



Norwegian Ministry
of Health and Care Services

The Big Difference: On Women's Health in Norway and Why Sex and Gender Matter

1 Summary of findings

Summary of a report from a Commission appointed by Royal Decree on 5 March 2021 to assess women's health in Norway and health from a sex and gender perspective.

The original report is in Norwegian and was delivered to the Ministry of Health and Care Services on 2 March 2023.

1.1 We have failed to account for sex and gender

Sex and gender¹ impact health and medical outcomes. Biological and behavioural differences between women and men influence both lifestyle choices and vulnerability to disease. A growing body of evidence suggests that sex and gender impact disease pathophysiology, clinical manifestations, and response to treatment (1).

The Commission finds that Norway lacks institutional frameworks and mechanisms to ensure the integration of sex and gender perspectives in health policy and healthcare services. This hinders a systematic approach and stands in stark contrast to the political ambition to strengthen women's health. Today, the field is characterised by fragmented government policies that obscure the need for system change.

Sex and gender differences in health are increasingly gaining recognition and acceptance in health and medicine internationally. Several countries have introduced guidelines and criteria to include sex and gender as variables in health and medical research. Norway, however, is still lagging behind. The Norwegian healthcare services remain focused on a sex-and-gender-neutral understanding of health. The Commission finds that the impact of sex and gender has not been

sufficiently recognised in medical research, education, public health work, nor in healthcare services.

These are serious findings that impact political priorities, knowledge development and dissemination, how women are met in healthcare contexts, and what treatment they receive. By not accounting for sex and gender, we are failing to ensure high quality healthcare for all.

The Commission highlights four areas in which the inadequate recognition of sex and gender is particularly prominent. These four areas form the basis for the Commission's assessments and recommendations:

- Women's health is considered low *prestige*.
- Inadequate *coordination* results in poor healthcare services.
- Weak *knowledge transfer* prevents expertise from reaching the healthcare services.
- *Women's voices and experiences* are not sufficiently listened to.

These will be elaborated on further below.

1.1.1 Women's health is considered low prestige

Although women's health has received increasing attention in the last few years, the Commission has found clear evidence that women's health, as well as diseases and health conditions that mainly affect women, are considered low prestige. The differences in prestige may have consequences for priority setting in health care.

Among healthcare personnel, there is a general hierarchy of 'prestige' and 'importance' that affects patients' experiences with healthcare services. Research suggests that a number of diseases which are more prevalent among women than men are ranked at the lower end of this status hierarchy (2). The musculoskeletal disease fibromyalgia – which affects significantly more women than men – is placed at the bottom of the hierarchy. Anxiety and depression, which affect about twice as many women as men, are also situated relatively far down this ladder of prestige (3).

¹ The Norwegian word "kjønn" translates to both "sex" and "gender". Biological sex influences physiology and disease, while the social construct of gender affects the behaviour of the community, clinicians, and patients in the healthcare system. We acknowledge the fundamental influence of both sex and gender in diagnosis, prevention, and treatment of diseases (1). Therefore, we use both sex and gender in the English version of this chapter.

Diseases ranked at the lower end of the prestige hierarchy tend to carry shame and stigma. There is still considerable stigma associated with diseases and health conditions that mainly affect women. Studies indicate, for example, that women experience stigma surrounding menopause (4).

Priorities in healthcare are made based on a set of principles for priority setting in the Norwegian healthcare system. However, the Commission finds reason to believe that disease prestige may also impact priority setting in a healthcare sector characterized by a scarcity of resources. The lack of adequate healthcare services for women affected by relatively common conditions, for example vulvodynia (chronic vulvar pain), is alarming. Even though vulvodynia affects women of all ages and can cause significant health problems, there is a lack of healthcare services available for these patients. The Commission is also concerned about maternal healthcare not being adequately prioritised in the allocation of resources.

The Commission finds that prestige is reflected in how the healthcare services are financed. Firstly, the current payment mechanisms in both the municipal and specialist health services do not financially incentivise healthcare providers to prioritise women's health. The Commission has found that the current funding programmes are particularly unsuitable for maternity care in the specialist health service. In addition, there is a financial deterrent to prioritise women's health in the municipal health service. For example, the reimbursement system for general practitioners (GPs) do not include rates for making follow-up calls to patients who have experienced miscarriages or induced abortions.

Prestige also affects how knowledge development and research is prioritised. Throughout history, women's health research has been neglected, which has resulted in significant knowledge gaps. We still know little about relatively common diseases that exclusively affect women, such as endometriosis and vulvar disorders (5). While sex affects the clinical outcome of treatment for many diseases, sex is not systematically reported on in Norwegian treatment studies, the Commission finds (6).

A disease being considered low prestige can affect the interaction between the patient and the healthcare service. It can result in challenges for the patient, such as making it difficult for the patient to claim their right to adequate care. Lack of knowledge about a disease and its characteristics may also lead to patients going through unnecessary consultations that do not result in

treatment being initiated. For example, it can take up to five years to receive a diagnosis of endometriosis (7). In addition, one must consider not only the lack of treatment, but the significant mental strain of being dismissed by the healthcare services. The Commission believes there are grounds to investigate whether the prestige of an illness within the healthcare services influences how long it takes to receive a diagnosis.

The fact that many women still struggle to access the healthcare they require stands in stark contrast to the government's stated goal of prioritising women's health.

1.1.2 Inadequate coordination has consequences for women's health

As it stands, there is no official body whose main responsibility is women's health and ensuring that sex and gender are embedded into the healthcare system in Norway. The Commission believes the lack of administrative anchoring and coordination results in sex and gender perspectives not being systematically included in guidelines and frameworks for public health policy. The lack of attention to sex and gender among policymakers undermines important sex and gender differences that impact the vulnerability to and course of disease, as well as treatment outcomes.

Inadequate care coordination across hospital and municipal healthcare services carry serious consequences for women's health. This is unfortunate, as many illnesses that specifically affect women are complex and require interdisciplinary collaboration and coordination across various service providers. One such example is women suffering from medically unexplained physical symptoms (MUPS) (8). This patient group has a high healthcare service usage rate, along with a high degree of sick leave, and are at increased risk of receiving the wrong diagnosis or treatment (9). This specific group highlights the need for services that are interdisciplinary and have the expertise to meet and treat patients with disorders that cross disciplines and specialities. This necessitates well-functioning systems for collaboration within the specialist healthcare services and the municipal healthcare services, and additionally between the two service levels.

Today, coordination is impeded by organisational barriers between the two service levels. Collaboration models have been tested between the municipal and specialist healthcare services, with a psychologist located at the GP's office.

Despite the positive feedback from patients, GPs, and psychologists, the current financial arrangements hamper such coordination solutions actually being implemented in practice (10).

Coordination challenges are also apparent in maternity care, where cooperation between the specialist health service and the municipalities is still lacking. For example, there is unjustified geographical variation in the use of specialist health services postpartum, as well as great variation in the number of home visits from municipal midwives. The Commission notes that there are coordination challenges that contribute to the municipalities being unable to accept patients ready for discharge from hospital.

The Commission also observes challenges linked to ensuring high-quality services over time. Today there is a high burden on the GP-scheme in Norway. Research shows that continuity in the relationship between GP and patient positively affects health; it reduces the need for emergency room use and hospital admissions, and results in lower mortality (11).

1.1.3 The missing knowledge transfer – knowledge is not disseminated

Today we know far more about conditions that typically affect women and about sex and gender differences in health than we did 20 years ago. New knowledge about how the risk factors for illnesses, the course of an illness, and the response to medications can all manifest differently between women and men has emerged both nationally and internationally. Nevertheless, the Commission finds that updated knowledge on sex and gender differences in health is not sufficiently integrated in healthcare policies. Moreover, it does not play enough of a role in the delivery of such services, nor in the information shared with the public. According to the Commission, this testifies to a failed 'knowledge transfer'. The Commission underlines that lack of knowledge on sex and gender in health is more than a matter of interest politics. This is a question of fundamental patient safety and quality in healthcare services.

In regards to healthcare policy, the objective is to facilitate knowledge-based clinical practice. Despite research on the importance of sex and gender increasingly receiving more attention, there are many indications that this knowledge is not being translated into knowledge-based practice. At the health authority level, work on sex and gender perspectives in healthcare appears to be fragmented. The Commission finds that the

importance of sex and gender is not systematically incorporated into national and professional guidelines – tools intended to ensure that the services are of high quality and to prevent unjustified geographical variation. For many diseases that mainly affect women, there are no treatment guidelines at all. One such example is lipoedema, a chronic condition that almost exclusively affects women.

Education programs for health professions serve as important arenas for upholding and expanding standards of knowledge on how sex and gender impact health. Particularly, vocational degrees should provide the frameworks for competence around sex, gender, and health in the healthcare services. However, sex and gender perspectives in healthcare and women's health are not yet integrated into professional degrees in the healthcare field. This points to a failing knowledge transfer to the educational institutions. It is alarming that the national guidelines for the various health and social sciences degrees barely mention learning objectives related to the impact of sex and gender on health and illness. For example, a patient who has suffered pre-eclampsia is twice as likely to later develop cardiovascular and artery disease. Pregnancy can reveal important risk factors for future illnesses that must be subsequently and systematically followed up. There is a lack of awareness of such pregnancy-specific risk factors among medical professionals. Even though the Regulations on Obstetrics – published by the Norwegian Society of Gynaecology and Obstetrics – recommend that GPs follow up on patients who experienced complications during pregnancy, such preventative follow-ups for women who have gone through pre-eclampsia are not typically conducted (12).

If clinical practice is not based on updated knowledge, this could result in inadequate patient care that may lead to negative health consequences. Evidence-based knowledge must be implemented and transformed into evidence-based practice.

The Commission finds that public health information channels and health campaigns to a large extent disregard sex and gender. Insufficient knowledge about how sex and gender impact health can lead to physical symptoms of serious health conditions going unnoticed. As an example, the symptoms of stroke are different for women and men. Atypical clinical manifestations such as anxiety, headache, and confusion are more frequent in women than in men (13). Insufficient knowledge of such differences among healthcare

personnel and in the population may have grave consequences – less likely than men to be assessed by healthcare personnel as having stroke, contributing to delayed recognition and treatment of stroke (13).

The Commission emphasises the importance of sex- and gender specific knowledge being disseminated, especially to the public and to women. Health competency among the public is important in public health work, for prevention and emergency situations.

1.1.4 Women's voices and experiences are not listened to

Historically, women have received little attention in the development of healthcare policies and practices. The Official Norwegian Report 1999: 13 *Kvinnens helse i Norge* [Women's Health in Norway] stated that the user perspective is especially important for women, as knowledge of women's health is insufficient and has been poorly integrated into the healthcare services. The Commission unfortunately finds this equally relevant today. Female patients, users and their families, as well as patient organisations, are rarely included in early phases of the decision-making processes. This is problematic, as the terms of such decisions are formulated in this initial phase. There are also no structures in place to ensure that women's experiences are followed up on in the evaluations of these systems' functions.

The Commission also emphasizes women's voices in the relationship between the individual patient and the healthcare services. As described in written submissions to the Commission, many women experience that their health complaints are ignored, and that they are not listened to when they interact with healthcare providers. Thus, their overall experience with the healthcare system is one that comes with particular challenges, the Commission notes.

Language barriers, low health literacy, prejudice and stereotypical notions hinder genuine user participation for women of indigenous and minority backgrounds. Research findings indicate that a considerable proportion of immigrant women do not understand the information they are given in a healthcare context, which is of significant concern. In other instances, their need for an interpreter during pregnancy and maternal care have not been met (14, 15). The health services must ensure the right of the patient to understand the information given. If this is not guaranteed, user participation is in practice

impossible, which is detrimental to the quality of the services and patient safety.

Women also interact with the healthcare services as next of kin and informal carers. The Commission received considerable insight that has illuminated how many female informal carers have experienced not being seen, heard, or acknowledged when interacting with the healthcare system. This aligns with the findings from the National Informal Caregivers Survey. The data demonstrates that some informal carers have experienced that their relationship to the patient is ignored, and that there is little room for user participation. Many informal carers also call for more accessible information and guidance from healthcare personnel, and to be able to meet with and talk to other people in the same situation (16, 17). For many women, the act of caring for a loved one becomes such a burden that they end up requiring healthcare themselves. Further, many find that being a carer is incompatible with participating in the workforce. The Commission believes that this is incompatible with the government's ambition to ensure people stay in the workforce for longer.

1.2 What do these challenges mean for women's health in Norway?

The Commission has highlighted four areas in which the inadequate recognition of sex and gender in relation to health is particularly prominent: prestige, cooperation, knowledge transfer and women's voices and experiences. These areas jointly impact and reinforce one another. This overall picture has formed the basis for the Commission's assessments and recommendations.

Most women in Norway enjoy good health. Nevertheless, the Commission finds a number of negative trends relating to the development of women's health over the past 20 years. The Commission urges that we understand these developments in light of women's health being low prestige, the inadequate coordination of various healthcare services, a failure to widely disseminate vital knowledge, and not sufficiently listening to women's voices and experiences.

The Commission is especially concerned that young women are reporting more mental health problems than ever before. The number of girls and women between the ages of 12 and 24 who have been diagnosed with a mental illness by specialist healthcare services has also increased over the last decade. The cause(s) of this increase is

unknown. The Commission finds that health authorities have not taken sufficient action to understand nor act on this increase. We must learn more about both the occurrence of mental health issues among young women, and effective treatment measures. If we are to succeed in dealing with this increase, clearer sex and gender perspectives are required to understand and treat both girls' and boys' mental health issues.

The Commission notes that pregnancy, birth, and postpartum care also face significant shortcomings and challenges, which have consequences for many young women who wish to start a family. These challenges exist because over the years, such healthcare services have not been prioritised sufficiently. Additionally, the coordination between the municipal and specialist healthcare services is unsatisfactory. There is a lack of systematic efforts to ensure geographic balance and an equal service provision in pregnancy, birth, and postpartum care.

Adult women in Norway report more physical health problems than has been the case in previous years, and the rate of women's sick leave is consistently higher than men's (18). The high number of women who become disabled, and who opt for working part-time in the middle of their life, is particularly concerning. We know little about the reasons for why women fall out of the workplace at this stage in life. The Commission notes that this phase of life is often silently overlooked in the media and public discourse. This is the case even though middle-aged women make up a significant proportion of the total workforce, both in terms of formal work and informal care work. Again, we must highlight the importance of understanding how sex and gender have major significance in health-related challenges.

This includes the overall burden many women experience when trying to combine employment, family responsibilities and informal care while going through menopause. Giving more attention to and learning more about this group is key in ensuring the best possible health for middle-aged women and in preventing further health challenges in old age.

While most of the elderly population are women, we do not know enough about women during this stage of life. Older women in Norway are among the biggest consumers of healthcare services and medications. However, the topic of health in old age appears to be viewed through a gender neutral lens. An understanding of the interplay between sex and age is important to real-

ise how these biological differences impact one's health. It also helps us understand how an illness manifests, understand appropriate treatment, and the effect (and side effects) of medications, among the elderly. Older women in Norway make up a large and growing number of the population, and the need for increased attention to and knowledge about women in this stage of life must be emphasised.

The Commission also stresses that in every stage of life, there are perpetual social differences in issues relating to health among girls and women in Norway. Especially when including factors such as income, education and minority status. The trajectory of women's health must be understood in light of such inequalities. In addition to the sex and gender of the patient, other factors further exacerbate these differences and impact women's health and healthcare use, such as sexual orientation and disability.

Overall, the Commission concludes that to take all women's health seriously, *sex and gender* must receive greater attention when understanding women's health throughout every stage of life. The sex and gender neutrality evident in today's action plans, strategies, guidelines, and evaluations stands in the way of developing effective measures that account for key differences between women and men.

1.3 What next?

To achieve the goal of health equity we must recognise the significant impact that sex and gender have on health and healthcare. The healthcare sector's inadequate understanding of sex and gender contradicts the government's stated efforts regarding women's health. Today, this effort towards ensuring good health among women can be understood as a political objective. However, this is not mirrored in the priorities set out by healthcare policies and the allocation of resources.

1.3.1 A billion Norwegian kroner for women's health

The Commission is of the opinion that sufficient funds must be allocated to ensure a comprehensive approach to women's health, rather than only publishing symbolic policies and implementing individual measures. The Commission proposes that a total of NOK 1 billion is invested to improve the quality of women's health and to focus on sex and gender perspectives in health-

care. The Commission puts forward several measures that will collectively ensure a systematic and coordinated effort within the field of women's health in Norway. We recommend that the government follows up on all measures, and that the government's future strategy for women's health is tailored according to the focus areas outlined in this report, namely status, coordination, knowledge transfer, and women's voices and experiences.

1.3.2 Raise the prestige of women's health

The Committee proposes that the following measures are implemented to raise the prestige of women's health and increase the focus on sex and gender perspectives in healthcare:

- Measure 1: Establish a national committee for women's health and sex and gender perspectives in healthcare
- Measure 2: Prioritise the implementation of a new financial model for childbirth care
- Measure 3: Review the diagnosis-related groups (DRG) to ensure that women's health is prioritised in the financing system in the specialist healthcare services
- Measure 4: Review and change the tariffs in the municipal healthcare services to ensure that prioritising women's health is financially rewarding/rewarded
- Measure 5: Require the use of sex and gender perspectives in all medical and health research
- Measure 6: Increase funding for research related to women's health
- Measure 7: Strengthen the Norwegian Research Centre for Women's Health
- Measure 8: Allocate funds for the establishment of more national research centres for topics related to women's health and sex and gender perspectives in health
- Measure 9: Increase funds for research in general practice through the general medical research units

1.3.3 Ensure coordination that works

The Committee proposes that the following measures are implemented to ensure the best possible

coordination of measures for women's health and sex and gender perspectives in health:

- Measure 10: Establish an interministerial working group for women's health and sex and gender perspectives in health
- Measure 11: Establish a central specialist unit for women's health and sex and gender perspectives in health
- Measure 12: Ensure that everyone has access to high-quality healthcare services regardless of their place of residence
- Measure 13: Investigate new financing schemes for collaboration

1.3.4 Improve channels for knowledge transfer

The Committee proposes that the following measures are implemented to improve the knowledge transfer between research, education, practice, and public information:

- Measure 14: Establish systems for safeguarding sex and gender perspectives in decision-making within the healthcare sector
- Measure 15: Review and update the national guidelines for illnesses and health conditions that affect women
- Measure 16: Incorporate sex and gender, including how sex and gender affect health, disease, and treatment, in the national regulations of the common curriculum for health and social care education
- Measure 17: Ensure that updated knowledge on medical research about important and relevant sex differences and the impact one's sex and gender has on health is a requirement in the National Curriculum Regulations for Norwegian Health and Welfare Education (RETHOS)
- Measure 18: Establish a network for collaboration on health, technology and sex and gender
- Measure 19: Facilitate better utilisation of health data in work related to women's health, and sex and gender perspectives in health
- Measure 20: Establish better systems for evidence-based practice in mental healthcare

- Measure 21: Update the current and provide new sex and gender specific information on helsenorge.no – the Health and Care Services' portal for health information and self-service solutions for the population
- Measure 22: Establish a digital portal for women's health information in order to disseminate knowledge about women's health
- Measure 23: Improve the health literacy of disadvantaged or vulnerable groups

1.3.5 Listen to women's voices

The Committee proposes that the following measures are implemented to ensure that women's own experiences are considered in the decision-making processes concerning women's health:

- Measure 24: Establish a user committee connected to the new specialist unit for women's health and sex and gender perspectives in health
- Measure 25: Initiate research on how women with health conditions and diseases that primarily affect women are handled by the healthcare services
- Measure 26: Investigate the possibility of introducing a national quality registry for female-specific health conditions and diseases
- Measure 27: National user survey on sex and gender differences in provider-patient interactions

1.3.6 A boost for women's health through a life cycle perspective

The Committee recommends boosting women's health through a life cycle perspective by implementing the following measures:

Children

- Measure 28: Prioritise the work in the healthcare services to prevent, detect and avert violence and abuse against children

Youth and young women

- Measure 29: Strengthen the health clinics for adolescents and the school health service

- Measure 30: Exempt persons aged 16-18 years from paying out-of-pocket fees when visiting their general practitioner
- Measure 31: Provide contraception free of charge to everyone under the age of 25
- Measure 32: Improve the services offered to children and young people with eating disorders
- Measure 33: Improve the sexuality education provided in primary and middle schools
- Measure 34: Improve teacher competence on sex and gender and health
- Measure 35: Prioritise research on mental health disorders
- Measure 36: Prioritise research on effective treatment of mental health disorders, and ensure use of evidence-based treatment
- Measure 37: Ensure effective measures against sexual harassment in schools
- Measure 38: Prioritise delivering high-quality healthcare services to patients with endometriosis or adenomyosis
- Measure 39: Strengthen all specialised vulvar clinics in Norway

Women and motherhood

- Measure 40: Ensure safe and high-quality follow-ups during pregnancy, childbirth, and the postnatal period to everyone regardless of their place of residence
- Measure 41: Strengthen the "low-threshold" (easily accessible) services offered to mothers in the municipal and specialist healthcare services
- Measure 42: Ensure that the work done to identify and follow up pregnant women with mental health disorders is carried out systematically during and after pregnancy
- Measure 43: Strengthen the multicultural doula service
- Measure 44: Ensure the right of undocumented pregnant women to health services during pregnancy, childbirth, and the postnatal period
- Measure 45: Improve the follow-up services offered to women after having an induced abortion or miscarriage
- Measure 46: Prioritise electronic antenatal health cards

- Measure 47: Establish gender-specific treatment programs for substance abuse
- Measure 48: Ensure equitable healthcare for vulnerable female prisoners
- Measure 49: Conduct more research on the health consequences of separation/divorce violence against women
- Measure 50: Constitute an official committee that investigates women, work, and health
- Middle-aged women
- Measure 51: Establish a national competence centre on chronic pain
- Measure 52: Include hormone treatment around menopause in the individual reimbursement or blue prescription scheme
- Measure 53: Increase knowledge on menopause and work life
- Measure 54: Prioritise preventative treatment for osteoporosis
- Elderly women
- Measure 55: Ensure competencies in geriatrics in the Norwegian health and care services
- Measure 56: Introduce guidelines for healthcare personnel that ensure that all elderly patients are asked if they have experiences with violence or abuse
- Measure 57: Establish a research program focusing on elderly women's health
- Measure 58: Frequent, systematic, and routine-based medication assessment among the elderly
- Measure 59: National guidelines to ensure proper housing and nutrition for elderly people
- Measure 60: Pilot project to ensure high-quality palliative care
- Sami women's health and Sami health in a sex and gender perspective
- Measure 61: Advocate for more research on Sami women's health and Sami health in a sex and gender perspective
- Measure 62: Ensure competencies on Sami language and culture in the health and care services through systematic work
- Measure 63: Strengthen the grant scheme for professional development and skills development in the health and care services aimed at Sami users
- Measure 64: Develop a national action plan against Sami hatred and strengthen the national effort against Sami hatred
- Measure 65: Ensure equitable and culture sensitive treatment for Sami patients that have experienced violence and abuse
- Measure 66: Strengthen the crisis shelters in the Sami settlement areas
- Measure 67: Establish a professional network for the coordination of suicide prevention in the Sami population
- Measure 68: Ensure that sexuality education is offered in Sami languages
- Informal carers and women's health
- Measure 69: Strengthen the knowledge base on informal carers and develop a new informal carer strategy and action plan 2025–2030
- Measure 70: Investigate the need for changes in the economic compensation scheme and leave provision for informal carers
- Measure 71: Increase competencies on informal carer cooperation among health care personnel
- Measure 72: Prioritise the work to implement carer agreements in the health and care services
- Measure 73: Strengthen the grant scheme for holistic support to carers with challenging care tasks
- Measure 74: Strengthen and further develop the information for carers on helse-norge.no
- Measure 75: Strengthen the role of volunteering in care work

References

1. Mauvais-Jarvis F, Merz NB, Barnes PJ, Brinton RD, Carrero J-J, DeMeo DL, et al. Sex and gender: modifiers of health, disease, and medicine. *The Lancet*. 2020;396(10250):565-82.
 2. Album D, Engebretsen E. Sykdomsprestisje. *Praktiske Grunde*. 2013;7(1-2):85-92.
 3. Album D, Westin S. Do diseases have a prestige hierarchy? A survey among physicians and medical students. *Social Science & Medicine*. 2008;66(1):182-8.
 4. Nosek M, Kennedy HP, Gudmundsdottir M. Silence, Stigma, and Shame: Distress During the Menopause Transition. *Journal of Midwifery & Women's Health*. 2008;53(5):482.
 5. Vist GE, Hestevik CH, Forsetlund L, Hval G, Underland V, Kucuk B, et al. Forskningskart om behandling av sykdommer hos kvinner. *Folkehelseinstituttet*; 2022.
 6. Østbø NM, Vist GE, Løchen M-L. Kjønnstratifiserte analyser i norske behandlingsstudier: en systematisk kartleggingsoversikt. *Folkehelseinstituttet*. 2022.
 7. Husby GK, Haugen RS, Moen MH. Diagnostic delay in women with pain and endometriosis. *Acta Obstetrica et Gynecologica Scandinavica*. 2003;82(7):649-53.
 8. Borchgrevink PC, Fredheim OMS, Fors EA, Hara K, Holen A, Stiles TC. Hva er sammensatte lidelser? *Tidsskriftet Den Norske Legeforening*. 2009;129(13):1368.
 9. Aamlund A. Medisinsk uforklarte plager og symptomer (MUPS) og sykefravær Allmennlegens rolle [Doktorgradsavhandling, Universitetet i Bergen]2015.
 10. Rugkåsa J, Tveit OG, Berteig J, Hussain A, Ruud T. Collaborative care for mental health: a qualitative study of the experiences of patients and health professionals. *BMC Health Services Research*. 2020;20(1):844.
 11. Sandvik H, Hetlevik Ø, Blinkenberg J, Hunskaar S. Continuity in general practice as predictor of mortality, acute hospitalisation, and use of out-of-hours care: a registry-based observational study in Norway. *British Journal of General Practice*. 2022;72(715):e84-e90.
 12. Staff A, Klepp K. Svangerskapet – en stresstest for kvinners hjerte- og karsykdom senere i livet: Oslo Universitetssykehus; 2022 [updated 20.04.22. Available from: <https://oslo-universitetssykehus.no/avdelinger/kvinneklinikken/svangerskapet-en-stresstest-for-kvinner-hjerte-og-karsykdom-senere-i-livet>.
 13. Hov MR, Larsen K, Bakke I, Sandset EC. Hjerneslag hos kvinner gir andre symptomer enn hos menn. *Tidsskriftet Den Norske Legeforening*. 2022;142(16).
 14. Bains S, Sundby J, Lindskog BV, Vangen S, Diep LM, Owe KM, et al. Satisfaction with maternity care among recent migrants: an interview questionnaire-based study. *BMJ Open*. 2021;11(7).
 15. Bains S, Mæland KS, Vik ES. Helse i svangerskapet blant innvandrerkvinner i Norge – en utforskende litteraturoversikt. *Tidsskriftet Den norske legeforening*. 2021;141(2).
 16. Opinion. Nasjonal pårørendeundersøkelse. *Helsedirektoratet*; 2021.
 17. Helse- og omsorgsdepartementet. Vi – de pårørende: Regjeringens pårørendestrategi og handlingsplan. 2020.
 18. Lunde ES, Ramm JS, Syse A. Kvinners liv og helse siste 20 år. SSB; 2022. Report No.: Rapport 2022/41.
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