters capable of measuring the hazards and satisfaction of family work are not available (REALE and VINAY, 2001; and REALE, 2003).

Several sociological studies have underlined the amount of work done by women within the family in its various forms. This invisible work, indeed, goes far beyond what is commonly called housework, but involves also the production of goods and services for family consumption; the bureaucratic activities necessary to use the public services; the activities to promote health and cure the first symptoms of illness; as well as the activities necessary for the education, socialization and caring of the children, the old, the ill and disabled members of the family.

In this respect - due to the lack of public services and to the traditional division of roles within the family - Italian women's work burden seems to be particularly high. The study of family use of daily time has underlined that on the average, Italian women spend 5 hours a day in paid work and 8 hour in non paid work, while men spend 8 hours in paid work and 1 hour in non paid work (ISTAT, 1993). Moreover, men's pattern in the use of time does not vary significantly by the different type of family they live in, while women's use of time is significantly affected by the presence of children in the family and of a partner as well. In this respect, women with children seem to be advantaged by the absence, rather than by the presence, of a partner in the family (SABBADINI and PALOMBA, 1993). In the end, as the former chairwoman of the National Commission on Equal Opportunities among Man and Woman has underlined, considering both paid and non paid work, more than 50% of Italian women work 60 hours a week and over one third work 70 hours a week, while less than one third of men work more than 60 hours a week (PIAZZA, 1999). Thus, family work and its

character of caring for others (as opposed to caring for oneself) can well be considered as a major risk factor for women's health. As a matter of fact, a research on stress and women's daily life (REALE ET AL., 1998) suggests a relation between hypertension, breast carcinoma and depression and the increase in family work responsibilities.

Violence is a frequent experience in the life of women and is considered a risk factor for poor health among women. According to an Italian study on a sample of users of various socio-health services, one out of ten women in the sample and 18% of those in the age bracket 18-24, had experienced physical or sexual violence in the twelve months preceding the survey. The perpetrators of the violence are almost always men close to the woman: her partner, former partner, father, brother, school mates or work colleagues (ROMITO, 2000). It is rare that women are listened to, believed or given adequate help by the social and health workers of the services they resort to (ROMITO, 2001 and ROMITO 2003).

On this matter the cited Technical Paper (WHO, 2000) states:

«Male violence against women, particularly in the home, has many damaging consequences for women's health, including intentional injury. (...) In most communities women appear to be at greater risk from intimate male partners or other men that they know, and the violence girls and women experience occurs most frequently in the 'haven' of the family. The damaging effects on women's physical and mental well-being can be extremely pervasive and go far beyond injury».

The effects of violence manifest themselves in common diseases for which women seek health care. A study in Italy on the relation between chronic gastrointestinal disorders and physical and/or sexual violence suggests that male violence against women has many damaging consequences for their health. This includes many types of disorders, in particular those without clear «objective» causes (PALLOTTA, 2001 and 2003). In several countries, epidemiological studies have shown that the prevalence of lifetime history of physical and/or sexual violence may be from 30 to 60% of women with chronic gastrointestinal disorders. In Italy, studies on patients of public services specializing in gastrointestinal disorders have shown a prevalence of 32% for physical and/or sexual violence. They have suggested also that the seriousness of the symptoms, the response to therapeutical treatments and the quality of life are directly linked with the severity of the violence suffered. In another it was found that 86% of women seeking assistance at an anti-violence Centre reported at least two gastrointestinal symptoms. (BACCINI-PALLOTTA-BADIALI ET AL. 1998; CALABRESE-BACCINI-PALLOTTA ET AL. 1999). All this suggests that physical and sexual violence represents an important factor in the decline of a women's health conditions.

Gender differences in diagnosis and treatment

Another important problem underlined by our work group is the **inadequate consideration of gender differences in diagnostic and therapeutic practices**. These practices have traditionally been developed around a male model and applied also on women without taking into consideration social and bio-psychological differences between the two sexes. In this respect the lack of consideration of gender differences in research can cause problems related to the development of instruments and techniques for the diagnosis and treatment of diseases in women. Some example will make this point clear.

The frequency of schizophrenia among women has been underestimated. For this psychiatric disorder, priority is given to the most serious cases from the point of view social disturbance. Women with schizophrenia often have more subtle symptoms which leads to an under-recognition of the problem. They often seek help later than men with the same condition, are treated more often on an outpatient basis and have fewer hospitalizations than male schizophrenics (BOIDI, 2001).

For cardiovascular diseases, in particular ischemic heart disorders, all diagnostic techniques such as imaging tests and stress tests used currently were created on the basis of a male model and are less effective for making the diagnosis in women. The surgical instruments for coronary revascularization (by-pass, coronary angioplasty) are the same of those used for men and little attention has been paid to the fact that women have smaller coronary arteries and blood vessels. There are no guidelines that define typical symptoms of myocardial infarction in women: the chest pain women report is considered «atypical» while male pain is considered «typical». The diagnosis of ischemic heart disorders is left up the clinical skill of the individual physician, given the absence of specific clinical diagnostic guidelines for women. There is evidence, moreover, of an under-utilization of thrombolytic therapy in eligible women with acute myocardial infarction, leading to a higher female mortality rate in early stages of infarction. For all the above reasons women are admitted to the appropriate hospital ward later than men and experience a higher rate of therapeutic and surgical failure (MODENA, 2001 and 2003).

On the other hand, for other specific female diseases we note an excessive medicalization and surgical intervention. This occurs often in the case of breast and uterine tumours and other disorders. For instance, hysterectomy is widely resorted to, but the rate varies very much from one country to another (one woman out of three over 60 years of age in USA and Australia, one woman out of five over 65 years of age in Great Britain). In Italy national data are not available, but according to several regional surveys the trend seems to be on the increase. In the Veneto region, for instance, the number of hysterectomies has been increasing between 1993 and 1996; according to the data collected, in that region one woman out of four undergoes a hysterectomy in her life span. Important variations between countries and physicians are reported also with regard to the choice of type of hysterectomy - whether limited to the cervix uteri or total, and whether involving also the surrounding tissues, the adnexa uteri and the ovaries. Other variations concern whether the intervention is done abdominally or vaginally, and the surgical technique used - traditional, laparoscopic or mixed surgery (MINUCCI, 2001 and 2003).

Often hysterectomy is associated with removal of the ovaries (oophorectomy) for no clear clinical indication, thus making this practice the only case where a healthy organ is intentionally removed. There is evidence of an extensive and inappropriate use of hysterectomy, not supported by efficacy standards; in fact, in this field reliable protocols and guidelines for the appropriate surgical indications are not available. It must be recalled also that hysterectomy may have many harmful outcomes, mainly those linked to the hormonal, physical and psychological impact of the loss of the uterus and other reproductive organs. Therefore, hysterectomy is appropriate only when it is the only possible way to prevent or to remedy a health condition and in any case should be limited to the removal of the smallest possible part of the organ, resorting to the less invasive procedure. Several surveys demonstrate that only 10-15% of hysterectomies are in relation to a malignant tumour, while

85-90% are in relation to benign conditions which could well be treated without surgery. Clear protocols are needed defining the clinical situations for which hysterectomy is appropriate and those for which a medical therapy or a surgical preservative therapy is adequate. The diffuse practice of hysterectomy undermines the criterion of integrity of the individual person, the uterus being considered only for its reproductive function (MINUCCI, 2001, 2003).

The exclusion of women in clinical trials

A very important problem that was addressed by the work group is the **exclusion or insufficient presence of women in clinical trials**. In spite of the physiological and pathological differences between females and males, up to now in medical and pharmacological research, adequate attention to women has not been given. In clinical trials conducted to test new pharmaceutical products, mainly adult males are employed. This means that, as a rule, to women the same right to an 'effective and safe' therapy – as stated in national and European norms – is not granted since there is no way to know if a product shown to be effective and safe in men is likewise in women. Moreover, even when women are employed in great numbers in these studies, the data are not as a rule analysed by sex (CECI, 2001 and 2003).

The exclusion of females in pharmacological trials may cause problems related to dosages, efficacy and side effects. There are several classical examples we can cite. Women have been excluded from the largest population study ever done, the «Aspirin study», designed to evaluate the impact of aspirin on the prevention of cardiovascular diseases. Because of insufficient numbers of women present in the study of pharmaceutical products for reducing cholesterol, these products have been shown to be dramatically less effective for the female population than documented in clinical studies and in the male population (CECI, 2001).

All clinical trials for the treatment of ischemic heart diseases have been conducted on the basis of the male model. In the example of pharmacological treatment of cardiac thromboses, doses inappropriately based on the relationship of body surface area to body weight in males (but which varies by sex) has resulted in more frequent haemorrhagic complications among women (MODENA, 2001, 2003).

Women come first as psycho-drugs consumers, however, because of their inadequate representation in clinical studies, knowledge on side effects and efficacy of psycho-drugs on females is more limited than on males. Also in the pharmacological treatment of psychic disorders (anxiety, depression, schizophrenia) women suffer more often from several side effects due to high dosages made to measure for men (BOIDI, 2001 and 2003).

In every clinical area there exist examples of drugs that are tested predominately on men but that are indicated with equivalent doses also for women, giving rise to potentially higher risks of ineffectiveness or more severe side effects among women treated by these drugs. This points out the urgent need for specific European guidelines on gender-specific testing of pharmaceutical agents before they reach the market and are indiscriminately prescribed both for women and for men.

Concluding remarks

In conclusion, the group work has underlined mainly two inappropriate criteria in approaching gender problems. The first one is the inadequate consideration of overall biological differences between sexes (aside from the reproductive sphere). The group work underlines that man and his biology is being constantly taken as the sole reference point for clinical studies; this has favoured the exclusion of women from clinical trials, an inappropriate methodological procedure that puts in question the validity of this activity. In fields such as cardiology, oncology, pharmacology and occupational medicine gender differences are not considered and the effectiveness of diagnostic tests and treatments is essentially measured on men. The exclusion of females in medical research causes problems of lower effectiveness and higher hazards of several medical practices in such matters as: the use of standard instruments for diagnosis and treatment; the dosages and side effects of pharmaceutical products; the definition of guidelines for prevention and treatment; the analysis of social risk factors - since the central point of reference is the male, his environment and his lifestyle.

The second inappropriate criterion underlined by the group work is the disparity in medical research in studying male and female diseases. As we have seen, health data disaggregated by sex are lacking and even when available they are often undervalued and do not provide the level of detail necessary to assess gender differences. Important risk factors are not taken into consideration for women: *in primis* violence - a risk factor that may cause severe harm to women's health - and also the environmental socio-work factor. The researches on stress, cardiovascular diseases, cancer, depression and occupational diseases appear to be gender biased in their basic hypothesis and approach: on one side the studies of male diseases almost always include environmental, social and work risk factors; on the other side, the studies of female diseases focus on risks related to the biological - reproductive - hormonal sphere. As we have seen, the male model of work is taken as the sole reference point while the double work model of women is excluded. The most dangerous outcome of these biases is that prevention is precluded to women: indeed, the exclusion of the female presence in clinical practice hampers the analysis of **social risk factors** and therefore also **primary prevention** for women in mental health, stress-related diseases, cancer as well as many work-related illnesses and injuries.

In the end, as noted in the cited WHO's Technical Paper(2000):

«There is now a growing body of evidence to indicate that medical research has been a profoundly gendered activity. The topics chosen, the methods used and the subsequent data analysis all reflect a male perspective in a number of important ways. (...) Gender bias is evident not only in the research topics but also in the design of a wide range of studies. Where the same diseases affect both women and men, many researchers have ignored possible differences between the sexes in diagnostic indicators, in symptoms, in prognosis and in the relative effectiveness of different treatments. (...) So long as researchers treat men as the norm, the medical care of women continues to be compromised».

*Proposals and Suggestion for European
Guide-lines in the field of Health (research and clinical practice)*

All the experts in the group work «*Medicine, Women, Health*» have underlined that medicine should assume as a whole the principle of integration of the gender point of view in all its ranges of action, from clinical practice to research, from diagnosis to prevention. In his work the group gives **suggestions** to overcome biases in medical research, diagnosis and treatment and to integrate in the European and National Health Programme the viewpoint of a gender sensitive health system.

A synthesis of the main positive actions recommended follows.

- i. Every research project in health, financed with public money, should be requested to include gender indicators in data collection and analysis; on this respect clear procedures to include the principle of gender difference in the collection of information at central, as well as at local level, should be defined. Circulation of gender-specific information at every level between health providers should be encouraged. Specific research projects on prevention and risk factors for emerging female diseases such as cardiovascular diseases, mental health disorders, HIV, cancer, etc, should be promoted.
- ii. It is important, to use appropriate gender-specific methodological instruments in all research fields. In comparing men and women, attention should be given to their different historical, biological and socio-cultural reality. In order to overcome disparity and prejudices, productive paid work should be considered in conjunction with reproductive non-paid work both for men and women; for this scope it is also necessary that these two aspects of work be comparable and evaluated both quantitatively (i.e. in terms of energy and time spent) and qualitatively (i.e. satisfaction, socialization, recognition).
- iii. Adequate attention should be given to physical and sexual violence and to its consequences in terms of health damage. As we have seen there is a wide gap in medical information and knowledge on the physical, psychological and social after effects of violence and sexual abuse. We suggest, therefore, that the theme of violence be brought up with all women during medical interviews; in addition, specific protocols and guideline are needed to assist providers to best address this topic with their women patients.
- iv. More generally, we believe that there is an extreme need for training medical personnel; for that purpose specific programmes on gender difference should be promoted and become an essential part in the curricula of all health providers.
- v. Specific services for women's health are needed in the field of mental health as well as in other medical areas; recommendations should be given to Regional and local health authorities to promote gender sensitive health services and activities.
- vi. Clear guidelines should be prepared to insert the gender point of view in diagnosis, prevention and treatment in order to make these activities more effective in behalf of women's health.
- vii. The group has underlined also the importance of proposing recommendations to be addressed at the European Community in relation to the procedures of sample selection in testing new pharmaceutical products (including women in clinical trials, analysing results separately by sex, giving specific information on side effects for women and men).
- viii. Finally, the group recommends the creation of specific Office on Women's Health (similar to the one set up in the U.S.A.) in the Health Departments of European Community, capable of promoting appropriate prevention, diagnostic and treatment

services for women and to promote culturally sensitive practices in medical education and research in order to implement a women friendly health system.

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