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From specific medical treatment of patients to a complex (mental) health care for human wellbeing

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1. Introduction

Health policies and trends in (mental) health care towards incorporating gender equality present a challenge and involve a complex set of strategical decisions in any country, the Czech Republic included. This paper will present a way forward by suggesting to gender mainstream health policies and to mainstream health policies into gender equality policies. This presents an important step forward in cultivating sensitivity towards the interrelatedness of (mental) health and gender.

Previous analyses reflecting on the gendered aspect of the Czech healthcare system in general, and its transformation after 1989 (reacting to the breakdown of the Soviet Bloc with paternalistic, centrally planned and ideologically framed approaches) have pointed out important trends challenging or reproducing the status quo in (mental) health care. The Czech "Entry analysis on health and gender" (Šmídová & Vondráčková 2019) or reports providing international comparative perspectives, such as "Gender equality and health in the EU" (Franklin et al., 2021), "2021 report on gender equality in the EU" (European Commission, 2021) or the WHO report "Gender equity in the health workforce: Analysis of 104 countries" (Boniol et al., 2019) document differences in health status and health policies among people in different countries from the gender perspective and present those that pose a challenge to un/equal treatment of these differences. These phenomena stretch beyond gender-based differences in life expectancy, mortality, and physical and mental health outcomes or occupational health and safety inequalities between men and women in the EU Member States, inequalities based on ethnicity and or migration status, as well as inequalities in access and consumption of health care services and necessary medication and technology. Issues such as healthcare governance, financing, health information system, gender sensitivity in healthcare and gender issues related to health care workforce education and training form an integral part of these international documents (Franklin et al., 2021; Sen et al., 2020).

In particular, the EuroHealthNet report states that men generally have worse health outcomes than women, but perceive their health as better. Women live longer, but spend fewer years in good health. Even though some of the reasons for this are partly biological, these are largely social and behavioural consequences. While women more often report experiencing mental health issues, such issues often go unrecognised in men, who represent 77% of all suicides. Men's poorer health may be associated with male norms of risk-taking and adventure, health behaviour paradigms related to masculinity and the fact that men are less likely to visit a doctor when they are ill. And when they see a doctor, they are less likely to report on the symptoms of disease or illness. Women are more likely to engage in health promoting behaviours and have more reliable interpersonal relationships and social support networks than men, which can reduce the risk of many health problems. However, at the same time they are more likely to suffer from interpersonal violence (EuroHealthNet, 2021).

Socio-economical determinants of health have a major impact on health outcomes and they are strongly affected by gender. For example, education is one of the most important socio-economic health determinants and higher levels of education typically provide a benefit in health outcomes. However, "while more women have a university degree, they are more likely to work in low-paid jobs and in lower positions. There is a substantial gap in the hourly pay, overall earning and pension between men and women in the EU Digital gender divide, unpaid primary carer activities, lead to lower participation of women in the labour market and phenomena of 'feminised poverty'. Single mothers, older women, minority ethnic women, and the women with disabilities are the most vulnerable in this relation" (EuroHealthNet, 2021).

For the Czech Republic, the general life expectancy at birth is slightly above the EU average (2019: Czech Republic 82.2 years vs. EU average 81.3 years for both sexes, Eurostat), yet the healthy life expectancy is below the EU average (2019: Czech Republic 62 years vs. EU-27 average 64.6 years). Even though a gender gap in life expectancy at birth for women and men in the Czech Republic was as high as 6 years in 2020 (Eurostat), it is barely reflected in healthy life expectancy (healthy life years in the Czech Republic in 2019 by sex: males 61.7 females 62.6) similar to the situation in other EU Member States (healthy life years in the EU-27 in 2019 males 64.2, females 65.1, Eurostat, (Franklin et al., 2021).

2. General approach to (mental) health policies – gender perspective?

Generally, the gender perspective – as one of the potential analytical tools pointing towards inequalities in the (mental) health care setup – is not regularly measured and analysed in the Czech Republic beyond a rather ad hoc evidence of prevalence of selected phenomena by sex category in statistical reports. The resulting conventional understanding fuelled by cultural stereotypes is that it is women who are more prone to various mental disorders or conditions. Yet, the missing proportion of men in statistics of (mental) health care, treatment and hospitalisations can also be interpreted by the overall cultural gender stereotypes and expectations resulting in men neglecting prevention and not seeking assistance and care. At the same time, and the COVID-19 pandemic has shown that in an alarming scope, the double burden of work and care that significantly more often falls upon women, takes its toll in chronic (mental) health conditions of carers – a feminised segment of (paid and unpaid) labour.

2.1 Overview of mental health care and its change in the Czech Republic

The Czech Republic (CR) has a nationwide system of public healthcare provision, covered by the compulsory health insurance, and is provided free of charge at the side of recipients of care for CR citizens. Due to the history of a paternalistic and centralised – plus ideologically loaded – system of high standard biomedical expertise until 1989, yet prioritising (substandard) institutional care over individual and community approaches, significant reform has been necessary.

Since the 1990s, new tendencies have gained ground in psychiatric care to replace institutional care with community care (Muijen and McCulloch, 2019). In many EU countries, a certain part of psychiatric care has been moved from inpatient facilities to community-based mental health services, which offer people with mental disorders professional assistance in their natural social environment, relying on their functional networks (Keet et al., 2019). Reforms of psychiatric care in CEE countries are hindered by several major constraints, including the persistent stigmatisation and discrimination of people with mental disorders; relatively high cost of community care in countries with limited healthcare resources; and the lack of experts at all levels, from psychiatrists to social workers (Dlouhý, 2014; Dobiášová et al., 2016).

Mental health care in the Czech Republic is financed via the health insurance system, taxes, and regional budgets (Dlouhý, 2014). Like in other CEE countries, national expenses on mental healthcare are below the EU-15 average (Krupchanka and Winkler, 2016), while more than half of public mental health expenditures are allocated to inpatient care (Broulikova, Dlouhy and Winkler, 2020). The CR has a long tradition of large psychiatric hospitals; the average number of beds in one psychiatric hospital was 492 in 2014, which is way above the EU-15 average of 185 beds per facility (Höschl, Winkler and Peč, 2012). In addition, Czech psychiatric hospitals have been criticised for their substandard conditions and low quality of care for long-term patients (Kalisova et al., 2018). Community services focusing on mental health are not fully developed (Tušková et al, 2020).

There has been an overall agreement on the fact that the Czech system of care for mental health needs reform. In particular, it is related to the overall development of the mental health care system in the Czech Republic, which has so far faced a number of problems, including insufficient funding, insufficient development of community care, uneven distribution and workload of outpatient services and outdated funding of inpatient facilities (MoH CR 2015). Another systemic problem is that in spite of the increasing number of psychiatric patients in the Czech Republic (as documented by ÚZIS in Schebelle et al. 2020) until recently (2013) no modern mental health care strategy of the country has been developed and that despite long-term international trends, this area in the Czech Republic still remains primarily in the hands of psychiatrists (Kondorová, 2017).

Pec (2019) summarised that “after the political changes in 1989, there was an expansion of out-patient care and several non-governmental organisations began to provide social rehabilitation services, but the main focus of care still rested on mental hospitals. In recent years, mental health reform has been in progress, which has involved expanding community-based services and psychiatric wards of general hospitals, simultaneously with educational and destigmatisation programmes”.

The new strategy for such a reform has been adopted by the Czech Ministry of Health starting only in 2013. It is the “Reform of care for mental health: strategy of the reform of psychiatric care” (MoH CR, 2013). The ongoing reform of psychiatric care in the Czech Republic promises to humanize and increase the quality of psychiatric care, better interconnection of all relevant services, destigmatisation of the mentally ill and their greater involvement in society and other measures (MoH CR, 2013). In accordance with the WHO recommendations, the Strategy proposes a new structure of the mental healthcare system with an emphasis on community care and the involvement of communities, families and recipients of the care in the planning and development of mental health policies (WHO, 2011); the costs of the reform are largely covered from EU Structural and Investment Funds (ESIF) (Duškov, 2019). So it is thanks to the allocated financial resources within the structural funds of the EU for its member and candidate states that we can carry out reforms of mental health care in the CR (Muijen and McCulloch, 2019).

The core of the reform focuses on creating a network of Centres for Mental Health (CMH) and lowering the number of beds in large mental hospitals (Vojtech a kol, 2018). The aim is to decentralise care, make it more accessible locally and provide complex patient centred care.[1] The foundation of these CMHs is heavily funded by EU structural programmes alike the reform as such.

As a follow-up to the above-mentioned reform, there are several new documents. These are the 2015 Action Plan entitled Health 2020, the National Strategy for the Protection and Promotion of Health and the Prevention of Diseases. Action Plan No. 3: Mental Health (MoH CR 2015) already looks at mental health in a broader and more complex context than just psychiatric and focuses more on prevention, development of community care through Mental Health Centres which “through a multidisciplinary team will provide health and social intervention for the mentally ill in their natural environment", and other new and innovated types of care (MoH CR, 2015). Practically for the first time in Czech health policy, users of psychiatric services have been

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[1] The issue of metal health and wellbeing relates to early stages of childhood, too. The Czech Parliament has passed a new legislation in August 2021 (in effect since January 2025) closing down infant homes, the long term criticised dominance of institutional care for infants and children under 3 years of age transferring the focus to foster care providing much more intimate and family like environment for these children in need. The infant homes have long been documented as places irreversibly affecting the mental health of its inmates, yet there still exists a strong professional lobby defending such institutional arrangement of care provision.

involved in the reform since the strategy development phase and are represented in the bodies responsible for implementing the reform (Wolfová, 2018).

At the moment, sustainability and evaluation of the change still remains a question. Furthermore, a gender or sexuality perspective is not part of these strategic documents as of now. Some caution is in place. The complexity of Mental health care reform should not be narrowed down to a replacement of the (so far dominant) institutional psychiatric care by CMS only. The central stakeholders still disproportionately come from within the biomedicalised discourse and from the state administration, leaving other actors, such as NGOs, who have so far often supplemented the absence of services provided at the centralised state level and which already have long term experiences with community and patient centred care, or representatives of recipients of care, only at a marginal role. This is the overall current practice even though the recent COVID-19 pandemic has demonstrated the importance of safety networks provided by various NGOs and project based provision of care for (mental) health proved vital.

2.2 Inside out or the patient perspective

In the EU, there is a strong policy commitment that patients and their families should partake in the mental healthcare policy. It is argued that patient involvement also improves the quality of care and leads to effectiveness of services (Colombo et al., 2012; Jørgensen and Rendtorff, 2018). Within the decision-making processes in psychiatric care, the accent has gradually shifted from the providers to the recipients, with patient involvement taking various forms at various levels (Hickey and Kipping, 1998; Tait and Lester, 2005; Tambuyzer, Pieters and Van Audenhove, 2014). While western EU countries show high levels of patient involvement in psychiatric care, CEE countries, lacking a tradition in this process, have only just started to allow patients some level of power (Krupchanka and Winkler, 2016).

The current Strategy for the Reform of Psychiatric Care (SRPC) was designed in collaboration with most stakeholders: the Ministry of Health (MoH), the Ministry of Labour and Social Affairs, health insurers, professional associations, representatives of healthcare facilities and regions, and representatives of patients and their families (MoH CR, 2013). As a result, patient organisations became considered as stakeholders in the mental health care policy at the national level (the Ministry of Health) as well as at the level of regions where they participate in the implementation of the reform. Measures designed to support patient involvement were also taken at the mezzo level, such as introducing peer consultants as compulsory positions within psychiatric care. In this case, the Czech Republic has followed the mental health care trends of Western countries (Dobiášová et al, 2021).

The initial stages of the Czech psychiatric care reform were characterised by bottom-up involvement of patients' organisations that mobilised and exerted pressure on changes in the mental health care system (Pec, 2019). Later, during the Czech mental health care reform's implementation, top-down patient involvement took place as representatives of patients and caregivers became permanent members of government institutions responsible for the mental health care reform. The role of patients in the reform of psychiatric care has become strengthened by the parallel processes that seek to institutionalise public involvement at the level of the entire healthcare system too. Public involvement institutionalisation has contributed to the establishment of a communication channel between patients and healthcare authorities (Dobiášová et al, 2021). The notion of patients' and caregivers' participation in government institutions may serve as an example of good practice for other CEE countries where patients' and caregivers' organisations have been pushing for mental health policy reforms but they have been faced with limited power in decision-making processes and their lack of representation at government level (Hook and Bogdanov, 2021). However, despite declared strong policy commitment to involve patients in the mental health care reform, the practice is hampered by several constraints, including those on the level of the patients themselves and their organisations, on the level of the mental health care professionals and psychiatric care reform managers and finally on the level of the whole society.

Dobiášová et al. (2021) point out that at patients' organisations level, there is a problem with lack of human and financial resources resulting in rivalry between those organisations. Another problem concerns various interest groups and "eminence based approaches" to those evidence based. Thus, some individuals working at key positions of reform implementations prioritise own interests at the expense of the patients' interests. Another barrier of patient involvement identified is the complexity of patients´ needs and expectations resulting in a "disunity" of the patient community in terms of targets of Czech mental health reform. Some serious conflicts also arise between patients and their caregivers. On the side of healthcare professionals, there is a problem of a persistent paternalistic attitude inherited from the communist period before 1989 and this attitude prevents the patients to be considered as equal partners (Dobiášová et al, 2021).

The report concludes that some of these constraints were taken into consideration in the reform, but some will need to be addressed at the level of the whole healthcare system (e.g. legislative recognition and public funding of patient organisations, specific education for healthcare specialists in order to respect and pay attention to differences among people with mental health problems). Some issues (e.g. stigmatisation of mentally ill people) will need to be tackled at the level of the whole Czech society (Dobiášová et al, 2021, 2021a).

2.3 Gender and mental health care in the CZ

The hierarchical, paternalist structure of (mental) health care provision contributes to reproduction of inequalities related to gender relations, too. This is partially the result of them not being reflected and addressed when targeting stereotypes present in our understandings and current approaches to women´s and men´s health, nor being part of professional training and organisational management of institutions dealing with (mental) health care. Yet, gender inequalities are perpetuated both at the side of individual actors (providers and recipients of care and other stakeholders), at the level of institutions and organisations responsible for dealing with (mental) health issues and also at the level of state polices and legislation – where the norms and guidelines are being formulated. Such a reflection and incorporation of the gender perspective relevant to (mental) health conditions are so far missing also in social science analyses of the status quo, such as the otherwise pertinent papers by Dobiášová et al. (2021a).

Czech governmental coordinated action targets important issues within mental health care and its medical and complex treatment (Protopopová and Duškov, 2019) – they reflect – especially in their recent reports – the missing complex approach and lack of cooperation and/or coordination with other segments of care and prevention programmes. Yet, in all documents analysed for this discussion paper, the gender perspective or any link to specific conditions reproducing gender inequality are non-existent.

An intersectional perspective concentrating on specific populations is still missing. This applies not only to the category of gender, which forms the pivotal axis of the discussed policy and this paper, but also to themes of migration and ethnicity, social, economic determinants of health – age, education, economic and employment status. Available statistical data often lack disaggregation by these categories or their combinations making it difficult to provide reliable analysis of data on the complex aspects of health. The reason is that in health and social care facilities no data – on, for example, ethnicity or nationality of patients – are collected (with exclusion of some dangerous diseases) (Schebelle et al., 2020). Thus, similarly to the existing opening analysis of the state of (mental) health of migrants in the Czech Republic (Tulupova 2019), findings are alike for the gender axis.

In particular, Tulupova (2019) has concluded that “The current situation in the field of mental health of migrants living in the Czech Republic is characterised by a critical lack of data on the state of their mental health, the use of outpatient and community services and the current mental health care needs of migrants. Mental health care services are very limited for migrants insured under the public health insurance system and almost non-existent for persons with commercial health insurance. The principles of culturally sensitive health care are little known and insufficiently implemented in the Czech health care system. Migrant men and women are not involved in policy-making and protection of the rights of the mentally ill people and are not among the target groups of the ongoing reform of the mental health care system in the Czech Republic. In individual cases, these obstacles can be overcome through the cooperation of various stakeholders, but in order to improve the current situation, it is necessary to focus on better mutual information and the development of coherence of services. Strategies, inspirations and practical advice in this regard are sufficiently provided by key international documents and recommendations of the World Health Organisation (WHO), the Organisation for Economic Co-operation and Development (OECD) and other international organisations, including professional medical associations” (ibid).

3. Mainstreaming gender in health policies

The overall description provided above indicates that there is no solid or systematic incorporation of any intersectional perspective into the current process of the reform and so far not even in its academic reflection. This is partly a result of the missing (not at all collected) data on the structural state level, and then by political and thus fiscal priorities reflecting the (lack of) conceptual approach of the current state administration pertaining all levels within and above the particular reform under discussion. (Mental) heath care does not form an exception in this respect in the overall Czech practice, including isolated endeavours to change the status quo in reflection and implementation of gender sensitive approaches.

There are many complex issues to target within the current Mental health care reform, such as its financing, access and delivery of health care services, access to essential medicines and health technologies, or current health information systems. Some of them are vital to be addressed and challenged, however. These involve:

- better understanding of the health workforce – including education of health care professionals;
- governance – including cooperation with social sector and addressing socio-economic health determinants,
- and evidence and research based approach to the reform, its implementation and assessment.

Gender as a category of analysis and one of the key criteria for implementation and assessment of any policy forms an integral axis of these areas and issues under concern.

4. Coordination and cooperation between institutions and participation of the civil society

The documents presenting the current mental health care reform (see above) emphasise the changing proportion in imbalance and direction of know-how flow of the current expert knowledge (authoritative biomedical expertise) towards a more inclusive approach incorporating experiential knowledge of the recipients of care and their carers, as well as other stakeholders. Yet, the Czech systems of care generally lack cooperation between health and social sectors as well as lack in addressing social and economic determinants of health in their complexities. This situation still needs to be challenged.

A new advisory board of the Czech Government has been established under the auspices of the Czech Ministry of Health in autumn of 2019: Advisory board on mental health (further in the text referred to as the Board). Thus, six years after the start of implementation of the envisaged reform, the body that crosscuts relevant ministries, state, nongovernmental as well as patient organisations and activities has been established to discuss, suggest change and reflect on current trends in the area. At the time of its foundation, there have been 22 members of the Board, half of them top representatives of the Government itself, representatives from pivotal state and local level administration, umbrella professional organisations, or health insurance companies, one independent member of the recipients of care and one representative of the informal caregivers.

The role of the Board is framed very broadly to coordinate both nation level and international strategies and policy implementation documents, drafting the National strategy for mental health 2020-30 (adopted in January 2020), and specifically to target the issue of suicides or the Alzheimer disease. Each of them in their own way require a gender sensitive approach. The Annual report 2019-20 of the Board states that their role is “advisory, initiating and coordinating the Government action in the area of complex support provided to persons with mental health conditions, in the area of prevention, and in early intervention”.

Despite the alarming gender disproportion in suicide rates (high especially among older men), no strategy addressing this phenomenon has been created so far. And a gender perspective is not a part of the activities of its Action plan 2020-2023 at all; with envisaged analysis and some actions potentially addressed-to-be only in the following periods of the National strategy 2020-30.

The COVID-19 pandemic and its effects have also driven attention to the mental health of Czech citizens. Special segments of the society have been addressed as those under new, escalated forms of stress, or, on the other side of the spectrum, total negligence during the lockdown periods. The Board has documented that the incidence of suicides has tripled in the pandemic period and instances of domestic violence have rapidly grown, too. A special working group dealing with the SARS-CoV2 impacts has been established there, too. Their work resulted in attempts to bring forward accessible psychotherapy, foundation of crisis intervention centres or strengthening preventive programmes in schools. The Board has also opened the question of patients´ rights and their violations.

Again, the impact of these analyses and the resulting Board declarations and potential change in policies is yet to be seen. The Board definitely presents new relevant data pointing towards structurally complex phenomena that are not distributed evenly in the Czech population. Sensitivity towards the intersectional character of these problems, and specific gender axis present in every one of them would be beneficial for the adjustment of services available and under way.

The cooperation and coordination of these policies and elements of the reform requires solid data and relevant informed analyses, too.

5. Evidence and research

Few research studies have been conducted and publicised, pointing out the consequences and interconnections between physical health, wellbeing and the state of mental health. These reflections, however, often come from outside the sector of the Czech state administration. Systematic monitoring and evaluation is missing. As a result, the research on mental health in general and in relation to relevant gender issues is still very limited in the Czech Republic and is available on the level of separate projects without basic system support. There is no systematic financial plan and coverage for monitoring and analysing relevant aspects of distribution of mental health in the Czech society.

Let us take the National Institute of Mental Health (NIMH) as an example. NIMH is a referential research centre for the field of mental health in the Czech Republic established directly by the Ministry of Health.[2] NIMH is also significantly involved in teaching and education at all levels, including teaching at medical faculties, up to postgraduate education and specialisation training (attestation in psychiatry). In particular, the coverage of individual research programmes from grants and projects, which make NIMH a unique research facility which, with the exception of IPOs (formerly RVOs, funds for the development of research institutions) has virtually no institutional money to cover even basic operations. The annual struggle for a balanced budget and one-off coverage of the institutional support deficit is exhausting and unsystematic, making any planning of the institute's activities and management impossible. In such an environment, neither further development strategies nor science policy can be formulated. The whole institute lives practically from earmarked funds obtained either in grant competitions (Czech Science Foundation, Czech Health Research Council etc.) or from projects (MLSA, etc.). Permanently and systemically enshrined institutional funding (mandatory expenditures), although minimal compared to universities or the Academy of Sciences (around 30%), is a condition without which the Czech Republic can neither plan nor make full use of the potential of the NIMH and its research outputs in the future.

The Social Psychiatry Group of the NIMH is significantly involved in the preparation and implementation of mental health care reform and at the same time is responsible for international cooperation, including cooperation with the World Health Organisation. This area also involves prevention programmes, including suicide prevention. NIMH researchers are actively involved in the enlightenment and destigmatisation of psychiatry, in cooperation with representatives of psychiatric care users and live interaction with the general public (such as the annual festival Na hlavu, or the recent Opatruj se -Take care, etc.).

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[2] The focus of the institute is research into the neurobiological mechanisms leading to the development of the most severe mental disorders (schizophrenia, disorders of mood, anxiety, sleep and cognitive disorders). Its activity also includes the development and testing of new diagnostic and therapeutic methods. The approach to addressing the issue is based on a mutual interconnection of the methodologies of molecular biology, animal modelling, and clinical research and testing.

There are few pioneering initiatives within the NIMH targeting specifically problems with explicit gender dimensions, such as a specialised outpatient clinic for pregnant and nursing women. And in 2019, the NIMH succeeded in the European Commission’s grant competition and participates in the international research project ‘Supporting Wellbeing and Integration of Transgender Victims in Care Environments with Holistic Approach’ (NIMH, 2019).

6. Good practices

Thus, good practices in mainstreaming gender into policies, strategies and the reform of mental health itself come predominantly from the international context in cross-border research collaborations, as civic initiatives funded outside the national schemes or as unflagging endeavours bound to individual committed heroes. These often stand or fall precisely on these enthusiastic actors or small teams involved in these specific projects. The civic sector initiatives that help to interconnect the stigmatised (mentally) ill, providers of care and the civic society to pull down barriers include the initiating festival Mezi ploty (Between fences, organised since 1992) or initiatives such as Nevypusť duši or Loono.

Among the more recent endeavours targeting already specific segments of care and services, there are: Movember for men, including activities of the organisation LOM, or others targeting experiences influencing mental wellbeing of women: Úsměv mámy, Kogito, Anabell. There are also projects and initiatives dealing with wellbeing of people with sexuality related phenomena, such as the Transparent, Prague pride or Queer geography for LBGT* and queer community.

It is important that policies implementing gender mainstreaming of (mental)health conditions are as specific as possible. We welcome the Czech policy reform under discussion here, which provides a relevant and topical summary of the so needed strategy. Yet, what remains important is to formulate also specific (step-by-step) plans for policy implementation. It is of course a difficult task in a context, when strategic decisions and financing remains outside the scope and auspices of the current state administration. The task of implementing gender equality into health policies is complex and overwhelming. Nevertheless, any change of the status quo would benefit from a list of constituent policies, presenting sub-strategies in detail. Some incentives where to start can come up from the NIMD focus on suicides and Alzheimer´s disease, from the newly emerged mental health constrains related to the impact of the COVID-19 pandemic and subsequent measures, or in mainstreaming and implementing the public and civic initiatives targeting specific segments of the population more intensely into the nationwide strategies and reforms.

It is of course also very beneficial to share and exchange good practices at events and projects such as this European Mutual Learning Programme and discuss their potential cultural implications, impact and potential necessary modifications for specific social contexts and systems of (mental health) care provision.

7. Issues for debate and ways forward

Most of the issues for debate and questions to be raised at the meeting have already been posted above. Here is a summary of the major ones:

- There is a significant absence of an integrated holistic approach that would address gender equality across all policies focused on health promotion, guaranteeing equal access to health care and labour market integration. What are the step-by-step guidelines to overcome this by sticking to specific and targeted policies?
- The lack of gender sensitivity in health care provision in relation to risk factors, access and uptake of health and social services is omnipresent in the Czech context. Are there any good practices dealing with that in international contexts?
- There is a significant need to cover the gap in education and awareness of policy makers, health and social care professionals, patients etc. in gender aspects of care provision reproducing the status quo including gender bias within the care system and between it and recipients of care. Stress "evidence", research and transparency over "eminence" which often reproduces (gender) stereotypes is needed. How to encourage and support intersectional research and relevant data collection and analyses in this area? It is not possible without government strategy and subsequent sustainable financial and structural support. What are the good practices available from other contexts? What can be the ways forward?

Our suggestion is to concentrate on just few particular policies stemming from the Czech policy reform document (presenting aptly the general context) for the start. Take the steps one by one. The aim should be at offering and bringing to consideration some very particular, specific steps for each of such a policy, yet do so with respect on how context bound such steps necessarily are, i. e. not yield to reductionism and partial perspective.

The educational way forward contains a continuous work on the development of gender and cultural sensitivity of health care system.

This is possible only with good science e.g. improvement of data collection on inequalities and intersectionality of disadvantages. And last but not least, wider and systematic governmental support of social science research and implementation of civic initiatives integrating gender aspects of (mental) health is vital in order to draft policies fitting the current state of the art in society beyond the dominant psychiatric medical approach.

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