are identified, which can influence the interaction between health professionals and local health policymakers. Special implementation activities are needed to overcome these barriers and to support the use of epidemiological knowledge by local health policymakers. Therefore, a special implementation programme has been developed by two Regional Public Health Service in the Netherlands and the Academic Collaborative Centre for Public Health Tilburg, to improve the uptake of epidemiological knowledge in the policy process. This programme was based on the theoretical assumption that interaction between local epidemiologists and policy stakeholders is essential for uptake. The aim of the programme was to develop a new implementation strategy and practical tools. We conducted an evaluation study to determine the most useful tools.

Methods

All implementation activities have been evaluated during the evaluation study. We interviewed different stakeholders and conducted a digital survey by users. We have determined the extent to which the epidemiological data were used and which were the most successful strategies to influence health policy.

Results

The programme helped us learn more about dissemination and implementation of epidemiological knowledge into the process of local health policy-making. We will show the practical tools and strategies developed and describe our experiences in 10 concluding remarks. Examples are:

- personal interaction with decision makers has been essential to value the epidemiological knowledge;
- local, regional and national partners are needed to promote the use of epidemiological knowledge; and
- a one-size-fits-all-strategy does not work for implementation, hence is necessary to reframe.

We will share the results and conclusions during the presentation and discuss the practical lessons we learnt.

G.2. Workshop: Why do women have higher sickness absence than men? A review of suggested explanations and their connection to gender theories of health and social security

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The workshop includes a short introduction and four presentations with discussion.

Women have a higher incidence of sickness absence than men. This has repeatedly been shown in studies and statistics over the last 50 years. Still there is no coherent explanation or theory that can contribute to the development of interventions at work or in society to reduce this gender inequality in public health. Several explanations have been put forward. They can be grouped into five main clusters: burden of illness; social inequalities at work and in the labour market; the construction of the sickness insurance; treatment and rehabilitation in the health services and at work; and women's double work. An obvious but not much evolved explanation is that women's higher sickness absence is a mere reflection of sex differences in health and illness or of women's overall higher burden of illness. Several researchers have put forward that sex differences in sickness absence in reality are related to socioeconomic inequalities rather than gender inequalities based mainly in detrimental exposures at work. The construction of the sickness insurance is important for the levels of sickness absence in different societies, but few studies have analysed sickness insurances from a gender perspective. A growing number of studies focus on how women and men are treated in the health service, and to what extent men and women are provided with similar rehabilitation measures in the health services and at work. Finally, there are some studies focusing on women's higher responsibility for unpaid work and family obligations and the relation to sickness absence. In this workshop, these perspectives, except for the construction of the sickness insurance, will be described in more detail, and their connection to gender theories on health and social security will be explored to increase the understanding of how a gender perspective can be developed in sickness absence research, but also to provide new angles to public health interventions.

Health problems and sickness absence in women—what are the associations?

Gunnel Hensing

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Issue

Why do women have higher levels of sickness absence in most societies and in most diagnostic groups compared with men?

Description of the problem

Whether sickness absence is a measure of ill health, of motivation to work, a reflection of the labour market situation or of the generosity of the social insurance system has been an issue for researchers of different disciplines. Longitudinal, prospective data from the Whitehall study suggest that medically certified sickness absence can be used as a global measure of health. The question then arises whether gender differences merely is a mirror of women's higher burden of illness rather than based on social inequalities at work, or at home. Most studies on sickness absence control for health differences, but it is well known that women report higher levels of symptoms and poorer self-perceived health compared with men. In a longitudinal general population-based study of women, clinical psychiatric disorders were diagnosed at a personal interview. Other indicators of ill health in the study were self-perceived mental and physical health. Women were then followed for 5 years and data on sickness absence were collected. At follow-up, an analysis of health indicators as predictors of sickness absence over the 5-year period was performed. Since health problems differ between women and men, not only in occurrence but also in type of illnesses, we choose a same-sex data base for this analysis.

Lessons learned

Work environment is important in prevention of sickness absence in both men and women. However, sex differences might also be explained by differences in ill health. If so, the responsibility for the health care is higher to identify and treat women's health problems, and secondary prevention could be developed in order to avoid prolongation of sick-leave spells.

Conclusion
Differences in ill health can contribute to understand sex differences between women and men in sickness absence.

Job- and family-related explanations of gender differences in sickness: a review of the evidence

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A prominent explanation of gender differences in sickness absence is that women to a greater extent than men have to combine employment with family- or household-related work and responsibilities. Another possible explanation is that women have less healthy jobs, or that they are more strongly affected by a given level of workplace exposures than are men. There is evidence for the importance of influence at work and exposure might differ between men and women. The gender-segregated labour market has also been discussed as a possible factor contributing to the higher sickness absence in women, but findings are contradictory. This article reviews the evidence with regard to these explanations. Methodological considerations related to selection bias in studies on sickness absence will be presented. Studies comparing men and women in different job and family situations as well as studies that more directly attempt to measure stressors at home and at work will be covered.

Sickness absence as an interactive process: gendered experiences of young, highly educated women with mental health problems

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Objective
Highly educated Dutch women experience more work-related mental health disability than their male counterparts, and yet little is known regarding the process. Using the theory of symbolic interactionism, we examined how women interpret their roles at work, during sick leave and upon their return to work.
Methods
Semi-structured interviews focusing on role perceptions and interactions with other actors were conducted with 13 women (aged 29–41 years) on sick leave or off work for periods ranging from half an year to 8 years.
Results
The women worked overtime because of workaholism, or to meet supervisors' expectations. This led to mental health problems and social isolation. Taking sick leave aided recovery, but further isolated the women. Insufficient support from the workplace and social insurance professionals intensified negative feelings. Psychological counselling provided alternatives whereby work and private roles could become more balanced. However, their reintegration into the workplace failed because the women could not implement these strategies when the organizational culture failed to change.
Conclusions
A long lead-up time preceded sickness absence and sick leave allowed for recovery and value adjustment. However, a variety of interpretations reinforced the women's individualized focus, thereby hampering their successful reintegration.
Practice implications
Given the importance of implementing effective sick leave prevention measures in the workplace, psychological treatment should focus on women's interactions with their work environment.

Sickness absence in women—what are the associations with domestic work?

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Issue
One explanation put forward for women's higher sickness absence, is they often have the main responsibility for the domestic work. Studies on the association between health and 'double burden' and 'interactions between paid and unpaid work', respectively are common. Few have addressed the association with sickness absence and the specific impact of domestic work.
Description of the problem
Compared with paid work, measures on exposure to domestic work are scarce and less developed. In previous studies on association between domestic work and sickness absence, different measures, such as number and age of children at home, responsibility for household work, working hours in domestic work, and interference between paid and unpaid work have been used. Results are inconsistent and improved measures have been asked for. In a study on employed women in Sweden, a multidimensional perspective of domestic work was used in constructing different measures of domestic work. No associations were found between sickness absence and 'domestic job strain'. 'caring activities related to adults', 'caring activities related to children' and 'domestic life events or difficulties' were associated with higher risk of sick-leave spells from 8 to 30 days. Lacking 'domestic work equity and marital satisfaction' was associated with a higher risk of a new sick-leave spell during the study period, while 'parental responsibility' was associated with lower risk of sick-leave.
Lessons learned
Domestic work combines life domains and work tasks with very different meaning and content. A multidimensional assessment of domestic work contributed to identify specific aspects of domestic work that might affect women's sickness absence, and that might be possible to prevent. Future research needs to improve measures focusing both general and specific domestic work aspects as well as contextual factors so that the complexity of domestic work becomes better defined and operationalized.

H.2. Session: Consumers perspective

Physician cancer-screening discussions—receipt of information about risks and benefits from the perspective of periodic health examination participants in Austria

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Background
Utilized by 781 370 participants (11.8% of those eligible) in 2006, the Austrian Periodic Health Examination (PHE) is available free of charge annually to men and women aged ≥18 years irrespective of insurance status. Three-quarters of all