"Putting on gender glasses" to understand working conditions

If occupational health is ignored, equality policies will always be ineffective. The opposite is also true: the fight for occupational health must focus on ensuring access for both men and women to all jobs under conditions compatible with their lifelong health.

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A high percentage of women's jobs require the performance of tasks of the type carried out within the household.
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Equality is not being achieved if you look at the data from European surveys on working conditions and employment. Regardless of the region, women work under less favourable conditions than men. Their pay is lower, their jobs are more insecure and they are responsible for most of the unpaid work. They are more at risk of poverty than men. However, the specific forms of inequality vary from one country to another depending on a range of factors: the degree to which the welfare state is family-oriented; the extent of horizontal segregation, which confines women to a limited number of activities and sectors; the amount of public investment in facilities such as crèches and care homes; the extent to which part-time work is the norm for women's work, etc. Although these variations are important, they do not affect the profoundly unequal structure of our societies.

Segregation

Segregation between men and women at work is one of the main characteristics that emerges from the European Working Conditions Survey[1]. It applies to both paid work and unpaid work. Among clerical support workers, intermediate healthcare workers, personal carers and cleaners, the percentage of women is around 80%. Among manual workers in construction, machine operators and manual craft workers, the percentage of men ranges from 85% to 90%. Education is also a female-dominated sector (67% women). The overall picture is startling: 60% of women and 64% of men work in occupations that are dominated by their own gender. Out of the 20 largest occupational groups, only five can be regarded as relatively mixed. However, these categories are defined in very general terms. Within seemingly mixed occupations, you will often find a division of labour revealing clearly male or female areas.

As regards employment conditions, the main segregation factor is part-time work, which now represents the norm for female employment in a number of European countries. The countries with the biggest difference between the paid working time of men and women are Austria, Belgium, Germany, Ireland, the Netherlands, Norway and the United Kingdom. Part-time work is associated with necessarily being more flexible in terms of working hours (which brings uncertainty with regard to the organisation of daily life) and benefiting from fewer opportunities for training and promotion. This is a central factor in the insecurity of women's work. In Germany, women have been particularly affected by the "Hartz reforms", which were adopted by an SPD-Greens government in the early 2000s. They hold two-thirds of mini-jobs (gross monthly salary below EUR 450) and three-quarters of midi-jobs (salaries between EUR 450 and EUR 850).

The distribution of unpaid work is very unequal. If you add together paid work, travelling time and unpaid work, the average weekly working time of women is 64 hours compared to 53.4 hours for men. The main difference lies in unpaid work: 26.4 hours for women as opposed to 8.8 hours for men.

Segregation affects health for various reasons. For both women and men, stereotypes about what work is "naturally" female or male result in risks being trivialised and actual workloads being minimised. More specifically for women, segregation tends to reduce the positive impact of paid work where this relegates women to activities that are viewed as an extension of unpaid work. This applies not only to all occupations associated with personal care, but also to those that are a continuation of domestic tasks, such as cleaning, ironing, etc. This association with unpaid work is also apparent in occupations that are seemingly unconnected, where the expectations of colleagues or users sometimes change the practical aspects of professional conduct. Surveys in very different environments reveal these pressures.

The organisation of work is marked by a more authoritarian hierarchy for female workers. In the 2010 European survey, 37% of

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1. The data cited are from the 2010 survey. At the time of writing this article, the 2015 survey data were not yet available.

women indicated that they were in a position to influence decisions that were important to their work, compared to 43% of men[2]. Among women, 46% said that they were consulted before targets were set (compared to 48% of men). If we look at career progress, 29% of female workers indicated that their work offered good prospects for career advancement, compared to 34% of men.

Different health effects

Working and employment conditions result in significant social inequalities in terms of health for both men and women. This finding is important but, in order to improve these conditions, we must examine to what extent health effects may differ for men and women.

Occupational segregation concentrates a higher proportion of men in activities where the physical risks are immediate and visible. As a result, frequency rates for accidents at work are higher for men than for women. This phenomenon is mainly due to the high concentration of men in sectors where accident rates are particularly high, such as construction, fishing or road transport. In most European countries, however, the statistics indicate that male and female frequency rates for accidents at work are becoming increasingly similar. Generally speaking, over the long term, the number of accidents at work suffered by men has reduced to a much greater extent than for women. When the statistics calculate the frequency rate compared to the number of hours devoted to paid work, the difference between men and women is also smaller.

Other risks in the workplace broadly reflect occupational segregation: more men are exposed to toxic chemicals (particularly carcinogens), noise and vibration. Women are more likely to be exposed to biological risks (particularly due to their concentration in the health and personal care sector). As regards carrying heavy loads, men are more affected by carrying objects and women by carrying people. Overall, the perception of immediate risks to health and safety is greater among men than among women. This short-term advantage disappears over the long term. The percentage of women who feel that they will not be able to do the same job at 60 is similar to that for men.

> Part-time work is a central factor in the insecurity of women's work.

This perception is confirmed by the employment statistics. There is a significant reduction in female employment rates from the age of 50 in most European countries. Women are more likely to withdraw from the labour market than men. The explanation for this phenomenon probably lies in the combination of two elements: firstly, women's health is affected by the cumulative impact of occupational exposures, and in particular by the wear and tear associated with repetitive and pressurised work involving significant emotional burdens and lower levels of recognition and autonomy than for men. The other element is probably the greater possibility of women having to stop work because their health has deteriorated or is at risk.

Presenteeism affects women more than men. Among women, 41% indicated that they had had to go to work when ill in the previous 12 months (compared to 38% for men).

Few surveys study in detail the conditions of unpaid work. The most systematic data are provided by the health surveys conducted in Spain[3]. These data are generally confirmed by sources available in other European countries. They allow a link to be established between domestic workload (generally measured by the number of people in the home), social class and state of health.

Accidents caused by unpaid work are very poorly documented in Europe. Most of the available statistics use a very general category of accidents in everyday life, which includes a wide range of events (accidents linked to leisure activities, fires, accidents caused by domestic work, drownings, suffocation by food, etc.). These statistics use causal factors from the International Classification of Diseases (ICD10) that are limited to physical agents (drowning, fire, bites and stings, electric current, etc.), without mentioning the activity that was at the root of the accident. Italy compiles more systematic data as it has introduced a compulsory insurance scheme for accidents suffered by individuals that purely stem from unpaid domestic work.

According to research for 2007[4], around 400 000 women apparently went to the accident and emergency services of Italian hospitals following accidents occurring at home, with 110 000 of these accidents seemingly being caused by domestic work. Hospitalisation

2. The responses taken into account are 'always' or 'most of the time'.
3. Rolhfs I. and Frigola M. (2007) La incorporación de la perspectiva de género en las encuestas de salud en los primeros años del siglo XXI: evolución y camino a seguir, *in* Borrell C. and Artazcoz L., Investigación en género y salud, Sociedad Española de Epidemiología, Barcelona.
4. Pitidis A. *et al.* (2012) Gli infortuni delle casalinghe – un fenomeno sommerso, Not. Ist. Super. Sanità, 25 (7-8), 13-16.

Unlike the case with "men's jobs", there is little social recognition of the risks entailed by those performed predominantly by women.
Image: © Belga

was required in 9 200 cases, and every year around 900 women apparently suffer serious long-term disabilities. Among these domestic work accidents, 63% occur in the kitchen. The study authors state: "The home is a safe place in the minds of society and individuals, but this is only true if the spaces and items in those spaces have been built and maintained and are used in an appropriate manner". This observation suggests that the conditions under which domestic work is carried out may reveal important social inequalities linked to the financial situation of families.

Breast cancer and work

With around 360 000 new cases every year and over 90 000 deaths, breast cancer is the main cause of death from cancer for women in the European Union.

The epidemiology of occupational risks has long neglected to study the interactions between working conditions and this cancer, which almost exclusively affects women. The scientific literature on this subject is more recent and less plentiful than that on lung cancer, which is the main cause of death from cancer for men.

This lack of scientific interest influences breast cancer prevention policies: most campaigns focus on early detection and individual advice regarding lifestyle (food, physical activity, etc.) and ignore primary collective prevention and improvement of working conditions. This is advantageous to the pharmaceutical industry, as pointed out by the French sociologist Marie Ménoret: "Zeneca Pharmaceutical, the world's biggest seller of anti-cancer drugs for breast cancer, thanks to its tamoxifen patent, is also the main producer of pesticides and other harmful products, which are known to be particularly carcinogenic".

Conversely, the analysis of breast cancers in men has on numerous occasions helped to identify the role of occupational exposures. Notably, the role played by chemical substances (particularly in solvents) and ionising radiation was identified long ago.

A report published in August 2015 by the Breast Cancer Fund in the United States confirms previously observed associations between various occupations and breast cancers.

Among nurses, the risk is 50% higher. It is four times higher among certain professionals. One of the theories adopted by the scientific literature is the role played by stress at work. New associations have become apparent in recent research. The risk of breast cancer is five times higher among hairdressers and beauticians, as also among food and beverage production workers. It is four and a half times higher among dry cleaning and laundry workers and four times higher among workers in the paper and printing industry and among those making rubber and plastic products.

The report lists the occupational risks explaining these figures. These risks mainly stem from a series of chemicals such as benzene and other solvents, polycyclic aromatic hydrocarbons (PAHs), pesticides and numerous other endocrine disruptors. Night work and ionising radiation are also singled out.

More information

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5. See Algava and Vinck 2015.

Being female doubles the likelihood of being "forgotten" by occupational health.

Prevention on the cheap

The European surveys do not allow prevention practices according to gender to be analysed. Those offering gender-differentiated data do not ask questions about prevention activities. The European Survey of Enterprises on New and Emerging Risks (ESENER), which does cover these aspects, does not allow the situation of men and women to be analysed separately. However, a few national surveys that are available contain similar responses. As a general rule, prevention activities are organised less systematically in female-dominated areas. The only notable exception is hospitals. The capacity of nurses to take action to improve their working conditions is one of the main factors explaining this exception.

In France, 61% of workers stated in 2013 that there was a committee on hygiene, safety and working conditions (CHSCT)[5]. This breaks down into 62.7% for men and 59% for women. The lack of CHSCTs helps to explain why prevention is less systematic and more bureaucratised. Accordingly, 35% of male workers were aware of the existence of a risk assessment document, compared to 24% of female workers. Where the existence of this document was mentioned, the likelihood of having been consulted on its contents was slightly higher among men than among women.

Although occupational health is supposed to cover all workers in France, over 16% of women have never benefited from a health check-up or state that their last check-up was more than five years ago. Being female doubles the likelihood of being "forgotten" by occupational health. Health check-ups are pointless unless occupational health also examines the collective working conditions. Around 25% of men reported that their workplace had been visited by an occupational doctor in the previous 12 months, compared to 20% of women. Some 54% of men had been given written health and safety instructions or guidelines, compared to 38% of women. There were also inequalities in safety training: around 35% of men had received such training in their company, compared to 26% of women.

The figures from the 2011 Spanish survey on working conditions also point in the same direction (INSHT 2012). Some 41% of men reported that the risks of their work had been assessed, compared to 32% of women. In the previous 12 months, companies had offered a check-up by the occupational doctor to 75% of men, compared to 61% of women. As regards information and training on risks, 62% of men had received these against 52% of women. Added to these factors associated with the gender of workers is a problem of representation. Where this exists, it is mainly carried out by men. Just under one-quarter of prevention representatives in Spain are women according to a 2009 survey.

What are the policy implications?

The figures summarised in this article are useful for critically analysing prevention policies. In recent years, some political institutions have recommended focusing prevention on high-risk sectors and reducing employers' obligations in low-risk sectors. This approach has frequently been highlighted in European debates. There are no sectors that can generally be regarded as "low-risk" as everything depends on the risk in question. In certain activities, the accident risk may be limited, whereas the chemical or work intensity risk may be higher. Likewise, tailoring prevention obligations to the size of companies would in all likelihood have discriminatory effects for women. Supporters of "better regulation" in Europe systematically conceal the gender inequalities that their policies may cause. Under the guise of an approach that favours "good sense", they reinforce the usual stereotypes that women's work involves fewer health effects than men's work.

However, the trade union movement should not limit itself to criticising public occupational prevention policies. It would also be useful to consider its own approach and strategies. Linking equality to the fight for occupational health remains a neglected aspect in the work of most trade unions. Their action for equality in the domestic sphere is generally modest. The link between different types of working time (paid and unpaid and other living time) deserves responses that go beyond the simple concept of "reconciliation", which does not challenge the perpetuation of gender inequalities. With this in mind, relaunching the fight for an equal reduction in working time is undoubtedly one possible response, provided that it is combined with the demand for the equal sharing of domestic tasks. ●

More information

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The ETUI and the fight for female workers' health

Still today, even in Europe, women's work is regarded as not particularly dangerous and therefore requiring fewer preventive measures for specific risks. Service jobs, which account for a very large part of total female employment, are regarded as safe. They conjure up reassuring images of work prioritising the qualities of care, kindness, a sympathetic ear and such like, which are associated with "female values". Women are therefore regarded as almost exclusively carrying out light work, with seemingly negligible consequences for their health, in terms of both accidents at work and occupational diseases.

These caricatures have particularly harmful and pernicious consequences for women's right to health. For around 20 years, the European Trade Union Institute (ETUI) has been working to highlight the impact of work on women's health. In the mid-1990s, ETUI researchers helped to organise the first scientific meetings on this subject, and also open them up to other circles, particularly trade unions and associations.

By publishing the pioneering work of experts from Quebec, the ETUI has helped to disseminate information throughout the European Union that has raised awareness of the gender division of labour and its consequences for the health of millions of female workers. The ETUI has constantly denounced the way in which women are discriminated against by systems for reporting and recognising occupational diseases. Through many publications, researchers from this institute have also highlighted the "double workload" phenomenon, which is ignored by society, whereby women have to do both paid work and domestic work (housework, looking after children and parents, etc.).

Below are a few key dates in the ETUI's fight for gender equality in the area of occupational health.

April 1996: First international congress on the issue of women's health at work in Barcelona. The European Trade Union Technical Bureau for Health and Safety (TUTB), which is now the Working conditions, health and safety unit, is represented by a British trade unionist.

1998: The TUTB publishes a guide to union action on risk assessment (written by Pere Boix and Laurent Vogel). The guide draws the attention of trade unions to the need for gender equality to be integrated in the occupational health policy of companies.

1999: The TUTB publishes the work *Integrating gender in ergonomic analysis* by Karen Messing (see the article on p. 18).*

September 1999: Second international congress on "Women, Work and Health" in Rio. The TUTB helps to extend the initiative beyond the academic world, particularly towards trade unions and feminist movements.

June 2002: Third international congress in Stockholm. The TUTB organises a workshop on trade union initiatives combining occupational health with the fight for equality. Laurent Vogel presents the results of a survey conducted in partnership with the Université Libre de Bruxelles (ULB) on occupational health and the gender dimension.

2003: The TUTB publishes the results of its survey conducted with the ULB in *The gender workplace health gap in Europe*.

November 2005: Fourth international congress in New Delhi.

October 2008: Fifth international congress in Zacatecas (Mexico). High attendance by women's organisations and trade unions from Latin America. Laurent Vogel presents an analysis of reproductive risks at work.

Autumn 2009: Launch of *HesaMag*, the ETUI's magazine on working conditions. One of the aims is to dismantle the stereotypes that women's jobs are the least dangerous. Themed issues specifically look at work in the cleaning sector, retailing and nursing care.

2011: The ETUI devotes two reports to the under-recognition of occupational diseases among female workers: *Women and occupational diseases in the European Union* and *Women and occupational diseases. The case of Belgium*. The report on Belgium prompts an opinion from the Belgian Council for Equal Opportunities for Men and Women, which makes various recommendations to improve the system for recognising occupational diseases.

January 2012: The ETUI and the Belgian Council for Equal Opportunities for Men and Women organise a study day in Brussels on gender inequalities and occupational diseases.

September 2014: The ETUI publishes *A gender perspective on older workers' employment and working conditions* by Patricia Vendramin and Gérard Valenduc (Université Catholique de Louvain).

March 2015: The ETUI organises the international conference on "Women's health and work. Sharing knowledge and experiences to enhance women's working conditions and gender equality" in Brussels.

*TUTB and ETUI publications can be ordered or downloaded on www.etui.org > Publications
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