



World Health
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REGIONAL OFFICE FOR **Europe**



Beyond the mortality advantage

Investigating women's health in Europe





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ABSTRACT

Women in the WHO European Region have better health than those in most countries of the world, but inequities are increasing for men and women within and between countries in the Region. Inequities not only create health consequences, but also social and economic costs. They cannot be reduced without investing in girls and women, but more knowledge is needed on their causes to inform policies and interventions. The WHO Regional Office for Europe is currently investigating the main health issues for women in the Region, including variations in health among those of different ages and the influence of gender and social determinants across their lives. This brief report presents some of the preliminary findings of the investigation, focusing on broad causes of mortality and morbidity during four age stages – the girl child, adolescents, adult women and older women – and emphasizing how factors that influence health cut across the stages. It shows how gender and socioeconomic determinants affect opportunities for girls and women in the Region to realize their right to health and well-being across the life-course and provides a basis for prioritizing actions for all sectors of governments and societies.

Keywords

DELIVERY OF HEALTH CARE

MORTALITY

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Contributors from the WHO Regional Office for Europe are:

- Gauden Galea, Director, Noncommunicable Diseases and Promoting Health through the Life-course
- Isabel Yordi Aguirre, Technical Officer
- Åsa Nihlen, Technical Officer
- Gunta Lazdane, Programme Manager
- Vivian Barnekow, Consultant
- Ivo Rakovac, Programme Manager a.i.



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Chapter one Introduction

Introduction

Women in the WHO European Region have better health than those in most countries of the world (1), but that does not hold for all women. Inequities – the systematic differences that are avoidable, remediable and unfair – are increasing for men and women within and between countries in the Region. Inequities not only create health consequences, but also social and economic costs.

Inequities cannot be reduced without investing in girls and women, but more knowledge is needed on the causes of inequities to inform policies and interventions.

Reflecting the objectives of the European policy for health and well-being, Health 2020 (1), and commitments expressed 20 years ago through the Beijing Platform for Action (2) and the Programme of Action of the International Conference for Population and Development (3), the WHO Regional Office for Europe is proposing to develop a regional strategy on women's health for presentation to the WHO Regional Committee for Europe in 2016. The timing is significant, as it marks the transition from the United Nations Millennium Development Goals to the Sustainable Development Goals, which highlight the need for action on gender equality and empowerment of women and girls.

It is proposed that the strategy will follow the life-course approach, reflecting the accumulation of advantage and disadvantage through exposure to protective and risk factors and presenting opportunities to prioritize actions by age and developmental stages.

The Regional Office is currently investigating:

- the main health issues for women in the Region
- variations in health among those of different ages
- the influence of gender and social determinants across their lives.

The investigation is aiming to mark progress in protecting existing gains and preparing for future challenges and will support the identification of priorities for the proposed regional strategy. While evidence produced by the investigation will not aim to compare men and women, the impact of gender inequalities on other determinants of health, such as education and income, will be highlighted where relevant.

This brief report presents some of the preliminary findings from the investigation. It has been developed to inform discussion at the technical briefing on women's health to be held during the 65th session of the WHO Regional Committee for Europe in Vilnius, Lithuania, 14–17 September 2015, which will be the starting point for a consultative process to develop a regional strategy on women's health to be presented at the 66th session of the Regional Committee in Copenhagen, Denmark, in 2016.



Chapter two Characteristics of girls and women's health in the WHO European Region

Characteristics of girls and women's health in the WHO European Region

Just over half of the 900 million people living in the WHO European Region (463 million) are women.

Countries and populations in the Region are diverse, with comparative measures of life expectancy, literacy, education, standards of living and quality of life varying widely. The Region is experiencing important demographic and epidemiological changes, including decreasing fertility rates and increases in ageing populations, migration flows and urbanization. Transitions are occurring at varying speeds and intensity for country groups and populations, with each change influencing the needs for health promotion, disease prevention and care.

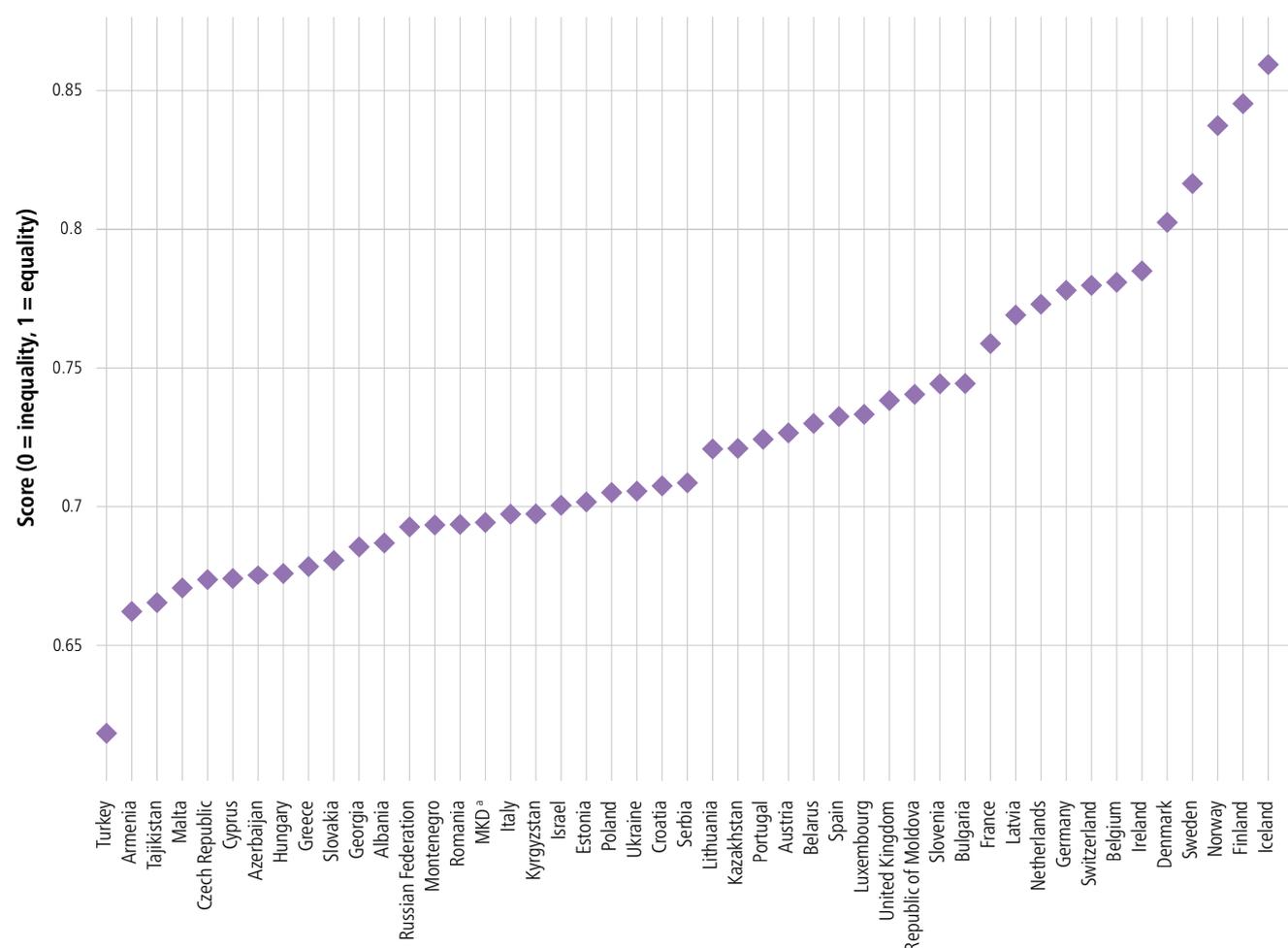
Some European women enjoy the highest levels of gender equality, while others live in very unequal societies. The World Economic Forum Gender Index benchmarks national gender gaps in relation to economics, politics, education and health. **Fig. 1** shows results for 47 countries in the Region in 2014, where a score of 0 means complete inequality and 1 complete equality (4).

Fig. 1

Source: World Economic Forum (4).

Gender gap in selected European countries

Global gender gap for 47 Member States of the WHO European Region (2014)



^aThe former Yugoslav Republic of Macedonia (MKD is an abbreviation of the International Organization for Standardization).

The Region has closed 72% of its overall gender gap and ranks in second place globally, but 18 countries still showed negative gender-equality trends between 2013 and 2014 (4) and complete equality exists in none of the highest-ranking countries.

Life expectancy is increasing for women and men across the Region. It improved for women in all countries (except one) between 2000 and 2012 and is higher than for men in all 53 Member States (5). This is referred to as women's mortality advantage (6),

but it may be offset by fewer additional years lived without disability or activity restriction: the extra years are not healthy years. **Fig. 2** presents data from 2012 on women's expected healthy life expectancy at birth and years spent in ill health, showing that 8–12 years (average 10) are spent in ill health (5).

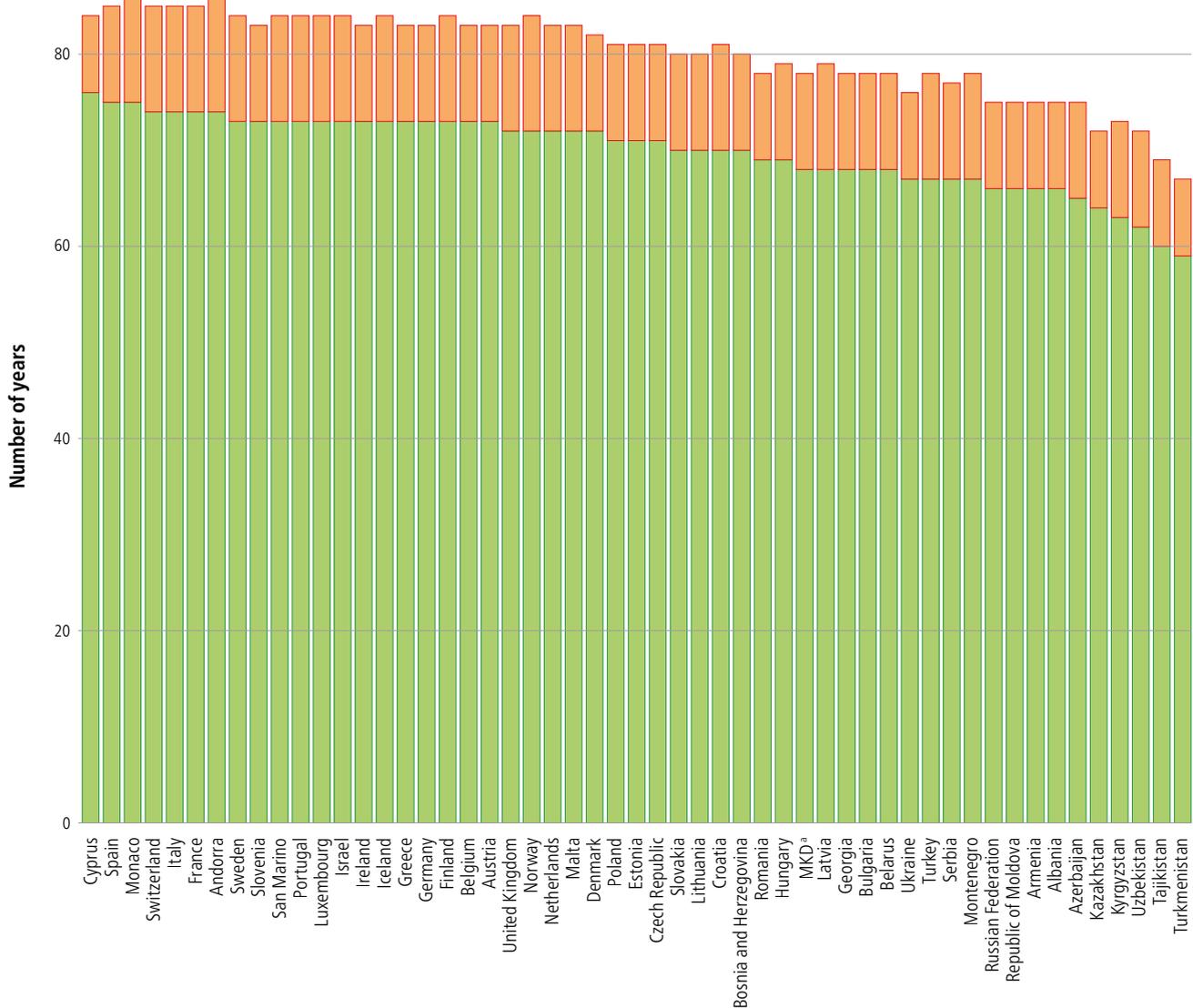
Fig. 2

Source: WHO (5).

Beyond the mortality advantage

Healthy life at birth and number of years spent in ill-health for women (2012)

Years in ill health ■
Healthy life expectancy at birth ■



^aThe former Yugoslav Republic of Macedonia.

Links between life expectancy and income show that generally, the higher the income of the population, the longer life will be. Income alone, however, cannot explain life expectancy (**Fig. 3**) (7). Female life expectancy at birth for women in Spain and France, for instance, is higher than that in wealthier countries such as Norway and Denmark (7). This emphasizes the need to look at determinants beyond income to better understand the relevant factors. Inequalities in healthy life expectancy among women are nevertheless widest in later life when incomes tend to be reduced, and the link between inequalities and material deprivation (households having an enforced lack of at least three of nine economic and durable items) is strong.

The main causes of ill health (morbidity) and death (mortality) among women differ across life stages and countries. Physical health conditions dominate in early life, depressive and anxiety disorders develop among young women moving into adult life, and low back pain, ischaemic heart disease and cancers are more prevalent in older age.

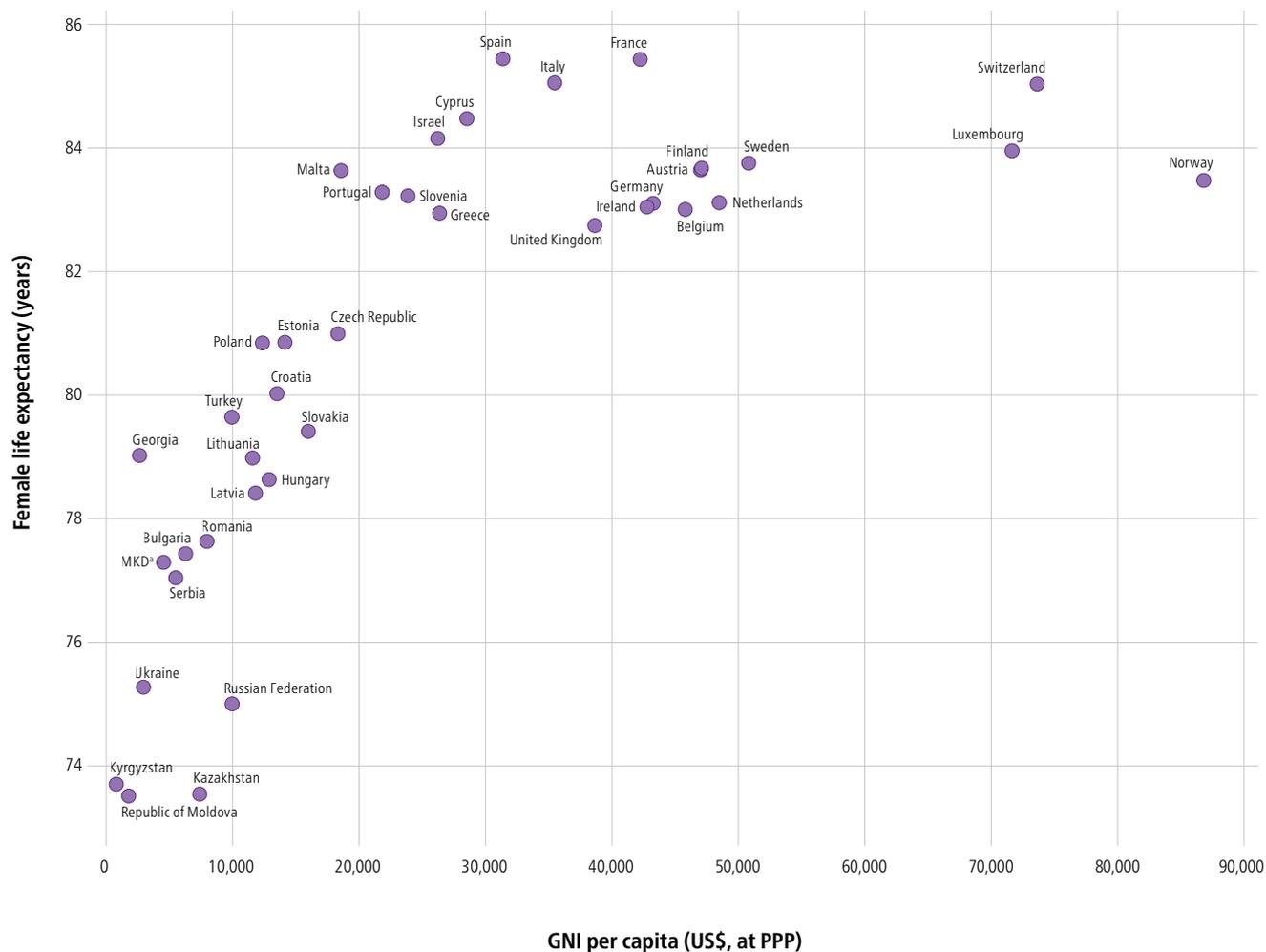
Characteristics of girls and women's health in the WHO European Region

Fig. 3

Source: WHO Regional Office for Europe (7).

Female life expectancy by gross national income (GNI)

Female life expectancy at birth (2013) by estimated GNI purchasing power parity (PPP\$) per capita (2011)



* The former Yugoslav Republic of Macedonia.

Looking at women's health and illness at different life stages allows the identification of specific interventions that can minimize risks and maximize protective factors and assets. **Table 1** (p. 8) (8) presents data for five age groups and four subregions (central Asia and central, eastern and western Europe) (8,9). The age groups do not mirror exactly those described in this brief report, as many of the factors that affect girls and women's health do not fit neatly or exclusively into the groups. **Table 1** nevertheless indicates the broad causes of mortality and disease burden across the relevant age stages, highlighting a number of priority health issues for women in the Region that are discussed by age stage in Chapter 3.

Many factors influence women's health across the life-course, including levels of gender equality, education, employment, working conditions and access to economic resources. Despite significant progress in areas such as education and participation, gender inequalities in employment, quality of work and job segregation continue to exert a negative influence. **Fig. 4** shows that in 2012, only 29 countries had a labour-force participation rate greater than 50% for women aged over 15 years, compared to 47 for males (10). Pay and pension gaps persist in all countries, limiting women's access to health-related resources: **Fig. 5** shows the gender pay gap in a number of European countries in 2013 (11). This represents the difference between average gross hourly earnings of male and female paid employees as a percentage of gross hourly earnings of male paid employees. The population consists of all paid employees in enterprises with 10 or more.

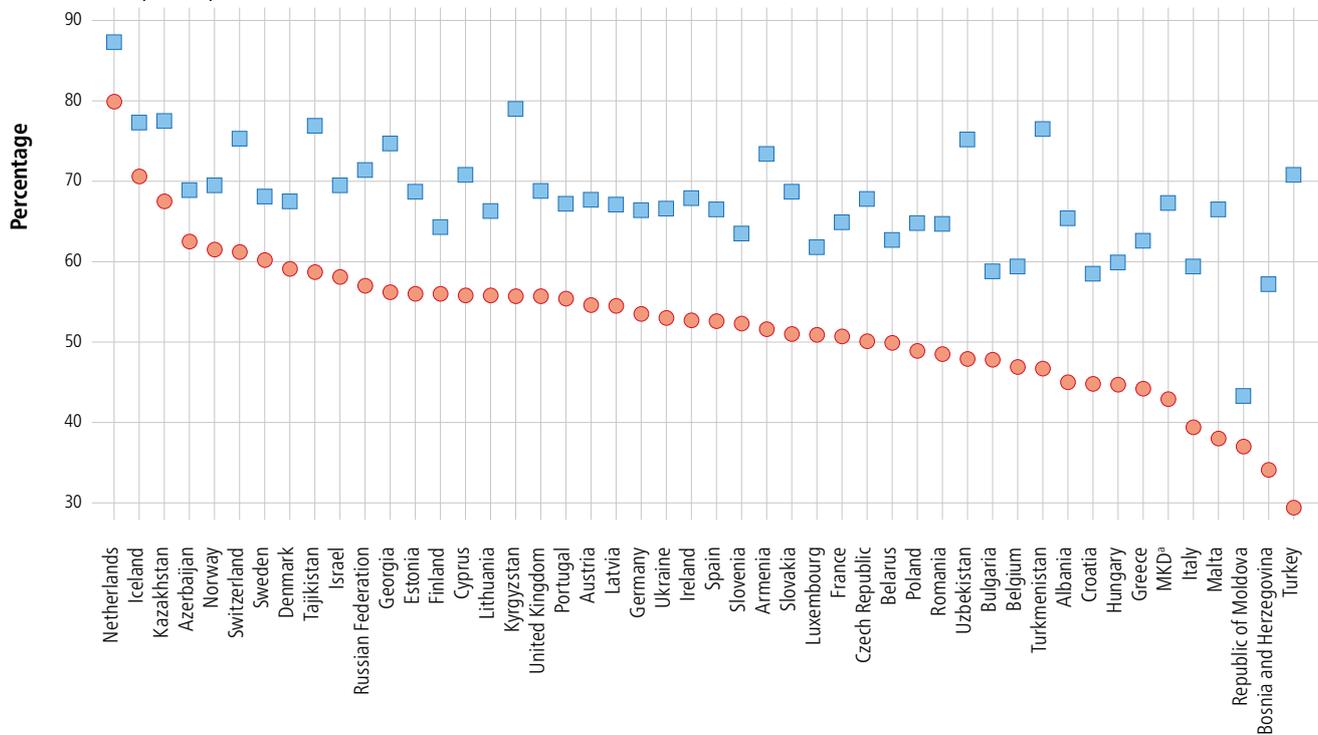
Fig. 4

Source: United Nations Development Programme (UNDP) (10).

Do European countries maximize the education gain?

Labour-force participation rate for males and females (2000–2012)

Female ●
Male ■



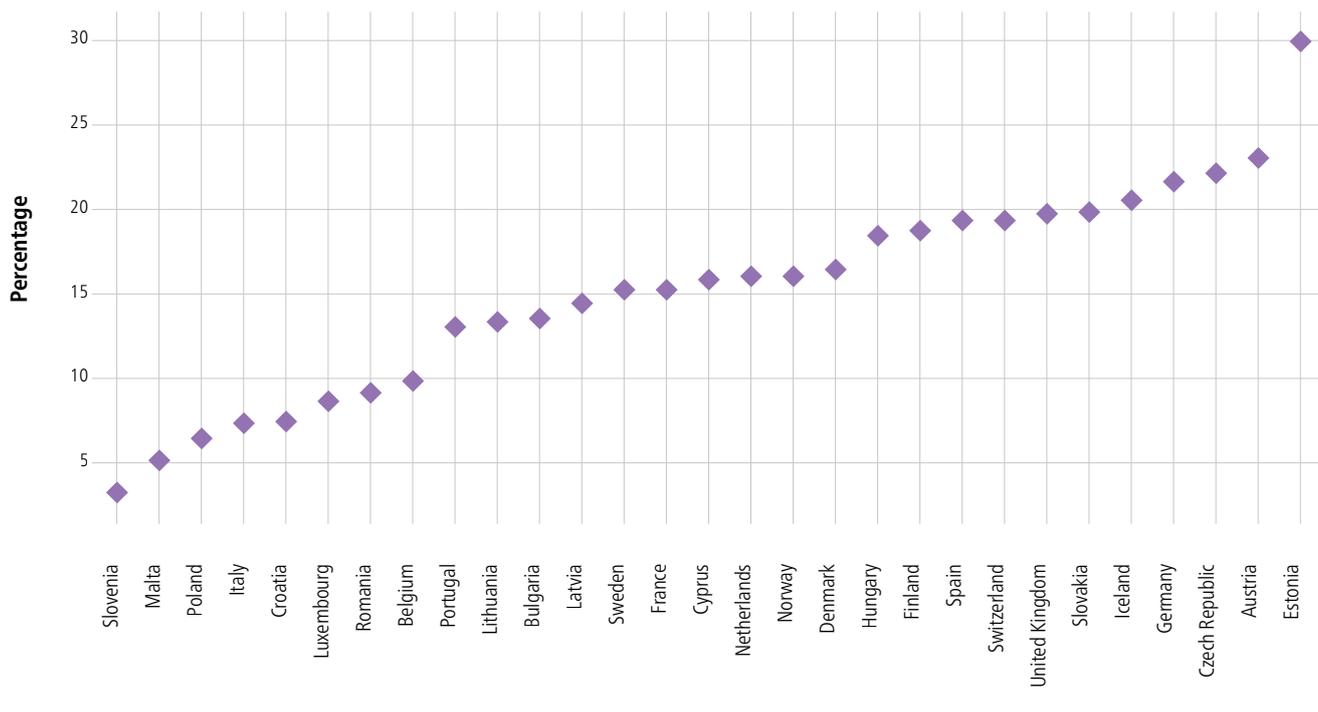
* The former Yugoslav Republic of Macedonia.

Fig. 5

Source: Eurostat (11).

Male and female pay differences

Gender pay gap in 29 European countries (2013)



Characteristics of girls and women's health in the WHO European Region

Table 1

Prioritizing health issues for females in the Region

Mortality and disease burden in disability-adjusted life years (DALYs)^a in females by subregion,^b age group and broad causes (2010)^c

Subregion	Age group	Rank	Central Asia				Central Europe						
			Cause	DALYs Total	Per 1 000	Deaths Total	Per 1 000	Cause	DALYs Total	Per 1 000	Deaths Total	Per 1 000	
Under 5	1	Lower respiratory infections	770 482	207.23	Lower respiratory infections	9 016	2.42	Congenital anomalies	84 944	28.79	Congenital anomalies	975	0.33
	2	Neonatal encephalopathy	401 712	108.04	Neonatal encephalopathy	4 624	1.24	Preterm birth complications	80 045	27.13	Preterm birth complications	918	0.31
	3	Preterm birth complications	310 761	83.58	Preterm birth complications	3 597	0.96	Lower respiratory infections	57 341	19.43	Lower respiratory infections	649	0.21
	4	Congenital anomalies	268 876	72.31	Congenital anomalies	3 103	0.83	Iron-deficiency anaemia	41 702	14.13	Neonatal encephalopathy	268	0.09
	5	Diarrhoeal diseases	136 220	36.63	Diarrhoeal diseases	1 317	0.35	Neonatal encephalopathy	24 611	8.34	Neonatal sepsis	114	0.03
5-14	1	Iron-deficiency anaemia	74 551	11.56	Lower respiratory infections	537	0.08	Major depressive disorder	40 128	6.80	Road injury	127	0.02
	2	Major depressive disorder	53 882	8.35	Road injury	310	0.04	Asthma	28 528	4.83	Brain cancer	66	0.01
	3	Lower respiratory infections	42 067	6.52	Drowning	236	0.03	Anxiety disorders	24 146	4.09	Lower respiratory infections	63	0.01
	4	Road injury	28 094	4.35	Leukaemia	169	0.02	Low back pain	22 627	3.83	Congenital anomalies	62	0.01
	5	Asthma	23 801	3.69	Congenital anomalies	143	0.02	Iron-deficiency anaemia	20 147	3.41	Leukaemia	57	< 0.01
15-49	1	Major depressive disorder	352 383	16.17	Ischaemic heart disease	3 843	0.17	Low back pain	438 782	14.92	Breast cancer	1 990	0.06
	2	Low back pain	223 736	10.27	Cirrhosis	2 853	0.13	Major depressive disorder	385 911	13.12	Ischaemic heart disease	1 674	0.05
	3	Ischaemic heart disease	194 631	8.93	Stroke	2 677	0.12	Anxiety disorders	259 529	8.82	Stroke	1 616	0.05
	4	Iron-deficiency anaemia	173 135	7.94	Breast cancer	1 632	0.07	Migraine	236 610	8.04	Cervical cancer	1 353	0.04
	5	Anxiety disorders	181 017	8.30	Tuberculosis	1 679	0.07	Musculoskeletal disorders	190 344	6.47	Cirrhosis	1 314	0.04
50-69	1	Ischaemic heart disease	424 913	78.02	Ischaemic heart disease	15 032	2.76	Ischaemic heart disease	546 811	35.83	Ischaemic heart disease	19 362	1.26
	2	Stroke	290 886	53.41	Stroke	10 583	1.94	Stroke	419 540	27.49	Stroke	16 007	1.04
	3	Diabetes	119 882	22.01	Cirrhosis	3 387	0.62	Low back pain	411 713	26.98	Breast cancer	8 227	0.53
	4	Low back pain	105 287	19.33	Breast cancer	2 183	0.40	Breast cancer	242 125	15.86	Lung cancer	6 965	0.45
	5	Cirrhosis	99 105	18.19	Diabetes	2 102	0.38	Diabetes	216 687	14.20	Cirrhosis	5 164	0.33
70+	1	Ischaemic heart disease	701 455	331.89	Ischaemic heart disease	67 114	31.75	Ischaemic heart disease	1 453 610	187.78	Ischaemic heart disease	154 332	19.93
	2	Stroke	383 217	181.31	Stroke	36 334	17.19	Stroke	1 244 150	160.72	Stroke	131 551	16.99
	3	Chronic obstructive pulmonary disease	85 516	40.46	Chronic obstructive pulmonary disease	4 714	2.23	Low back pain	241 328	31.17	Hypertensive heart disease	21 186	2.73
	4	Diabetes	66 029	31.24	Hypertensive heart disease	3 558	1.68	Falls	223 443	28.86	Other cardiac and circulatory disorders	13 912	1.79
	5	Low back pain	51 491	24.36	Cirrhosis	2 978	1.40	Diabetes	218 397	28.21	Chronic obstructive pulmonary disease	12 162	1.57

^a The broad causes of mortality and disease burden can be measured in disability-adjusted life years (DALYs), which present a way of quantifying the burden of disease from mortality and morbidity. One DALY can be considered as one lost year of healthy life. The sum DALYs across the population, or the burden of disease, can be thought of as a measurement of the gap between current health status and an ideal health situation in which the entire population lives to an advanced age free of disease and disability.

^b Central Asia includes Armenia, Azerbaijan, Georgia, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan. Central Europe includes Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Czech Republic, Hungary, Montenegro, Poland, Romania, Serbia, Slovakia, Slovenia and the former Yugoslav Republic of Macedonia. Eastern Europe includes Belarus, Estonia, Latvia,

Source: Institute for Health Metrics and Evaluation (IHME) (8).

Eastern Europe						Western Europe						
Cause	DALYs		Cause	Deaths		Cause	DALYs		Cause	Deaths		
	Total	Per 1 000		Total	Per 1 000		Total	Per 1 000		Total	Per 1 000	
Congenital anomalies	289 131	52.03	Congenital anomalies	3 338	0.60	Congenital anomalies	470 170	33.75	Preterm birth complications	4 738	0.34	1
Preterm birth complications	178 865	32.18	Preterm birth complications	2 053	0.36	Preterm birth complications	412 248	29.59	Congenital anomalies	5 415	0.38	2
Neonatal encephalopathy	149 109	26.83	Neonatal encephalopathy	1 692	0.30	Neonatal encephalopathy	127 279	9.13	Neonatal encephalopathy	1 422	0.10	3
Lower respiratory infections	93 248	16.78	Lower respiratory infections	1 060	0.19	Diarrhoeal diseases	100 097	7.18	Neonatal sepsis	959	0.06	4
Iron-deficiency anaemia	90 407	16.26	Neonatal sepsis	628	0.11	Sickle cell anaemia	71 299	5.11	Sudden infant death syndrome	503	0.03	5
Under 5												
Major depressive disorder	87 260	9.18	Road injury	333	0.03	Major depressive disorder	40 128	6.80	Road injury	127	0.02	1
Iron-deficiency anaemia	62 384	6.56	Drowning	239	0.02	Asthma	28 528	4.83	Brain cancer	66	0.01	2
Low back pain	31 942	3.36	Congenital anomalies	184	0.01	Anxiety disorders	24 146	4.09	Lower respiratory infections	63	< 0.01	3
Asthma	30 999	3.26	Leukaemia	133	0.01	Low back pain	22 627	3.83	Congenital anomalies	62	< 0.01	4
Road injury	29 205	3.07	Brain cancer	111	0.01	Iron-deficiency anaemia	20 147	3.41	Leukaemia	57	< 0.01	5
5-14												
Major depressive disorder	1 021 990	18.92	HIV/AIDS	17 701	0.32	Low back pain	2 080 214	17.80	Breast cancer	10 148	0.08	1
HIV/AIDS	879 182	16.27	Ischaemic heart disease	8 464	0.15	Major depressive disorder	1 905 176	16.30	Self-harm	6 132	0.05	2
Low back pain	724 974	13.42	Cirrhosis	6 227	0.11	Anxiety disorders	1 025 651	8.78	Road injury	3901	0.03	3
Ischaemic heart disease	423 044	7.83	Road injury	4 860	0.08	Neck pain	913 634	7.82	Lung cancer	3 759	0.03	4
Musculoskeletal disorders	373 769	6.92	Interpersonal violence	4 405	0.08	Musculoskeletal disorders	860 346	7.36	Cirrhosis	2 929	0.02	5
15-49												
Ischaemic heart disease	2 224 090	81.09	Ischaemic heart disease	81 238	2.96	Low back pain	1 571 949	28.16	Ischaemic heart disease	31 782	0.56	1
Stroke	1 279 850	46.66	Stroke	48 090	1.75	Ischaemic heart disease	999 113	17.90	Breast cancer	31 142	0.55	2
Low back pain	642 110	23.41	Breast cancer	16 165	0.58	Breast cancer	924 955	16.57	Lung cancer	22 891	0.41	3
Major depressive disorder	538 476	19.63	Cirrhosis	12 042	0.43	Major depressive disorder	916 105	16.41	Stroke	18 923	0.33	4
Breast cancer	480 073	17.50	Colorectal cancer	10 503	0.38	Musculoskeletal disorders	763 190	13.67	Colorectal cancer	15 398	0.27	5
50-69												
Ischaemic heart disease	5 312 700	356.25	Ischaemic heart disease	528 990	35.47	Ischaemic heart disease	3 014 445	187.78	Ischaemic heart disease	369 936	10.86	1
Stroke	3 227 140	216.40	Stroke	321 666	21.56	Stroke	2 137 985	160.72	Stroke	257 998	7.57	2
Low back pain	441 133	29.58	Colorectal cancer	19 042	1.27	Alzheimer's disease	1 517 636	31.17	Alzheimer's disease	101 493	2.98	3
Alzheimer's disease	307 921	20.64	Chronic obstructive pulmonary disease	15 634	1.04	Low back pain	1 071 956	28.86	Lower respiratory infections	80 990	2.37	4
Chronic obstructive pulmonary disease	290 799	19.50	Hypertensive heart disease	13 825	0.92	Falls	1 014 591	28.21	Other cardiac and circulatory disorders	69 261	2.03	5
70+												

Lithuania, Republic of Moldova, Russian Federation and Ukraine. Western Europe includes Andorra, Austria, Belgium, Cyprus, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Israel, Italy, Luxembourg, Malta, Netherlands, Norway, Portugal, Spain, Sweden, Switzerland, Turkey and United Kingdom.

† The absolute DALY and deaths data available per subregion and age group from IHME have been converted into relative numbers using demographic data from 2010 (8) to allow data comparison. The conversion has been made by dividing DALYs and deaths results per subregion and age group by the total populations for the respective subregions and age groups. A random cohort of 1000 women was chosen to facilitate data comparison.

Women of all ages disproportionately bear the burden of informal care for children and older people. Formal care alternatives are few in many countries and may be inaccessible, unaffordable and of low quality. This places pressure through high expectations on women of all ages to provide intergenerational support. The so-called sandwich generation is created for mothers and grandmothers, in which the combined effect of increased longevity and delayed fertility means women provide care to younger and older generations in the family (12).

The most striking imbalance of power between women and men is the presence in all countries and among all population groups of violence against women. This is both a human rights violation and a major obstacle to gender equality. Violence has serious and long-term effects on women's physical and mental health through direct and indirect pathways, leading to physical and psychological trauma, stress, fear and a host of health and well-being problems (13).

Rural or urban residence, minority status and disability are also important dimensions that need to be taken into account when looking at inequalities in women's health. In addition, specific processes such as climate change, conflict situations, migration and human trafficking increase women's vulnerability to ill health.

MAIN ISSUES TO BE ADDRESSED

- Pathways to women's health and ill health are complex and require multilayered analysis.
- Inequalities among women persist within countries and across the Region. Health systems need to provide adequate responses to the needs of women living in rural areas, older women, women experiencing violence, social exclusion and economic deprivation and those facing multiple discrimination.
- Data disaggregated by sex and other determinants are needed for this analysis, informed by solid understandings of the influence of gender aspects and other social determinants on health and health inequalities.
- Many of these determinants lie outside the health sector, so mechanisms for intersectoral collaboration on data collection, analysis and action need to be in place.



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Chapter three Women's health across the life-course

Women's health across the life-course

A complex interplay of biological, behavioural, psychological and social protective and risk factors contributes to health outcomes across the span of a person's life. This chapter focuses on broad causes of mortality and morbidity during four age stages – the girl child, adolescents, adult women and older women – emphasizing how factors that influence health cut across the stages.

The girl child

Opportunities are present during this age stage for actions to prevent future ill health and fully realize health and well-being potential. Strong evidence to support such actions exists, but inequalities in health linked to gendered and social factors such as place of residence, maternal/family socioeconomic status, ethnicity and migrant status continue for girls across the Region.

European countries have some of the lowest infant and child mortality rates in the world, but considerable inequalities persist, with a 25-fold difference in infant mortality between the countries with the lowest and highest rates. The overall infant mortality rate and those for females and males in the Region have been decreasing, and the difference between sexes did not change much between 2000 and 2012. Indications of large inequalities within countries exist, but data are lacking.

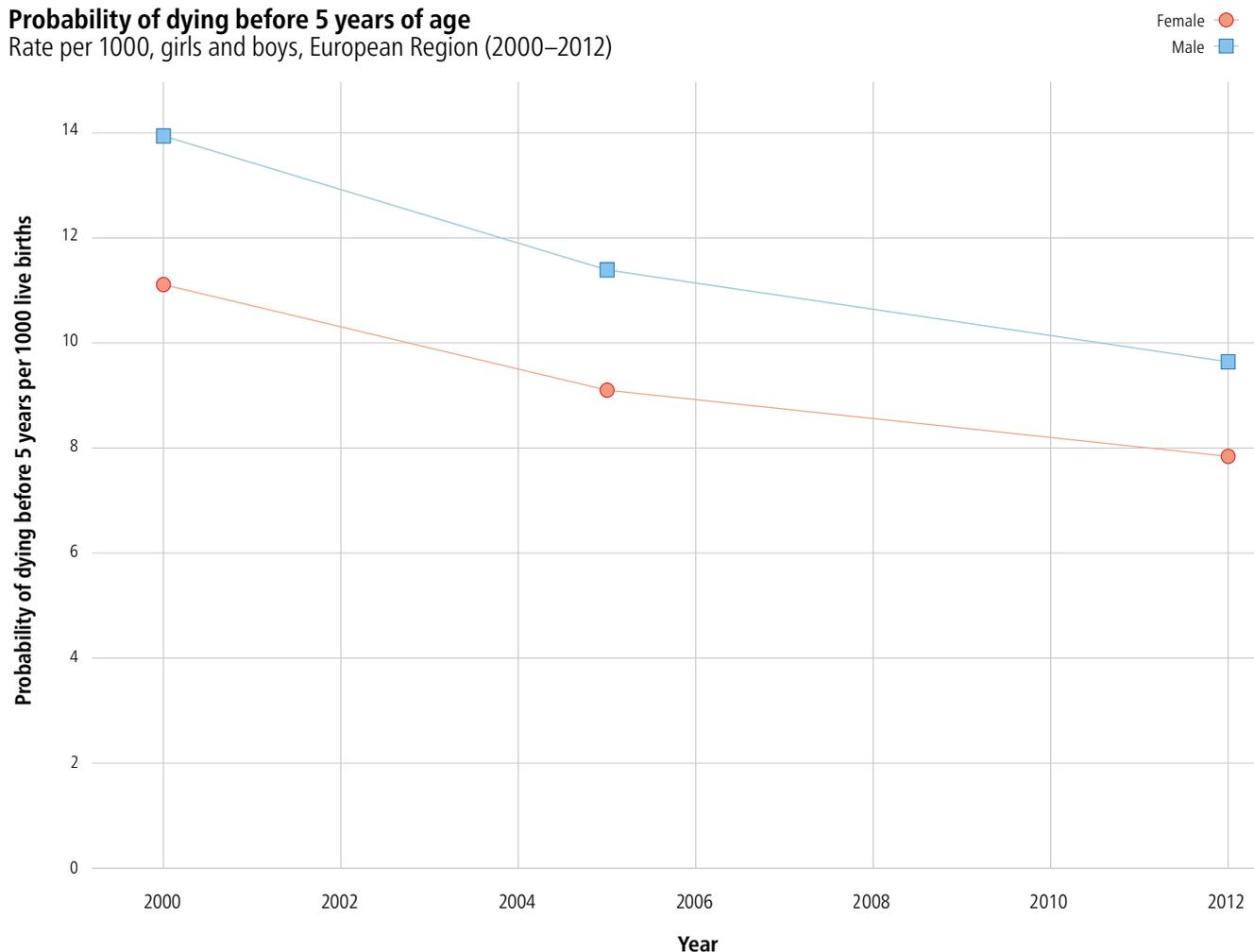
The leading causes of deaths for boys and girls under 5 years in the Region are neonatal conditions, injuries, pneumonia and diarrhoea (14). Girls under 5 are less likely to die than boys (Fig. 6) (7), and the gap in male and female mortality is decreasing (8). There is greater divergence in the main causes of mortality between girls and boys and among girls in different parts of the Region after 5 years.

Fig. 6

Source: WHO Regional Office for Europe (7).

Probability of dying before 5 years of age

Rate per 1000, girls and boys, European Region (2000–2012)



Broad causes of disease for girls under 5 years are congenital abnormalities, preterm birth complications, lower respiratory infections, neonatal encephalitis and sepsis, iron-deficiency anaemia, diarrhoeal diseases and sudden infant death syndrome (see **Table 1**, p. 8). Among girls aged 5–14 years, they are road injuries, asthma, major depressive disorders and anxiety (15).

LINKS BETWEEN GENDER AND POVERTY

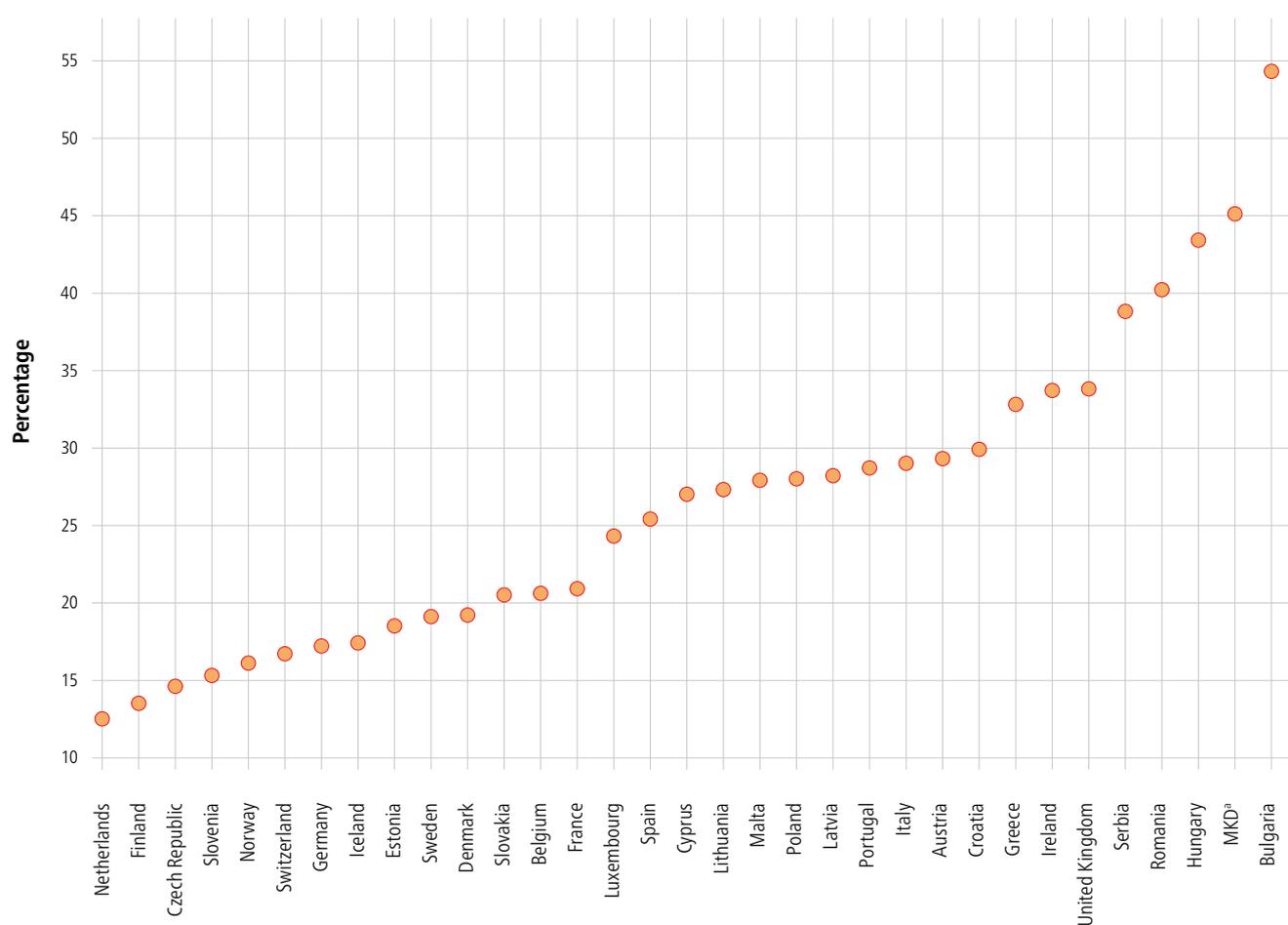
Poverty has negative consequences for issues as diverse as infant mortality rates, feeding practices and access to adequate water, sanitation and hygiene conditions. **Fig. 7** shows the percentage risk of poverty or social exclusion for girls aged under 6 years in a number of European countries in 2013 (16).

Fig. 7

Source: Eurostat (16).

Girls at risk of poverty and social exclusion

Risk of poverty and social exclusion for girls aged under 6 years in some European countries (2013)



* The former Yugoslav Republic of Macedonia.

Gendered feeding practices in some countries directly affect girls' nutritional status and their future growth and development. Malnutrition in girls has an impact in later life and an intergenerational effect, as it is linked to maternal mortality and low birth weight.

Overweight and obesity, which are linked to maternal socioeconomic status and other social factors, are increasingly important causes of poor health for girls as they move through the life-course. The proportion of 2–10-year-olds girls with obesity in the Region decreased significantly from 17% in 2005 to 10% in 2012 (17).

Women's health across the life-course

VALUING GIRLS: THE INFLUENCE OF GENDER ON GIRLS' HEALTH AND WELL-BEING

A clear preference for sons is present in several European countries. This is one of the starkest manifestations of gender discrimination and is based on the different value afforded by society to girls and boys. Patriarchal family systems nurture son-preference. Gender-biased sex selection is seen in some countries in the Region, reflecting strong gender-based discrimination. The modernization of reproductive technologies has compounded the problem of gender-biased sex selection, but it has not caused it (18). Governments have an important responsibility to address the root causes of discrimination through awareness-raising activity, legal and policy action, and other supportive measures for women and girls.

Gender stereotyping begins early in life and has lifelong negative implications for girls' health, expectations and opportunities. Gender stereotypes have many effects on women's social and economic lives in relation to well-being, self-confidence, mental health, working opportunities, work-life balance, sexism and violence. It also affects health system responses to men and women's needs, including under- and overdiagnosis of certain conditions. Social protection policies such as paid maternity and paternity leave not only improve child care provision, but also challenge gender stereotypes.

A GOOD START IN LIFE: EARLY CHILD DEVELOPMENT

Early childhood education and care is a key determinant of health as it promotes a good start in life. Participation rates have increased significantly in the Region, with 87% of 4-year-olds and 93% of 5-year-olds attending a formal programme in 2006. **Fig. 8** shows early childhood education differences among countries measured by gross enrolment rates (19). Despite improved availability, however, inequalities in coverage and access for some groups of girls, such as Roma, those from remote rural areas and girls with disabilities, persist. These groups face general challenges in accessing health, education and social services, including early childhood education and care (20).

The WHO European child and adolescent health strategy 2015–2020 calls for all children and adolescents born and/or growing up in the Region to have access to age- and gender-appropriate health and sexuality information and support to develop their confidence and skills in making informed choices and decisions, developing positive relationships and participating in decisions about their health and well-being (14).

VIOLENCE AGAINST GIRLS

Child maltreatment and other adverse experiences in childhood have far-reaching consequences for girls' mental and physical health and social outcomes. Evidence of the intergenerational transmission of violence is growing, with victims of violence in childhood being more likely to drift into abusive relationships as women and perpetrate maltreatment on their own children (21).

While female genital mutilation, defined by WHO and other United Nations agencies as "the partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons" (22), is practised as a social convention linked to sociocultural perceptions mainly in specific countries in Africa and the Middle East, girls and women in Europe have also experienced this particular form of violence (23). The most common immediate health consequences are severe pain, shock, haemorrhage, oedema and infections, with long-term problems including repeated urinary tract infections, painful menstruation, cysts and abscesses, sexual health problems, infertility and complications in childbirth (24,25).

MAIN ISSUES TO BE ADDRESSED

- Greater effort is needed to ensure health system responsiveness and prioritization of health interventions for girls and their mothers.
- Initiatives to improve coverage should be informed by more systematic collection and use of sex- and age-disaggregated data linked to socioeconomic factors.
- These actions need to be accompanied by improved funding and scaling-up of efforts to tackle gender stereotypes and practices that are not only harmful to girls and women's health, but also challenge their human rights. Political, legal and social interventions that raise awareness, eliminate harmful practices and reduce inequalities among girls should be deployed.

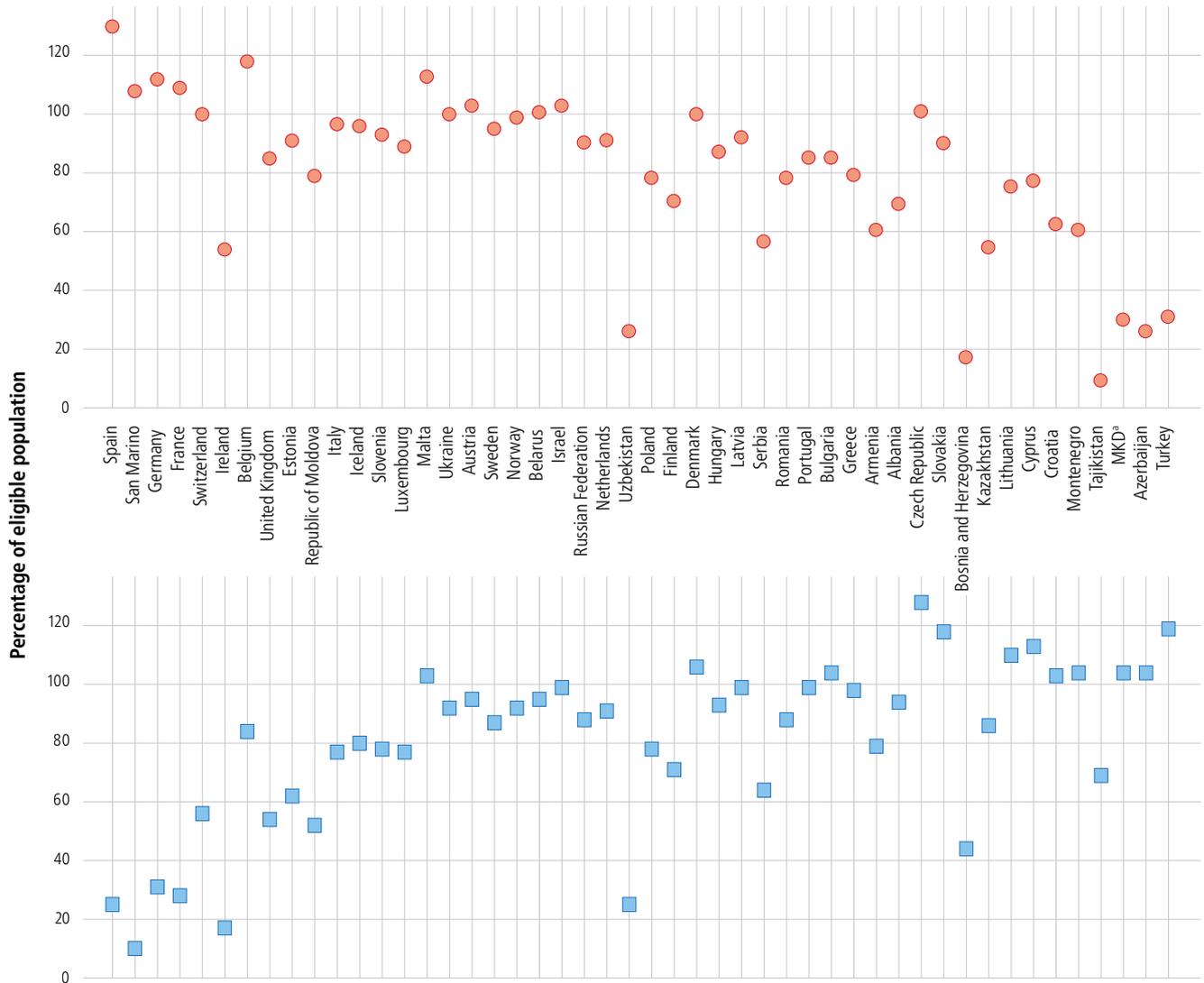
Fig. 8

Source: United Nations Children's Fund (UNICEF) (19).

Opportunity for early childhood development

Pre-primary school participation for girls and boys (2009–2012)

Female ●
Male ■



^a The former Yugoslav Republic of Macedonia.

Adolescents

Adolescence is generally synonymous with good health and development, but it is also a time of great biological, social and emotional change that has an important impact on girls' well-being, self-confidence and behaviour. Nearly 35% of the global burden of disease has its roots in adolescence (26), making it a crucial life stage for health-promoting interventions.

Causes of mortality and morbidity among adolescent girls include mental and behavioural disorders, musculoskeletal conditions, neurological disorders, intentional injury and transport injuries. Major contributors include intimate-partner violence, childhood sexual abuse, unsafe sex, occupational risks, drugs and alcohol use, and iron deficiency (see **Table 1**, p. 8).

Understanding the influence of gender and socioeconomic determinants is central to minimizing health risks and building on strengths. The Health Behaviour in School-aged Children (HBSC) survey is a key source of data, covering health and well-being

Women's health across the life-course

behaviours in 11-, 13- and 15-year-olds in most countries in the Region. The 2010 international report from the HBSC survey focuses on the social determinants of health and well-being among young people (27).

High and higher education attainment and literacy are contributing factors to improving health and well-being, but inequities in access to education for girls based on where they live and their socioeconomic and cultural background exist in some countries. Girls with low family affluence living in disadvantaged circumstances tend to be less satisfied with life, which explains why interventions need to go wider than the school setting to ensure coverage. Outreach programmes that include adolescents' full participation are crucial to improving girls' health and well-being.

SEXUAL AND REPRODUCTIVE HEALTH

Adolescent girls are at risk of unsafe and often unwanted sexual activity that may lead to unintended pregnancy, sexually transmitted infections and unsafe abortion. Birth rates among adolescents are decreasing but remain high in some countries and/or among some population groups. Adolescent pregnancy rates are an important marker of within-country inequities for mothers and their children. Women who experience pregnancy and childbirth at a young age often face increased risks, including premature mortality (28): those who were teenage mothers are about 30% more likely to die prematurely by any cause and almost 60% more likely to die unnaturally (suicide). Teenage motherhood is also associated with elevated risk of deaths from cervical and lung cancer (29) and a decrease in life opportunities if girls are unable to continue and complete their secondary education, go to university or receive vocational training.

Fig.9 illustrates adolescent birth rates cross-linked to mean years of schooling in the Region (30). Generally, the higher the mean years of schooling, the lower the adolescent birth rate. A few countries, however, show both high mean years of schooling for women and some of the highest adolescent birth rates in the Region (31): this highlights the need for countries to look beyond education in seeking solutions.

The onset of sexual activity also brings risks of sexually transmitted infections, including HIV/AIDS. There are many gaps in sexual and reproductive health services for adolescents, not least of which is poor availability of, and access to, modern contraceptive methods, with limited reimbursement schemes acting as a barrier to use.

Sexual education is crucial. It is of the utmost importance that young people are informed and feel supported during adolescence. They are exposed to many new sources of information, particularly in relation to sexuality, but many of the sources are distorted, perpetuate gender stereotypes and degrade women (32).

MENTAL HEALTH OF ADOLESCENTS: A GROWING CONCERN

More than 10% of adolescents in the Region have some form of mental health problem (14), with neuropsychiatric conditions being the leading cause of disability. Major depressive disorders are the most common mental health conditions in children and adolescents, followed by anxiety, behavioural (conduct) and substance-use disorders. The Region includes countries with the highest adolescent suicide rates in the world: for some countries, suicide is among the leading causes of death of young people.

Research shows a distinct gender pattern in mental health after the age of 13 years: different problems afflict boys and girls, with girls generally reporting more problems. Depressive symptoms and anxiety are twice as common for girls and teenage boys score higher on self-esteem scales. Death by suicide is higher among boys, while self-harm and suicide attempts are more common in girls (33).

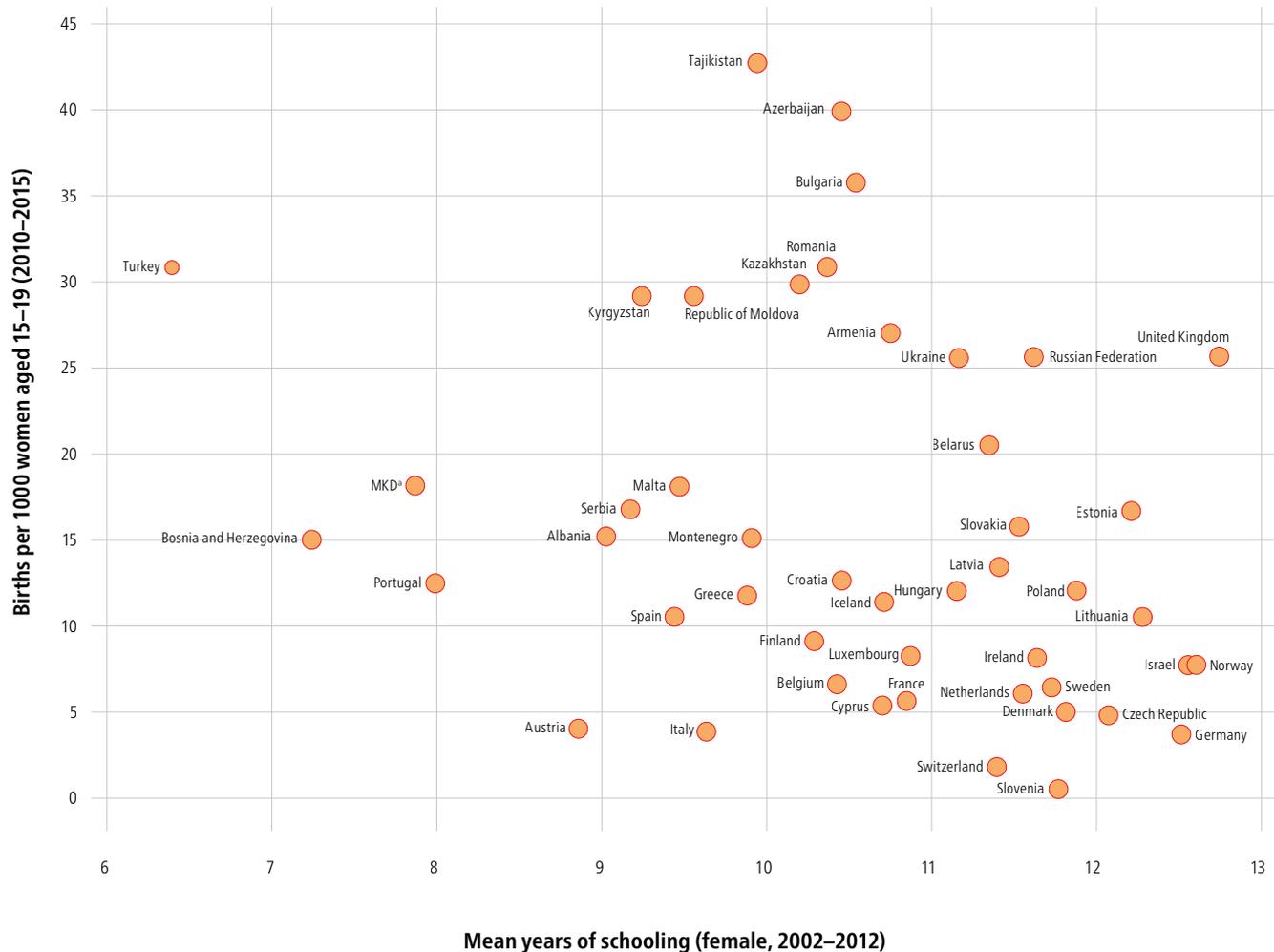
RISK FACTORS: LINKS BETWEEN BIOLOGY, GENDER AND SOCIOECONOMIC DETERMINANTS

Adolescent girls are more likely to engage in health-promoting behaviours such as eating fruit and limiting soft-drink intake (27) but have low levels of physical activity, which begin to decrease significantly between ages 11 and 15 in most European countries. The decrease for girls is steeper between 11 and 13 years than between 13 and 15 (27), suggesting that opportunities to participate in physical activity may be gender-biased. Traditional gender norms about teenage girls and women not participating in organized physical activity may act as a barrier (34).

Fig. 9

Source: UNDP (30).

Correlation between schooling and adolescent birth rates
Adolescent birth rates (2010–2015) by mean years of schooling (2002–2012)



^a The former Yugoslav Republic of Macedonia.

In many countries, girls are catching up in their use of tobacco and alcohol, abetted by active targeting by industry.

Inequities in tobacco use among girls are increasing. While the smoking epidemic among women began with the most affluent (linked to increased salaries and ideas of emancipation), it is now increasingly associated with low socioeconomic status, particularly in countries with strong smoking cultures. Smoking usually starts at a younger age in socioeconomically disadvantaged groups, with greater daily consumption and consequent increased risk of addiction (and far greater difficulty in quitting). Adolescent girls and young women with lower socioeconomic status may be less aware of the health risks of smoking and second-hand smoke due to limited access to information in appropriate formats, potentially making them more vulnerable to the advertising strategies of the tobacco industry (27).

Fig. 10 shows the prevalence of smoked tobacco use among adolescent girls in 2013/2014, highlighting differences among girls of the same age living in different countries (WHO, unpublished data, 2015).

Due to their smaller body size, higher body fat and lower water content, girls absorb alcohol faster than boys. A recent report found an “alarming” and significant increase in risky drinking practices (such as binge drinking) among young people, with more

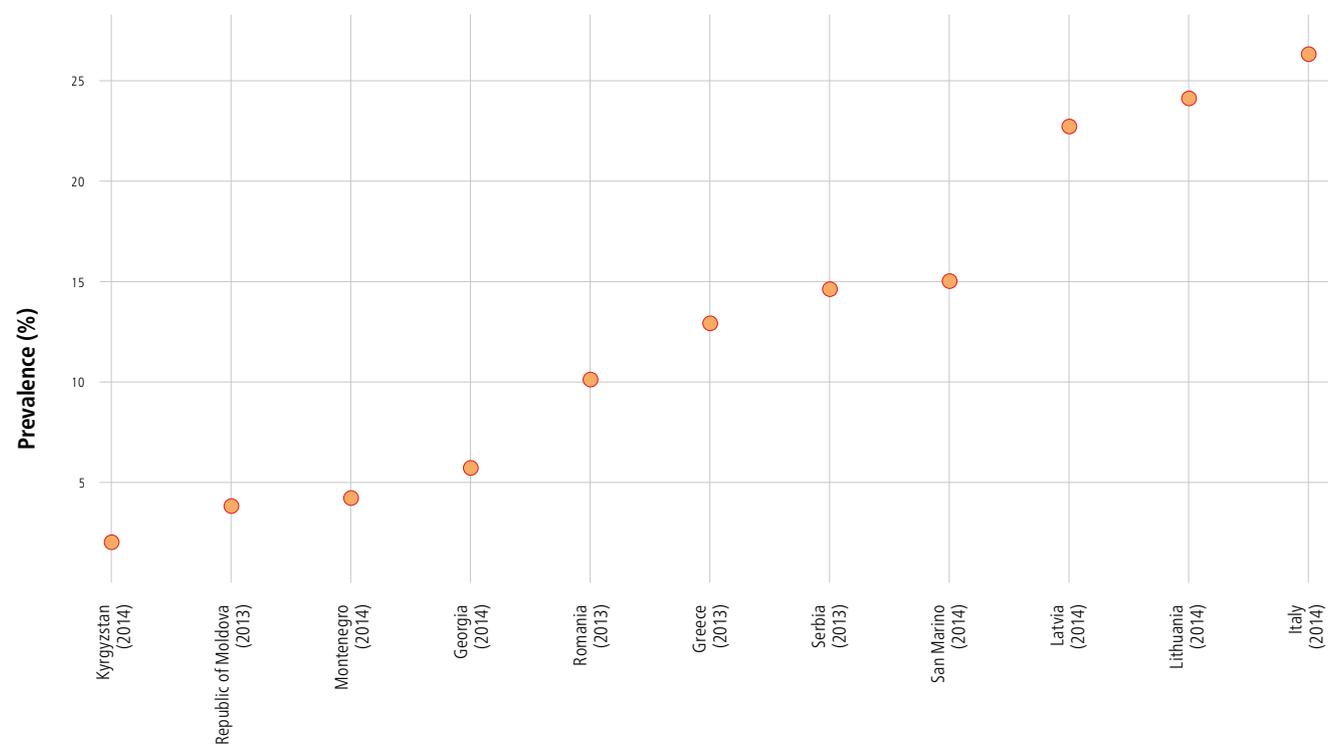
Women's health across the life-course

Fig. 10

Source: WHO, unpublished data, 2015.

Tobacco smoking among adolescent girls

Current smoked tobacco use, adolescent girls aged 13–15 years, in selected countries



than two thirds of children in Organisation of Economic Co-operation and Development (OECD) countries having drunk alcohol by age 15 and 40% having been drunk at least once. The report stated that in relation to alcohol, girls are “catching up” with boys (35). Stigma due to gender stereotypes around female harmful and hazardous use of alcohol may act to prevent young women seeking help or treatment at an early stage (36).

Gender stereotypes also drive girls to have a negative image of their bodies. Almost 40% in the HBSC survey reported dissatisfaction with their bodies, which was almost double the rate for boys. Twenty-two per cent of 15-year-old girls claimed to be on a diet, although only 10% were overweight (compared to 9% of boys being on a diet and 18% being overweight). Attempts to lose weight are a common feature of girls’ lifestyles by the time they are 13 and increase with age (27).

Recent studies show that adolescent girls’ use of social media may have negative health effects that include loss of self-esteem, worrying, anxiety, difficulty relaxing and sleeping, and impaired face-to-face communication skills (37,38). Negative emotions provoked by constant comparisons with peers and the so-called fear of missing out are primarily responsible. Social media has also been associated with serious health effects such as social media addiction (39) and cyberbullying.

GENDER-BASED VIOLENCE STARTS EARLY

Fear of gender-based violence, including forced early marriage, rape and bride-kidnapping, and concerns about confidentiality in small or rural communities can discourage adolescent girls from seeking help from sexual and reproductive health services (40).

Like gender stereotyping, gender-based and sexual violence starts early in life. Schools are common settings for violence against girls, with boys the most frequent perpetrators. Changing adolescent attitudes that are underpinned by stereotypical views of masculine and feminine identities is an important entry point for action. **Fig. 11** shows the percentage of boys and girls aged 15–19 who consider a husband to be justified in hitting or beating his wife for at least one of the following reasons: if his wife

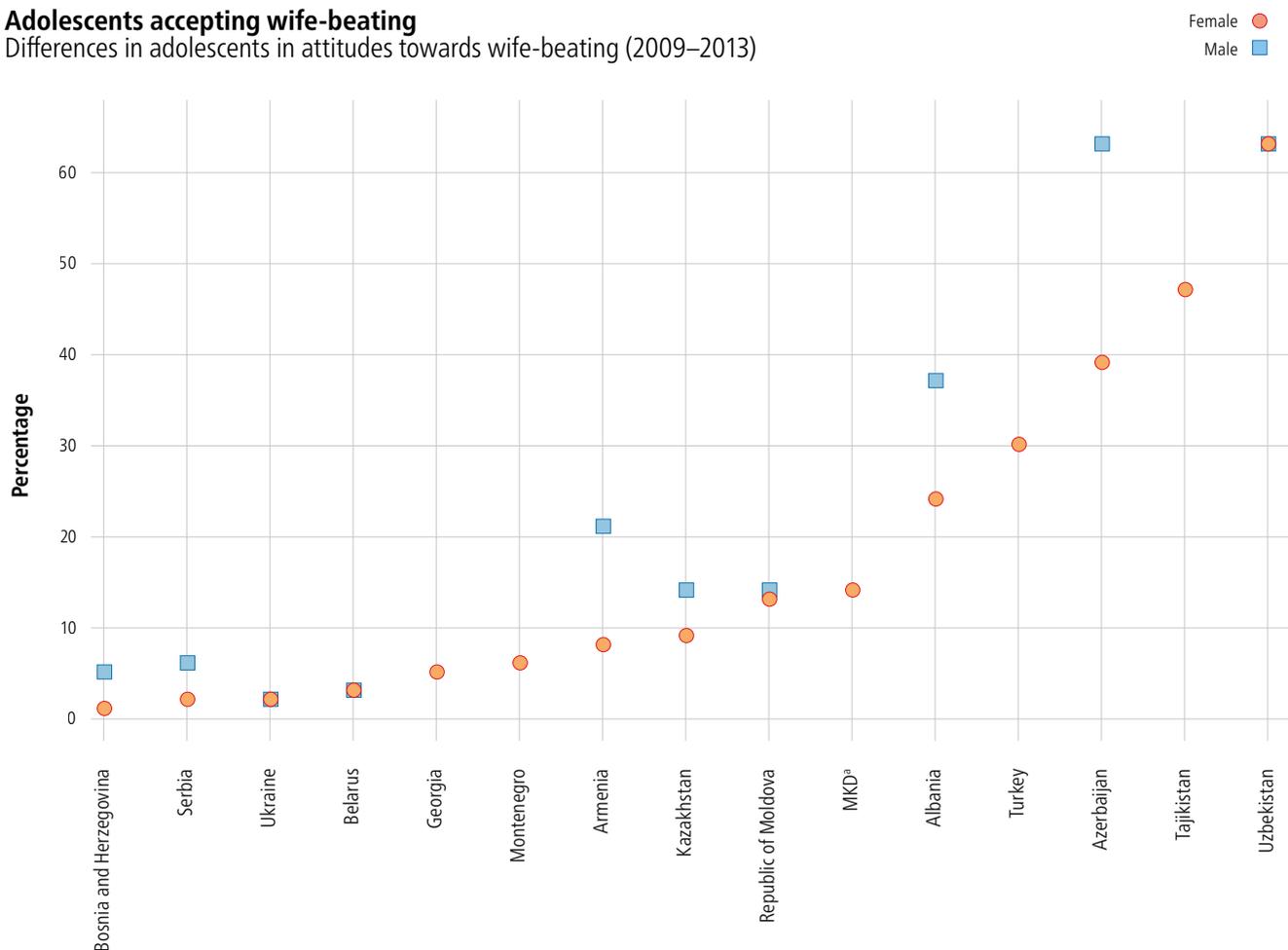
burns the food, argues with him, goes out without telling him, neglects the children or refuses sexual relations. A high percentage of adolescent boys think wife-beating is justified for things like burning the dinner, but an equivalent percentage of adolescent girls in some countries share this view (19).

Fig. 11

Source: UNICEF (19).

Adolescents accepting wife-beating

Differences in adolescents in attitudes towards wife-beating (2009–2013)



^a The former Yugoslav Republic of Macedonia.

MAIN ISSUES TO BE ADDRESSED

- Special attention should be paid to the impact of interventions beyond childhood and their intergenerational effect.
- Adolescent girls should have access to comprehensive sexuality education that empowers them to live a healthy, pleasurable sexual life free of coercion, unintended pregnancy and disease (41). Education of boys is crucial to achieving this.
- Policy measures to limit tobacco and alcohol use, promote an adequate diet and improve physical activity are important, but greater attention is needed to improve coverage for girls who are disadvantaged and/or not in the mainstream system.
- Interventions need to go wider than the school setting to ensure coverage. Outreach interventions, use of social media and adolescents' participation in programmes are crucial.
- Girls need protection from gender-based violence, including being subjected to early marriage, exploitation, abuse, and intimate-partner and sexual violence.
- Gender stereotyping, with its negative impact on girls' behaviour and opportunities, needs to be reflected in health-promotion and disease-prevention policies for adolescents.
- Improved age and sex disaggregation of health information and intervention research cross-linked to socioeconomic determinants will help to highlight the particular needs of adolescent girls and the approaches necessary to meet them.

Women's health across the life-course

Adult women

Applying a life-course approach includes looking at women's health needs beyond their potential role as mothers. Women are living longer but have an increased risk of developing disease and disability earlier in life. This is partly due to threats from noncommunicable diseases and their risk factors, but also because their particular responses to such diseases has until recently gone unrecognized and unaddressed.

Gendered exposures and vulnerabilities in women's health that emerge more often during adulthood may be compounded by a lack of awareness among medical and health professionals of women's increased and/or differential risks for particular diseases and conditions. For example, women experience different symptoms for cardiovascular disease and have an increased risk of asthma in adulthood due to sex- and gender-related factors, including the menstrual cycle and greater exposure to chemicals in housecleaning products (42,43).

The probability of dying between 15 and 60 years is low for women but the mortality rate is not equally distributed, with some countries in the Region reporting 110 deaths per 1000 female population and others fewer than 50 (5). Broad causes of disease in adult women include mental and behavioural disorders and musculoskeletal and neurological conditions, but cardiovascular and circulatory problems, cancer, chronic respiratory diseases, cirrhosis, HIV/AIDS and tuberculosis (in some parts of the Region) are now comprising an increasing proportion. Major contributors are alcohol, tobacco and drug use, intimate-partner violence, high body mass index (BMI) and low physical activity (see **Table 1**, p. 8). HIV/AIDS is an important cause of disease for women aged 15–49 years in countries in eastern European and a cause of death for women of this age group living in the eastern European and central Asian subregions (44).

A high proportion of women in most countries report bad or poor self-rated health. Differences become considerable when education and, particularly, incomes and age are factored in. The largest improvements in self-assessed health have been observed among women aged 26–40 years with the highest incomes. **Fig. 12** shows a steep and negative gradient between women in the highest and lowest wealth quintiles within countries (45). Gender inequalities at work (such as wage inequality), home (unequal burden of housework and their role as informal carers) and in the wider community (ongoing acceptance of higher levels of violence against women) are important contributing factors.

A recent OECD report on how reducing inequality brings benefits for everyone recommends an increase in women's participation in economic life as one of four main areas for policy action (46). This would involve the elimination of unequal treatment, removal of barriers to female employment and career progression, and improvements in earnings potential for women on low salaries.

NONCOMMUNICABLE DISEASES: RISK FACTORS AND INEQUITIES

Changing norms and targeted industry interventions have led to women catching up with men in alcohol and tobacco use in some parts of the Region. Alcohol and tobacco use and low levels of physical activity are important causes of disease in adulthood. Low physical activity, high BMI, dietary risks and high blood pressure increase in significance as women move through adult life.

Social determinants such as low education levels, local cultures and low incomes influence most of these risk behaviours. For instance, there is a higher prevalence of obesity among women with lower levels of education: while 26% of obesity in men in the European Union (EU) can be attributed to inequalities in education status, the respective percentage for women is 50%. The socioeconomic determinants of harmful and hazardous alcohol use do not necessarily follow the same pattern as for tobacco and obesity, in that people with lower levels of education and/or income do not necessarily drink more, but harmful use has great health and social consequences for women (47).

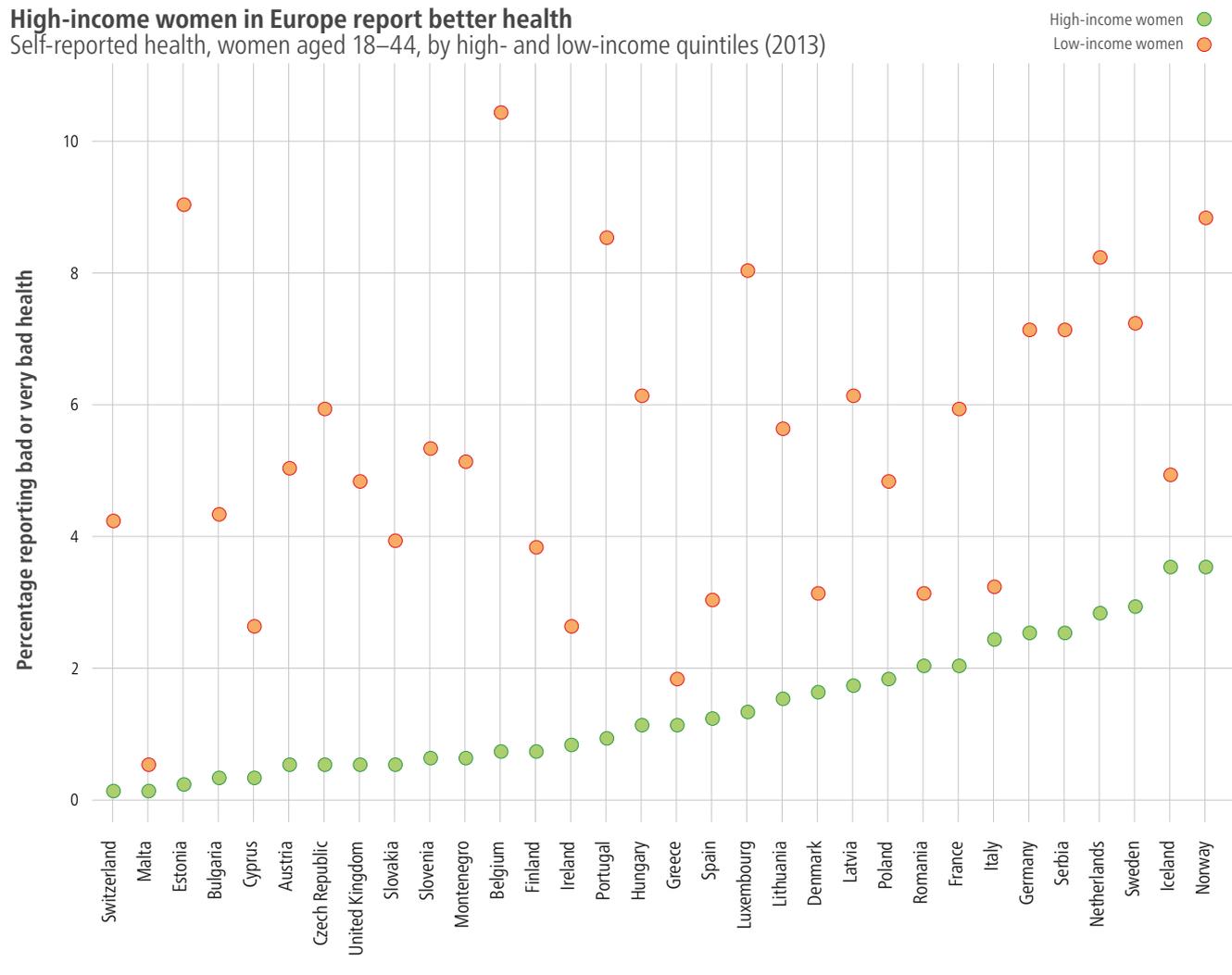
Despite improvements, breast cancer remains a common cause of disease for women in all subregions except central Asia. Initiatives to improve screening and/or treatment outcomes for breast and cervical cancer need to be linked to a range of

Fig. 12

Source: Eurostat (45).

High-income women in Europe report better health

Self-reported health, women aged 18–44, by high- and low-income quintiles (2013)



social factors, including education, socioeconomic status/position, neighbourhood composition, immigrant status and urban environment (48,49).

Harmful air pollution resulting from cooking and heating with solid fuels on open fires or traditional stoves has a disproportionate effect on women and children, who receive the highest exposures (50). Research on work-related diseases has made some progress in relation to cancers and reproductive health, but has not yet considered women's working situations and health conditions such as musculoskeletal disorders (51).

Depression disorders are a broad cause of morbidity among adult women but data and analysis on the impact of socioeconomic determinants are not readily available.

SEXUAL AND REPRODUCTIVE HEALTH OF ADULT WOMEN

Maternal health problems, including those resulting from unsafe abortion, are important causes of mortality and morbidity. Maternal mortality almost halved in the Region between 1990 and 2006, but progress has been uneven. Striking inequalities between women across the Region and among women within countries persist (52), despite the interventions needed to prevent such problems being both well known and cost-effective.

Women's health across the life-course

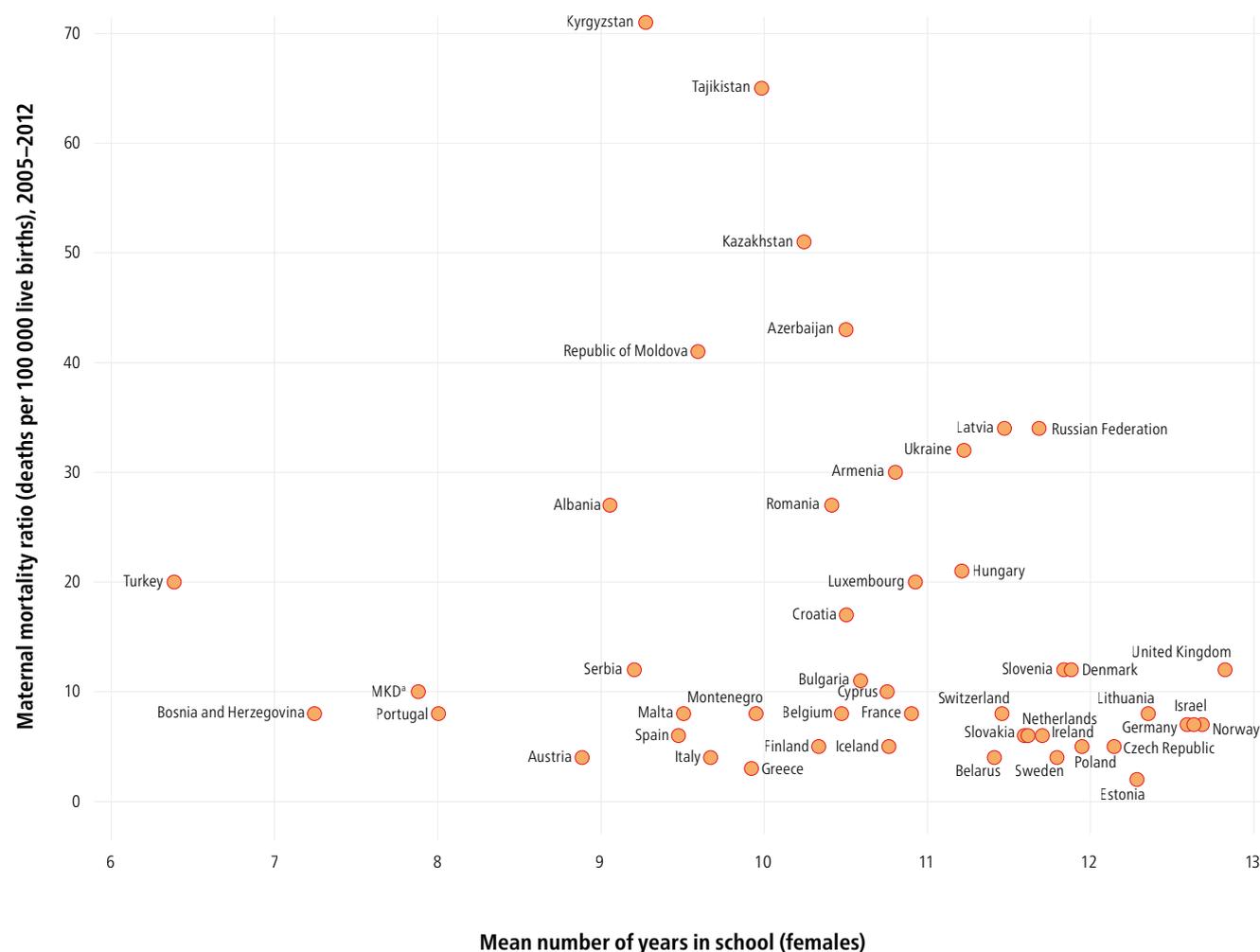
Studies have identified links (and often a negative gradient) between perinatal mortality, maternal socioeconomic status (ethnicity, immigrant status and education level) and neighbourhood composition (ethnic minority neighbourhoods and deprivation) (53,54). **Fig. 13** presents data on the risk of maternal mortality by schooling between 2005 and 2012 in the Region (55). Education is only a proxy indicator of inequalities in the maternal mortality rate, but the rate is relatively high in some countries with a high level of secondary education for women. This emphasizes the need to look at other factors, such as access to care and the quality of maternity services, which in many cases are overmedicalized. Indirect factors (such as cardiovascular diseases) are becoming the leading cause of maternal mortality in many countries (56).

Fig. 13

Source: UNDP (55).

Risk of maternal mortality by schooling

Maternal mortality ratio compared to the mean number of years in school (2005–2012)



* The former Yugoslav Republic of Macedonia.

Women's reproductive years have enormous effects on their general health and well-being. They need to be empowered to control reproduction (1). Few countries, however, have implemented a comprehensive sexual and reproductive health and rights strategy with a specific focus on family planning and access to modern contraceptive choice. Many countries in the Region have a high unmet need for contraception (1), which is one of the indicators for Millennium Development Goal 5 (improving maternal health). This has a greater impact on women's health and well-being across the life-course.

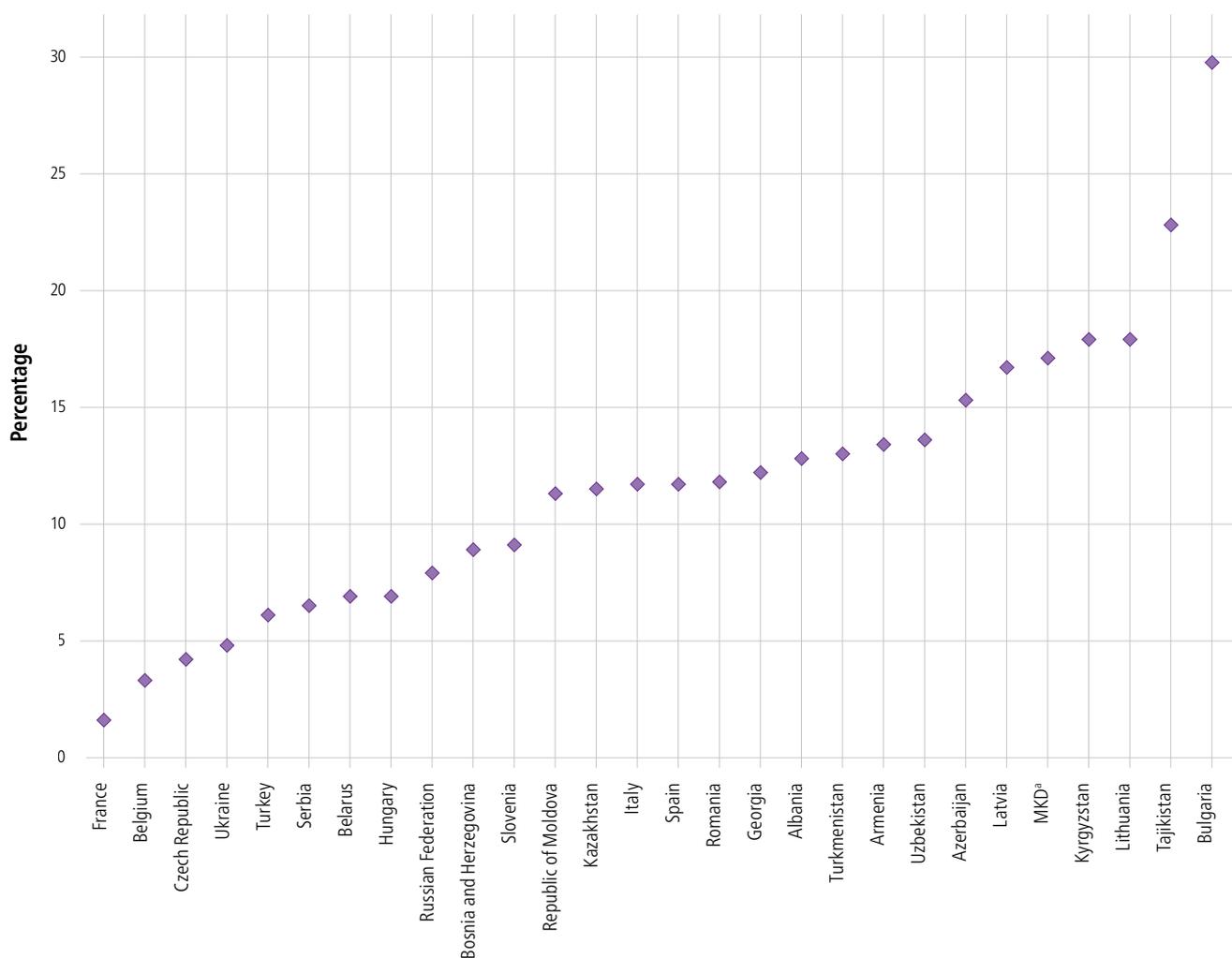
Fig. 14 shows that unmet need for family planning in Member States for which data are available ranges from 5% to nearly 23% (57). Unmet need is defined as the percentage of women who are fertile and sexually active but are not using any method of contraception and who report that they either do not want any more children or wish to delay the next child. It should be noted, however, that surveys are the only reliable source of data for a range of sexual and reproductive health indicators, including those related to Millennium Development Goal 5 (such as unmet need for family planning, contraceptive prevalence and evaluation of sexual health). In many cases, surveys have either not been carried out or are not representative, meaning this kind of information is not available.

Fig. 14

Source: United Nations Statistics Division (57).

Unmet family planning needs may differ widely across the Region

Unmet needs for family planning (last year available)



*The former Yugoslav Republic of Macedonia.

VIOLENCE AGAINST WOMEN

Violence against women is a pervasive human rights violation with profound implications for women's health across their life spans. WHO estimates that a quarter of women in the Region have experienced violence from an intimate partner at least once in their life. Risk factors include social isolation, harmful alcohol use, being a victim of child maltreatment and unfavourable societal gender and violence norms and attitudes (58). Women's education, membership of the formal workforce, property ownership rights for women and strong legal frameworks against violence are protective factors (59).

Women's health across the life-course

MAIN ISSUES TO BE ADDRESSED

- Health systems are what may be referred to as blind to the different health needs of women beyond reproduction.
- Health systems need to be designed with a greater focus on wider social, economic and cultural environments in which adult women live their lives and where health and well-being are created, with a particular emphasis on women who may be disadvantaged.
- Women's risk and protective factors to noncommunicable diseases are changing across the Region and within countries. Health promotion messages and health service responses need to reflect these changes to prevent and address women's health problems.
- Policy has a crucial role in ensuring access to information and services to enable women to make informed choices about their own sexual and reproductive health.
- Death and morbidity due to pregnancy continue to affect women in the Region. Policies, evidence-based information and health service responses should address the underlying inequities.
- Responses to issues with a strong impact on health, such as violence against women, cannot be solved by the health sector alone, but only in collaboration with other sectors.

Older women

Almost 80 million of the 131 million people aged over 65 years in the European Region in 2010 were women. This is expected to grow to 108 million by 2030, which is consistent with the global pattern – a phenomenon known as the feminization of ageing (60). Although older age is now considered to begin later in life, the focus here is on women aged over 60 years to reflect past and current pension and retirement ages across the Region and data availability.

Broad causes of diseases among older women in the Region are largely the same across the four subregions defined in **Table 1** (p. 8) – cardiovascular and circulatory conditions, cancer, chronic respiratory conditions (including chronic obstructive pulmonary disease), diabetes and other noncommunicable diseases. Differences between the two age groups reviewed here (50–69 years and 70 and over) include mental and behavioural disorders and musculoskeletal and neurological conditions gradually decreasing with age, and ischaemic heart disease, stroke, Alzheimer's disease and diabetes becoming more common. Major contributors and risks include alcohol and tobacco use, high blood pressure, high BMI, dietary risks, low physical activity, high total cholesterol and fasting blood plasma glucose, and household air pollution (44).

As in other stages of life, women have worse self-reported health, with differences influenced by determinants such as education and income. **Fig. 15** shows that the higher the level of income, the more likely it is that women will report their health as very good or good (45).

THE RISK OF POVERTY: GENDER AND SOCIOECONOMIC DETERMINANTS

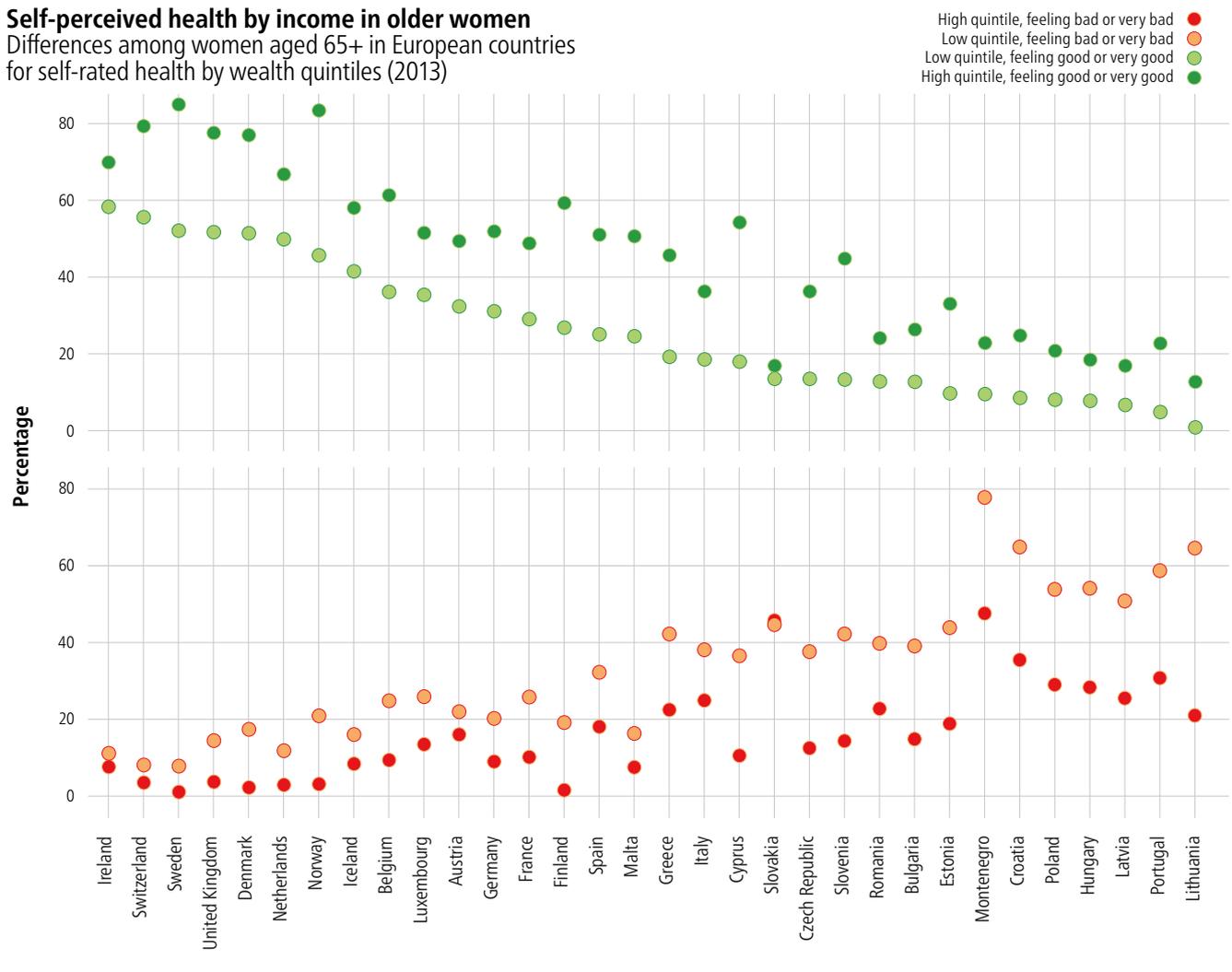
The risk of poverty among older women is related to inequities in previous life stages, including the gender wage gap, which has a significant impact on pensions and opportunities to realize full health potential (61). **Fig. 16** shows differences in risk for poverty or social exclusion among older women in a number of European countries in 2013 (16). The risk of poverty was far higher for women in some countries compared to others and increased with age within countries in most instances. Those who lived in single households had the highest poverty risk in most.

Gender stereotypes continue to have negative health and well-being impacts for women in areas such as self-rated health and are exacerbated by ageism. Health professionals' attitudes towards ageing can influence treatment patterns for women. One survey, for instance, found that the likelihood of an older woman with breast cancer undergoing chemotherapy depended on the physician's specialty and sex, the type of care structure, the physician's perception of the age at which patients become elderly, and his or her knowledge of assessments for older people. This meant that some physicians did not always prescribe potentially beneficial treatments for older patients (62).

Fig. 15

Source: Eurostat (45).

Self-perceived health by income in older women
Differences among women aged 65+ in European countries
for self-rated health by wealth quintiles (2013)



MENTAL HEALTH AND DISABILITY

Mental ill health and disability are major problems for older women. Depression is common and symptoms can differ from those in earlier life: it may, for example, present in the form of unexplained physical symptoms such as general aches and pains. This physical manifestation of a mental disorder, combined with high comorbidity (the concurrent existence of more than one disease or condition), can create problems in accurately and speedily diagnosing depression in older people. Alzheimer's and other dementias increase steeply after the age of 60 and faster in women.

Ageing is also associated with increasing prevalence of disability, with a substantial increase seen in people aged 80 years and over. Sensory impairment, musculoskeletal problems, frailty, incontinence, pain and sleeping disorders are significant causes of disability for older women. Sensory impairment particularly affects hearing and eyesight and musculoskeletal problems such as lower back and neck pain account for 13–17% of years lived with disability in older people across the Region.

Frailty is a state of increased vulnerability to poor resolution of balance after a stressor event (such as a fall) that increases the risk of adverse outcomes, including more falls, delirium and disability (63). It can be considered the tipping point at which age-related decrease in function is accelerated and the body's natural equilibrium mechanisms start to fail. Frailty is not a purely biological and natural phenomenon, however; rather, it develops over the life-course (63) and has important social determinants. Women aged 65 years and over who have lower educational attainment show an increased risk of worsening in frailty state (weakness, weight loss, exhaustion, slowness and low activity).

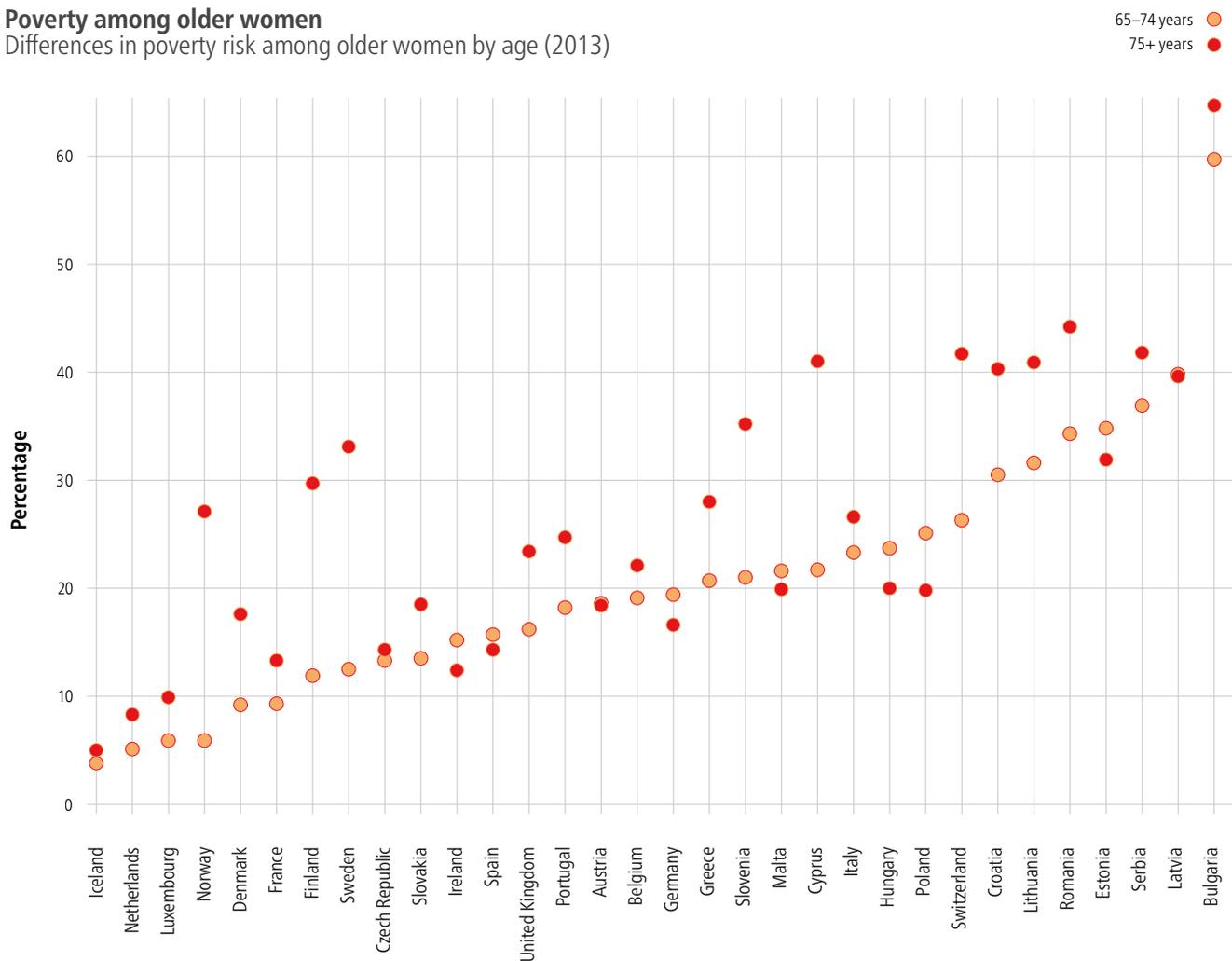
Women's health across the life-course

Fig. 16

Source: Eurostat (16).

Poverty among older women

Differences in poverty risk among older women by age (2013)



Two other areas that significantly affect quality of life (physical and social) for older women are urinary incontinence, and pain and sleeping disorders. Approximately a third of older women experience urinary incontinence, which is linked to increased social isolation, falls, fractures and admission to long-term care facilities. While pain and sleeping problems are common in older age for women and men, women have been found to have different ways of self-managing them and are more likely to explore a range of alternative sleep remedies and behaviour change strategies (64).

THE RESPONSE OF THE HEALTH SECTOR: CARING FOR THE CARERS

Older women living alone are often less able to afford long-term care out of their own pocket, while simultaneously having an increased need for formal care due to lack of support from close relatives. Country data suggest that women are most vulnerable to changes in publicly available health services because of their traditional role as carers (61). Older people have the highest risk of developing adverse drug reactions, which in Europe cause 20% of visits to physicians and up to 30% of hospital admissions (65). The cut-off age for clinical trials of around 65 years and women's low participation rates (62) weaken the evidence base for clinical decision-making in relation to older women.

VIOLENCE AGAINST OLDER WOMEN: DOUBLE DISCRIMINATION

Older women who have been subjected to violence at earlier ages may continue to suffer long-term psychological consequences and are themselves the target of physical maltreatment and gender-based violence as a result of gender and age-based

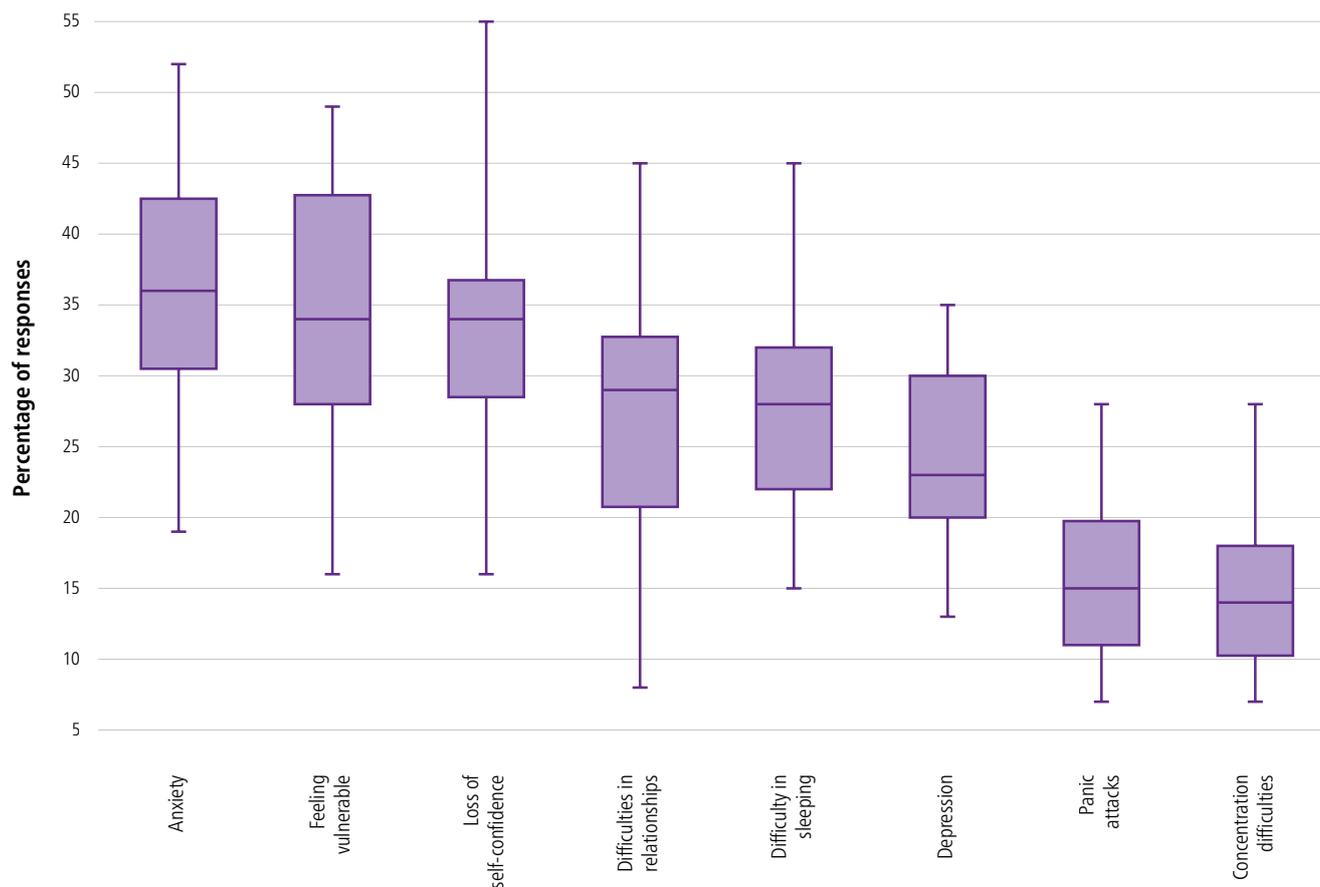
discrimination. **Fig. 17** shows the longer-term psychological consequences of violence by a partner reported by women aged over 60 years in EU countries (66). It highlights health consequences that are reflected in conditions identified above as broad causes of disease among women, including depression, anxiety, feeling vulnerable and having difficulty sleeping.

Fig. 17

Source: European Union Agency for Fundamental Rights (66).

Emotional consequences of serious physical or sexual violence since the age of 15

Long-term psychological consequences of physical and sexual violence by a partner reported by women aged 60+ years in the EU



MAIN ISSUES TO BE ADDRESSED

- Older women comprise a significant proportion of the population. Data collections and studies of how gender and social determinants affect older women's health need to improve, particularly for women living in countries outside the EU and those who are over 85.
- Health systems and services should focus on promoting healthy ageing from earlier age stages in coordination with wider social services.
- Systems and services need to be designed to ensure accessibility, availability, acceptability and quality for older women to enable them to have opportunities to lead a healthy and fulfilling older age. These need to take into consideration older women's higher risk of poverty, which is linked to inequities in earlier life stages.
- Low participation of women in clinical trials results in gender bias and lack of awareness among health care professionals about the importance of sex-specific differences across the life span. Older women who take several medications due to comorbidities and increased longevity must be included in clinical trials.



Chapter four Beyond the mortality advantage: moving forward

Beyond the mortality advantage: moving forward

The shared goal of Health 2020, to “significantly improve the health and well-being of populations and reduce health inequalities” (1), will not be achieved unless countries invest to reduce the health impacts for women of inequities related to age, level of education, place of residency, income, ethnicity and other social determinants.

Inaction has costs. It undermines social cohesion and is harmful to long-term economic growth (1,46). Countries cannot afford not to act. Health is a major societal resource and asset that benefits all sectors, but it is undermined by ongoing inequality. Tackling the impact of gender and social determinants on women’s health is an important part of the solution.

A rights-based approach is required. Women comprise over 50% of the Region’s population and deserve equal access to the factors that promote, protect and create health, including education, economic participation, increased earning potential and political decision-making power. Doing the right thing requires urgent political commitment and investment in proven interventions and programmes and the removal of structural, political and social barriers that prevent the realization of women’s full health and well-being potential.

Building on the gains: the unfinished agenda

LEADERSHIP

Governments need to provide strong leadership to ensure that women and men in the Region reach their full health potential equally.

Women’s longer life expectancy is often seen as an advantage, but many women in the Region spend most of the additional years in poorer health. The Beijing+20 review process highlights considerable advances in promoting and protecting women’s health, and its reports are rich in detail about positive actions that have been taken. But while countries have been busy building a foundation, they now need to do more and do better (67).

Investing in health is a political choice, as is creating gender equality. Europe should continue to lead worldwide efforts to achieve gender equality, but should not forget girls and women living in the European Region. Gender equality/equity indexes show that while progress has been made, there is scope for improvement at regional and country levels.

EMPOWERMENT AND PARTICIPATION: WOMEN’S VOICES

Girls and women have the right to participate and be engaged. This is not new: it is consistent with Member States’ existing commitments to take measures to end discrimination against women in all forms.

Initiatives such as the “Voices and profiles” page on the Beijing Platform for Action Turns 20 website are key, providing positive images and messages that challenge gender stereotypes (68). Developments such as this must represent the diversity of girls and women in the Region and feature their own words. As Lanning et al. (69) state:

Much of the debate about gender equality is either narrowly focused on women at the top or takes place in the abstraction ... it leaves us with a weak political voice for the collective demands required to transform the majority of women’s lives. A re-examination of the meaning of gender equality is required to shift the debate so that it is better focused on the perspectives and interests of women from different backgrounds, and on how to involve them in shaping the world they live in ... we need ... less about how women can succeed in a man’s world game, and more about how to change the rules of the game.

Leaders need to ensure that a range of ways and opportunities for girls and women to be heard and to have influence are available, learning from and improving existing mechanisms such as institutional gender mainstreaming, participation quotas, legislative changes, transformative measures (including paternity leave) and new ways of looking at evidence.

Empowering women means engaging men in gender equality. Gender stereotypes and unequal structures have negative health implications not only for women, but also men.

BUILDING ACCOUNTABILITY

Commitments are not converted into actions without accountability. Mechanisms such as the Beijing+20 review process, the Millennium Development Goals and Sustainable Development Goals, human rights treaties and monitoring activity related to Health 2020 provide important frameworks for building accountability. Health policy-makers need to be fully engaged in these processes to promote sustainable health improvements for women.

Strengthening accountability for women's health requires more systematic collection and analysis of data and information disaggregated by sex, age and other stratifiers. This is necessary to track progress, identify and close knowledge gaps and implement and evaluate appropriate policies. Data and information about gender and other social determinants for girls and women living in the European Region are currently lacking. Specific areas for attention include:

- moving beyond describing gender differences to identifying how they intersect with other social factors to create inequities for women; and
- moving beyond socioeconomic determinants to the more complex intersection between gender, socioeconomic and cultural factors for all age stages.

Evidence in these areas needs to be used to support analysis, action, monitoring and evaluation.

WORKING WITH OTHER SECTORS

The effects of education, employment, and family and social protection policies on women's health need to be addressed. Opportunities in education settings to reduce gender inequalities, address specific health risks and create supportive environments for health promotion should be taken, integrated health and social services for women, mothers and their children should be strengthened, and access to social protection to reduce the risk of poverty throughout the life-course should be ensured.

The education sector is crucial to breaking gender stereotypes that drive women towards traditional roles and career paths. There is a need to develop education that enables girls and women to change broader social and cultural norms.

Policies should recognise women's multiple contributions to health care and encourage men's further participation. Working with the social sector to recognize and acknowledge the unpaid work of women in health care, child care, health promotion and social services will not only improve women's chances of leading healthier lives, but also help to redress the current inequitable distribution of caregiving.

Removing barriers to women's paid employment and ensuring increased job and financial security are priority areas for action. Pension inequities between men and women need to be redressed to reduce their negative health impacts on older women: while not limited to the health sector, it could lead by example in taking action in this area (46).

Making health systems work for girls and women

Biological and gendered factors create specific exposures, vulnerabilities and health needs for women and men. Health systems in many countries are largely blind to how these differences demand specific responses.

SEXUAL AND REPRODUCTIVE HEALTH

It is important to review the structure of universal health coverage, financing arrangements and available services or packages, identifying where exemptions are made and on what grounds.

Universal health coverage should provide for a broader range of services than may currently be available in countries where, for example, contraception services are not reimbursable. This means having a sexual and reproductive health and rights policy based on consideration of gendered exposures and vulnerabilities at country level, covering all women and men and addressing key gaps such as unmet need for contraception.

Beyond the mortality advantage: moving forward

The policy should also address:

- comprehensive sexuality education
- access to evidence-based information on sexual and reproductive health and rights
- reproductive choice and the provision of counselling and quality sexual and reproductive health services
- reimbursement schemes
- safe motherhood
- control of sexually transmitted infections and HIV/AIDS
- sexual abuse and violence
- trafficking of women
- education and training for health care professionals and service providers
- mechanisms for preventing discrimination in services
- specific measures for empowerment of all groups of all ages.

PEOPLE-CENTRED SERVICES ARE ALSO WOMEN-CENTRED SERVICES

People-centred services should enable one-stop access to a comprehensive range of services that are coordinated across levels and providers, reflect the health needs of all girls and women and are consistent with the provisions of universal coverage. This includes integration of maternal sexual and reproductive health and broader health concerns with a human rights and social determinants of health perspective (70).

Health services that span across the life-course should be gender-sensitive beyond women's role as mothers and take into account priorities like noncommunicable diseases and mental health. Health care workforces should be competent in assessing wider factors that influence women's health in areas such as cardiovascular disease, diabetes and other chronic conditions – exposure to chemicals through paid work or housework, for instance (71).

LEADING BY EXAMPLE

Gender inequalities within the health workforce need to be addressed. Women are rarely represented at executive or management-level positions, tending rather to be concentrated in lower-paid jobs where they face greater exposure to occupational health risks (71,72). This means reviewing how health sector workforce and employment policies promote and/or make gender inequality worse for women. Key areas for attention include gender balance in leadership in academic medicine, public health and nursing, maternity/paternity leave and child care arrangements (70).

Where to from here?

This brief report shows how gender and socioeconomic determinants affect opportunities for girls and women in the Region to realize their right to health and well-being across the life-course. It provides a basis for prioritizing actions that are consistent with Health 2020 (1) and gender-focused recommendations from the review of social determinants and the health divide in the WHO European Region (67), and for supporting discussion on the aspiration to create a regional strategy on women's health for presentation to the 66th session of the WHO Regional Committee for Europe in 2016.

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The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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Beyond the mortality advantage

Investigating women's health in Europe

Women in the WHO European Region have better health than those in most countries of the world, but inequities are increasing for men and women within and between countries in the Region. Inequities not only create health consequences, but also social and economic costs. They cannot be reduced without investing in girls and women, but more knowledge is needed on their causes to inform policies and interventions. The WHO Regional Office for Europe is currently investigating the main health issues for women in the Region, including variations in health among those of different ages and the influence of gender and social determinants across their lives. This brief report presents some of the preliminary findings of the investigation, focusing on broad causes of morbidity and mortality during four age stages – the girl child, adolescents, adult women and older women – and emphasizing how factors that influence health cut across the stages. It shows how gender and socioeconomic determinants affect opportunities for girls and women in the Region to realize their right to health and well-being across the life-course and provides a basis for prioritizing actions for all sectors of governments and societies.

World Health Organization Regional Office for Europe

Scherfigsvej 8, DK-2100 Copenhagen Ø, Denmark

Tel.: +45 39 17 17 17

Fax: +45 39 17 18 18

E-mail: contact@euro.who.int

Website: www.euro.who.int