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Women's health and well-being in Europe: beyond the mortality advantage





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beyond the mortality advantage

ABSTRACT

Women's health is at a crossroads. Global efforts to advance women's health have been endorsed by countries through the adoption of the 2030 Agenda for Sustainable Development and are being taken forward through the Sustainable Development Goals and the global strategy for women's, children's and adolescents' health. To strengthen action as part of progressing the Health 2020 agenda, a strategy on women's health and well-being in the WHO European Region 2017–2021 will be considered by the 66th session of the WHO Regional Committee for Europe in September 2016. This report provides background to the strategy. It presents a snapshot of women's health in the Region, discusses the social, economic and environmental factors that determine women's health and well-being, brings into focus the impact of gender-based discrimination and gender stereotypes, considers what the concept of people-centred health systems would need to entail to respond to women's needs, and considers perspectives important for the international and national frameworks that govern women's health and well-being in Europe.

Keywords

WOMEN'S HEALTH

WOMEN'S RIGHTS

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Foreword

Women in Europe are living longer and healthier lives. Important progress has been made in the WHO European Region in relation to gender equality and other social, economic and environmental determinants of women's health and well-being. Health systems are slowly adapting to address women's health issues beyond reproduction.

This is the general picture of women's health in Europe today, but as with all generalities, it masks highs and lows. Some women are ahead of the game, while others are falling behind. Large health inequities among women remain within and between countries in Europe. Women's life expectancy across the Region differs by up to 15 years, with certain groups of women within countries continuing to be more exposed and vulnerable to ill health and having lower well-being scores. The causes of these inequities include the range of determinants of women's health and well-being and health system responses to women's needs. Gender inequalities, discrimination and gender stereotypes are important underlying factors influencing behaviour and practices that affect women's health across the life-course.

Beyond borders and differences, certain common trends can be detected across countries in Europe. The population is ageing, with 70% of the 14 million people currently over 85 being women – a population group that will grow in years to come. For many women, however, the years longer lived are often characterized by ill health or disability: women in Europe live on average 10 years in ill health. Our population is also becoming more diverse as globalization allows men and women to move more freely between countries. Some do so for very positive reasons – for love, work or study, for instance – but others may be compelled to migrate to flee poverty, oppressive regimes and conflict. Migration represents opportunities and reflects progress, but requires flexibility, adaptation and openness within and between countries.

Cardiovascular diseases continue to comprise a major part of the overall disease burden for women, but rates of mental ill health are increasing throughout the Region and across all ages. High levels of depression and anxiety among adolescent girls in Europe is of particular concern. Gender-based violence against women remains not only a violation of women's rights, but also a serious public health problem in all countries in the Region. Well-being is gaining in importance as a concept and measure not only of good health, but also of general societal progress.

With the adoption of the 2030 Agenda for Sustainable Development and the Sustainable Development Goals (SDGs), governments have made clear the indivisible nature of economic, social and environmental development. They have reaffirmed human rights, gender equality and women's empowerment as being crucial to progress on all goals and targets. This means that reaching the targets of SDG3 on health and well-being will be enabled by other SDGs, particularly SDG5 on gender equality and SDG10 on reducing inequalities within and between countries.

This report considers women's health and well-being in the European Region from a 2030 Agenda perspective. It provides an overview of the main epidemiological trends and risk factors for women's health in Europe today so we can better prepare for the future. It looks at the issues determining women's health, drawing on findings from the Commission on Social Determinants of Health and the European review of social determinants and the health divide. It advances Health 2020 – the European policy framework for health and well-being – for women across the Region and sets a frame for moving forward. It provides the evidence and conceptual background for a WHO European strategy for women's health and well-being for 2017–2021 that is underpinned by the values of Health 2020, acknowledges gender as a determinant of health alongside social and environmental determinants, and recognizes gender mainstreaming as a mechanism to achieve better, more equitable and sustainable health for all in the European Region.

Last but not least, this report recognizes the responsibility of health systems in responding to women's health needs and promoting gender equity in the health sector's formal and informal workforce.

Zsuzsanna Jakab

WHO Regional Director for Europe

Acronyms and abbreviations

BMI	body mass index
CARINFONET	Central Asian Republics Health Information Network
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CIS	Commonwealth of Independent States
DALY	disability-adjusted life-year
EIGE	European Institute for Gender Equality
EU	European Union
EU-SILC	European Union statistics on income and living conditions
HBSC	Health Behaviour in School-aged Children (study/survey)
ISO	International Organization for Standardization
LGBTI	lesbian, gay, bisexual, trans and intersex
OECD	Organisation for Economic Co-operation and Development
SDG	Sustainable Development Goal
SEEHN	South-eastern Europe Health Network
SOPHIE	Evaluating the Impact of Structural Policies on Health Inequalities (research project)
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
WEF	World Economic Forum

Introduction	The European strategy for women's health and well-being
	Methodology
	Summary outline of report

Introduction

Women's health is at a crossroads. The past two years have seen a stock-take at global and European levels of international commitments made up to two decades earlier. This process, combined with unprecedentedly inclusive global discussion on future priorities and directions, culminated in September 2015 with the 2030 Agenda for Sustainable Development and its accompanying Sustainable Development Goals (SDGs) (1).

Global efforts to advance women's health have been endorsed by countries through the adoption of the 2030 Agenda and are being taken forward particularly through SDG3 on health and well-being, SDG5 (achieving gender equality and empowering women), and SDG10 (reducing inequalities within and between countries). These commitments build on and reaffirm progress made towards achieving the Millennium Development Goals (2000), the Beijing Platform for Action (1995) and the Programme of Action from the International Conference for Population and Development (1994).

Some of the challenges and opportunities for women's health posed by the 2030 Agenda are addressed through the WHO global strategy for women's, children's and adolescents' health (2016–2030) (2) and its operational framework, which were adopted by the Sixty-ninth World Health Assembly in May 2016.

The umbrella policy framework for health and well-being in the WHO European Region, Health 2020 (3), adopted by the 53 Member States in September 2012, acknowledges gender as a determinant of health alongside other social and environmental determinants, and includes gender mainstreaming as a mechanism to achieve gender equity.

Based on these commitments, and to strengthen action on women's health issues as part of progressing and operationalizing the Health 2020 agenda, a strategy on women's health and well-being in the WHO European Region 2017–2021 will be considered by the 66th session of the WHO Regional Committee for Europe in September 2016. This report provides background to the strategy, reviewing the situation for women's health and well-being in the European Region today.

The European strategy for women's health and well-being

This report has been developed in parallel with the European strategy on women's health and well-being to respond to and support the directions it sets. A snapshot of women's health in Europe from a life-course perspective was presented in 2015 through the short report *Beyond the mortality advantage – investigating women's health in Europe* (4). This provided background for a technical briefing for the Regional

Committee the same year. From this, Member States concluded that a WHO European strategy on women's health and well-being should be developed.

The strategy was advanced in stages following the WHO governing body process and through a number of consultations with countries, experts, partners and civil society. Drafts were considered in relation to ongoing strategic processes on sexual and reproductive health, migration, noncommunicable diseases, integrated service delivery, HIV and hepatitis led by the WHO Regional Office for Europe. It was launched with this report at the 66th session of the Regional Committee in September 2016.

Methodology

The report does not seek to offer a comprehensive analysis of the state of women's health in the Region. The limited availability of age- and sex-disaggregated data for all 53 Member States that can be cross-linked with key social determinants militates against this. Data presented in the report are largely drawn from WHO databases and reports, and publications from the United Nations, other agencies and regional organizations. More in-depth analysis of the impact of intersections between gender and other determinants of health has been supported by articles published in scientific journals identified through literature reviews and suggested by experts during the consultation process for the development of the strategy. Sources are referenced in the text.

Although in some cases the report compares women with men, specifically to illustrate gender biases or gaps in provision of care or access to resources, gender comparison is not its aim. Similarly, it does not set out to compare countries, but rather to identify priorities from gaps in health system responses.

The framework for reviewing evidence was adapted from the Role of Gender as a Social Determinant of Health framework developed by the Women and Gender Equity Knowledge Network of the WHO global Commission on Social Determinants of Health, with the aim of looking at women's health (5). The intention is not, however, to develop a gender analysis: the report does not present analysis of the determinants of men's health and masculinities. Instead, the gender framework is used to identify the multiple and complex pathways through which gender influences the impact of socioeconomic determinants on inequitable health outcomes for women, mainly through discriminatory values, norms, practices and behaviours, differential exposure and vulnerability to ill health, and biases in health systems and research.

The report also explores simultaneous interactions between aspects of social identity and the process of discrimination, and highlights the impact of gender

inequalities among women in the Region. These perspectives are complemented by recognition of the ongoing need to strengthen governance for women's health and health equity.

Summary outline of report

Chapter 1 presents an epidemiological snapshot of women's health in the European Region, including data on life expectancy, burden of disease and the main risk factors. It looks at averages, trends and differences between countries, diseases and age groups and considers well-being as a concept and measure that has growing importance in increasing understanding of women's health issues in Europe.

Chapter 2 discusses factors that determine women's health and well-being in Europe today – the social, economic and environmental circumstances that serve as protective factors for health and those that may cause ill health, directly or indirectly. It considers how education, work and income (including pensions, social protection and family policies), and environmental factors may affect women's health and presents examples of processes that may increase women's exposure and vulnerability to ill health, such as migration and economic crises. Gender and gender inequalities underpin the discussion, as they are important and necessary dimensions for fully understanding the social, economic and environmental determinants of women's health and well-being.

Chapter 3 brings into focus gender-based discrimination and gender stereotypes and their effects on the health and well-being of women in Europe. It looks at the intersections between gender inequality and other forms of discrimination (such as sexual orientation or disability) and highlights the impact on women's health of specific forms of gender-based discrimination, including gender-biased sex selection and gender-based violence. The interplay between gender stereotypes, discrimination and health is also briefly covered.

Chapter 4 moves the focus to the health system. The health system is not only a determinant of women's health through its design, operation and financing, but is also an actor with the potential to provide transformative solutions for women and their health across the life-course, most notably through the services it provides and the changes in formal and informal care it introduces. The chapter considers what the concept of people-centred health systems would need to entail to respond to women's needs and how gender perspectives can make a difference.

Finally, Chapter 5 takes the discussion on to consider perspectives important for the international and national frameworks that govern women's health and well-being in Europe. This includes aspects related to policy coherence for gender equality, gender budgeting, monitoring and accountabilities, and the empowerment of women as key actors of change.

1 Highlights of women's health and well-being

Women's life expectancy is high for MOST women in Europe

Beyond the mortality advantage: causes of ill health

Measuring women's well-being

Conclusions



1 Highlights of women's health and well-being

There are 466.7 million women living in the European Region, representing just over half of the total population (6). Understanding women's health is therefore central to understanding the demographic and epidemiological changes, such as ageing and migration, occurring in this very diverse Region. Currently, 70% of the 14 million people over 85 living in the Region are women, and it is estimated that this age group will increase to 40 million by 2050. Women also represent 52% of the estimated 73 million migrants living in the Region (7).

This chapter presents a snapshot of the status of women's health and well-being across the Region. It draws largely from available mortality and morbidity data from WHO, European Union (EU) and Institute for Health Metrics and Evaluation databases, and publications from other United Nations agencies. While in some cases it compares women with men, the data presented aim to identify the main health issues for women and differences among girls and women across the Region. Comparison between women and men is more often employed in subsequent chapters to illustrate gender as a determinant of health and the intersections between gender and other socioeconomic inequalities (8).

Women's life expectancy is high for MOST women in Europe

It is widely recognized that women in the Region enjoy better health and live longer than those in many countries in other parts of the world, and that their overall life expectancy has increased in recent years. This generally positive scenario, however, masks striking differences among women living in the same and different countries.

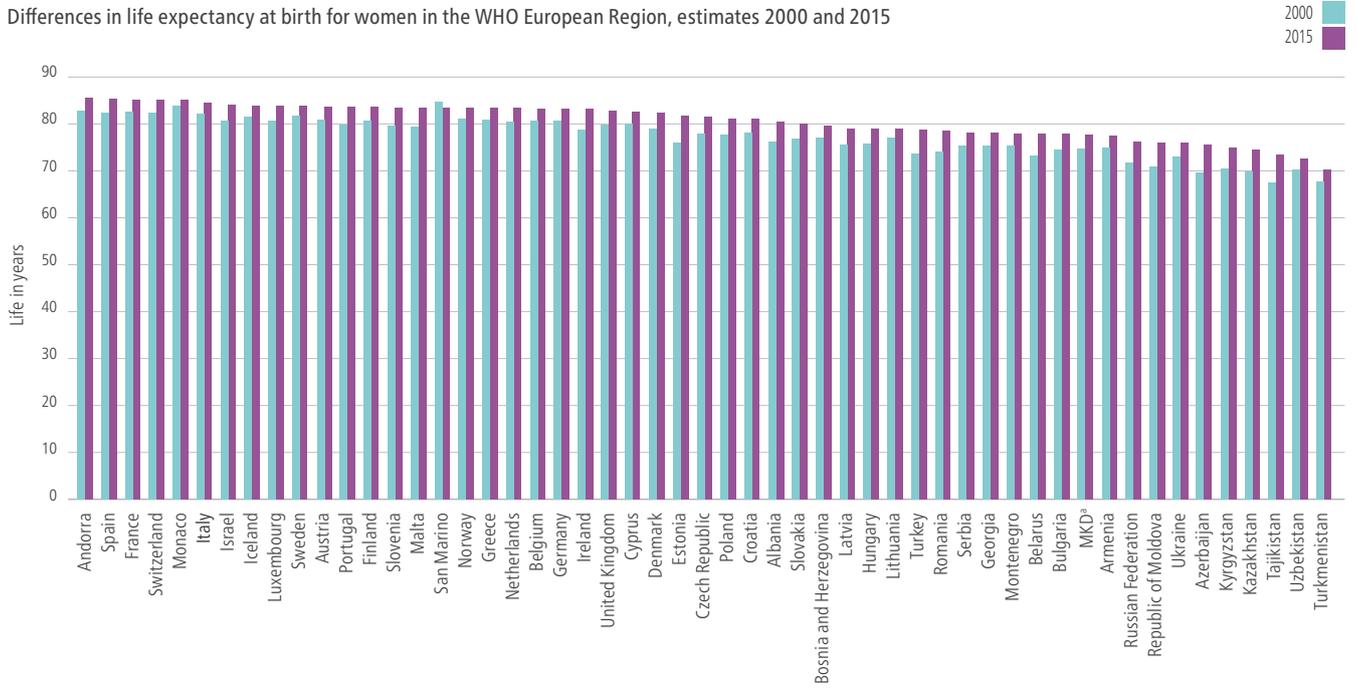
The first difference is illustrated in Fig 1.1, which shows up to 15 years of difference in average estimated life expectancy among women across the Region over the past 10 years, ranging from 85 to 70 years (9).

Fig. 1.2 confirms the consistent increase in life expectancy and underlines the permanence of the gaps between different parts of the Region. Countries to the west (including EU Member States before May 2014), those with populations below 1 million (such as Andorra, Monaco and San Marino) and Nordic countries have the highest life expectancy in the Region. Fig. 1.2 also shows data for countries of the Central Asian Republics Health Information Network (CARINFONET), the Commonwealth of Independent States (CIS), the South-eastern Europe Health Network (SEEHN), and EU Member States since May 2014.

Fig. 1.1.

Source: WHO (9).

Differences in life expectancy at birth for women in the WHO European Region, estimates 2000 and 2015



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

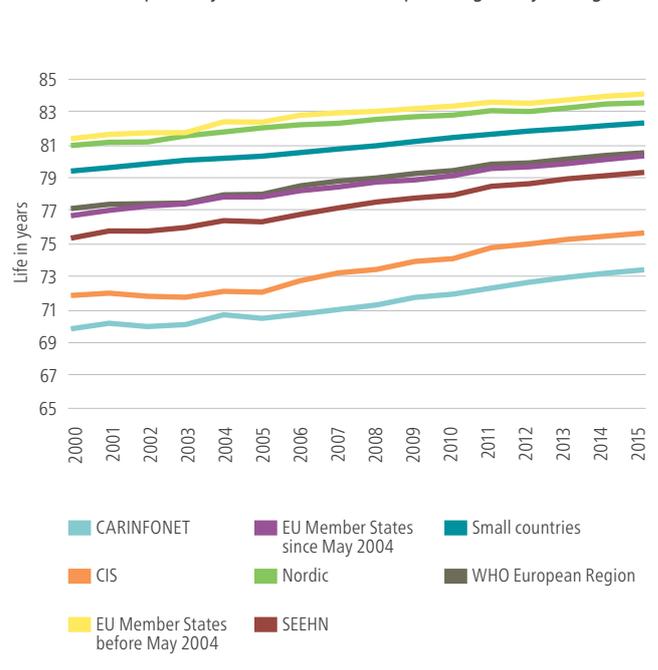
The increases in life expectancy observed over the past two decades (an overall trend that has also been seen in men) have largely been credited to the period of economic growth in the west of the Region since the 1980s and the period of stability and prosperity experienced across the Region since the early 2000s (10). Detailed analysis of causes of mortality has shown that the increase in life expectancy in women (and men) has in large part been due to a decrease in mortality from cardiovascular disease (11).

Countries to the east, including the central Asian republics, countries of the Caucasus and the Russian Federation, have seen a more divergent trend over the past 21 years. This is due in part to the consequences of a period of economic stagnation during the 1980s and rapid social change during the 1990s that had both positive and negative effects on health (10).

Fig. 1.2.

Source: WHO Regional Office for Europe (6).

Trends in life expectancy of women in the European Region, by subregion



In addition to the differences between countries in the Region, there are also differences in life expectancy at subnational levels. In many instances, these are not solely determined by geographic location, but by wider social and political determinants of health, as illustrated in Chapter 2. A significant body of evidence, including studies such as the WHO European review of social determinants and the health divide (8), have highlighted that many differences in health are determined by gender, socioeconomic status, environment, education, culture, religion and societal factors.

Beyond the mortality advantage: causes of ill health

Women live longer than men – this is often referred to as the mortality advantage – but spend many of their additional life years in ill health (12). It was estimated in 2013 that even in countries with some of the highest overall life expectancy in the Region, women spent almost 12 years of their life in ill health (Fig. 1.3).

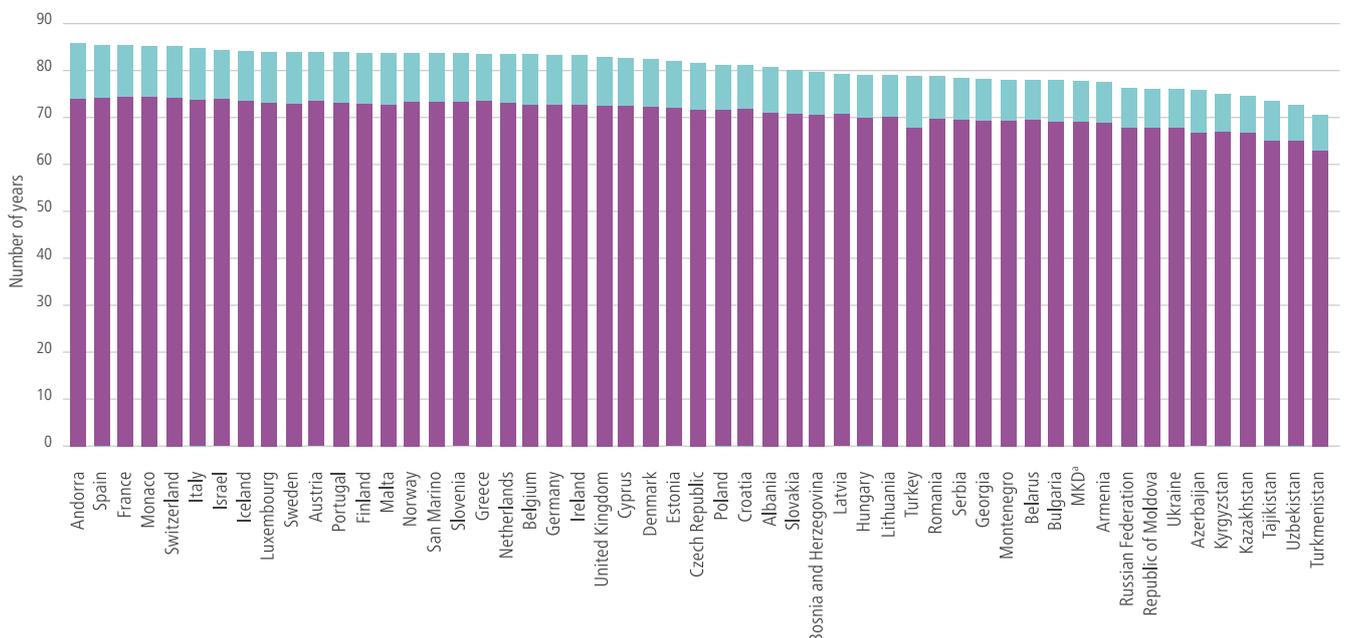
The greatest mortality burden for women in Europe is due to cardiovascular diseases (such as stroke and coronary heart disease) and cancers, while mental health disorders and musculoskeletal conditions are the main causes of morbidity. Fig. 1.4 clearly highlights the role of coronary heart disease and mental health conditions in the burden of disease for women

Fig. 1.3.

Source: WHO (9).

Life expectancy at birth and number of years spent in ill health for women, European Region, 2015

Life expectancy at birth (years) ■
 Years in ill health ■



^a The former Yugoslav Republic of Macedonia (MKD is an abbreviation of the ISO).

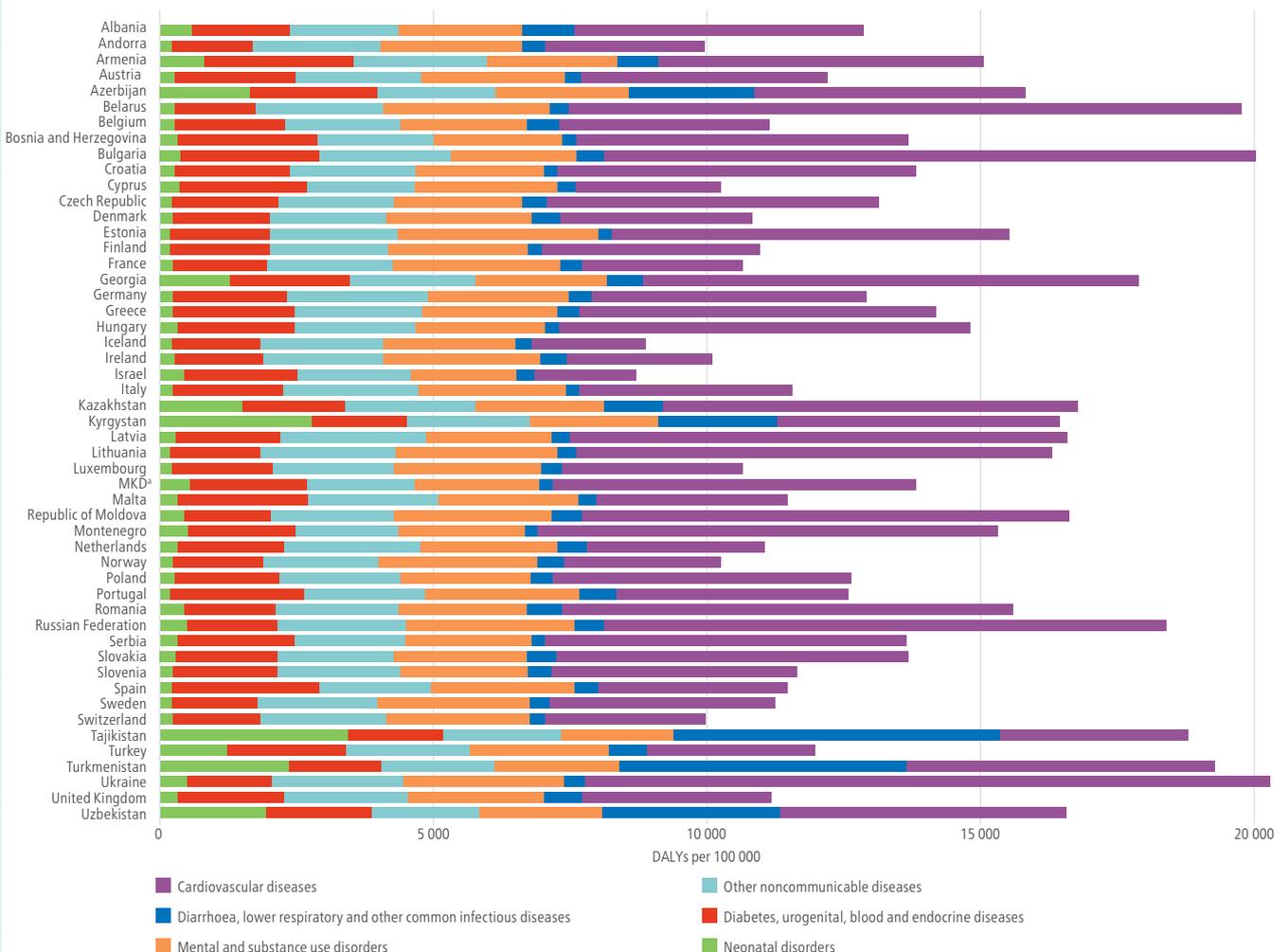
of all ages, expressed through disability-adjusted life-years (DALYs). It also shows the burden imposed by diarrhoea, diabetes, neonatal disorders and noncommunicable diseases.

The main burden of morbidity between ages 18 and 49 lies in mental health, musculoskeletal and neurological disorders, and cancers. HIV/AIDS is also an important health risk and a cause of death for women aged 15–49 years in countries in eastern Europe and central Asia. Although data on the probable source of infection are missing for many cases, it is an issue of concern for women that heterosexual contact is the main mode of transmission, with potentially greater exposure for migrant women and partners of migrant men. The Russian Federation and Ukraine are among the countries in eastern Europe with the fastest growing numbers of HIV cases (14).

Fig. 1.4.

Source: Institute for Health Metrics and Evaluation (13).

Burden of disease for women, all countries in the European Region, expressed through DALYs



*The former Yugoslav Republic of Macedonia (MKD is an abbreviation of the ISO).

Lower back and neck pain is one of the leading causes of disability in women aged over 70 across the Region. The older the age group, the higher neurological disorders (such as Alzheimer's disease) rank among the causes of disability. Impairment of the senses (sight and hearing) causes higher percentages of disability in the east of the Region (it is highest in central Asia). Fig. 1.5 presents years of life lost for women in the Region who are between 60 and 69 and over 70 for selected conditions.

Variations in morbidity and mortality by age and geographic location are found in older women. The leading causes across the Region, measured by

years of life lost, are cardiovascular diseases (ischaemic heart disease and stroke) and cancers (lung, colon and rectum, and breast). Together, these conditions explain more than 80% of years of life lost in people over 65 years in most of the Region, although the proportion is smaller in western Europe (9).

Noncommunicable disease: an increasing burden

Although ischaemic heart disease and stroke are the main causes of mortality for women in the Region, cardiovascular disease is still perceived as a men's health issue. As Fig. 1.6 shows, cardiovascular disease presents a greater burden of ill health and mortality in the east of the Region.

The trend in burden of disease across the Region highlights that while mortality from heart disease continues to decline, the burden of disease has remained high (Fig. 1.7). Regional variation (including that found in women under 75) highlights the extent to which this mortality is amenable to interventions from the health sector and beyond. Fig. 1.7 shows that the burden is more than double for women living in countries towards the east, including the central Asian republics and the Russian Federation, than for those in Nordic countries.

Years of life lost due to cardiovascular disease increase with age as the protective effect women have during the reproductive years disappears post-menopause (15).

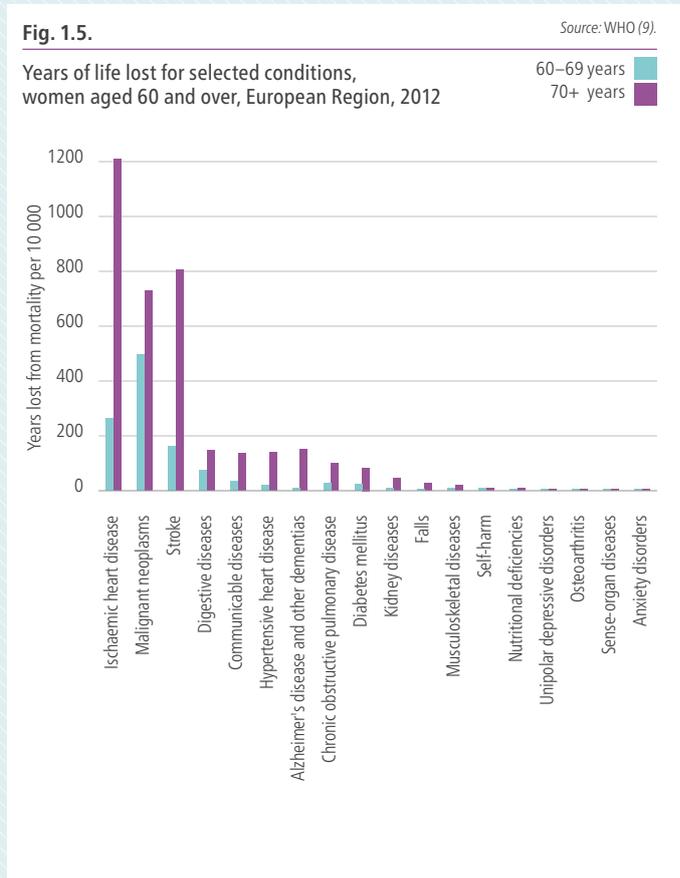
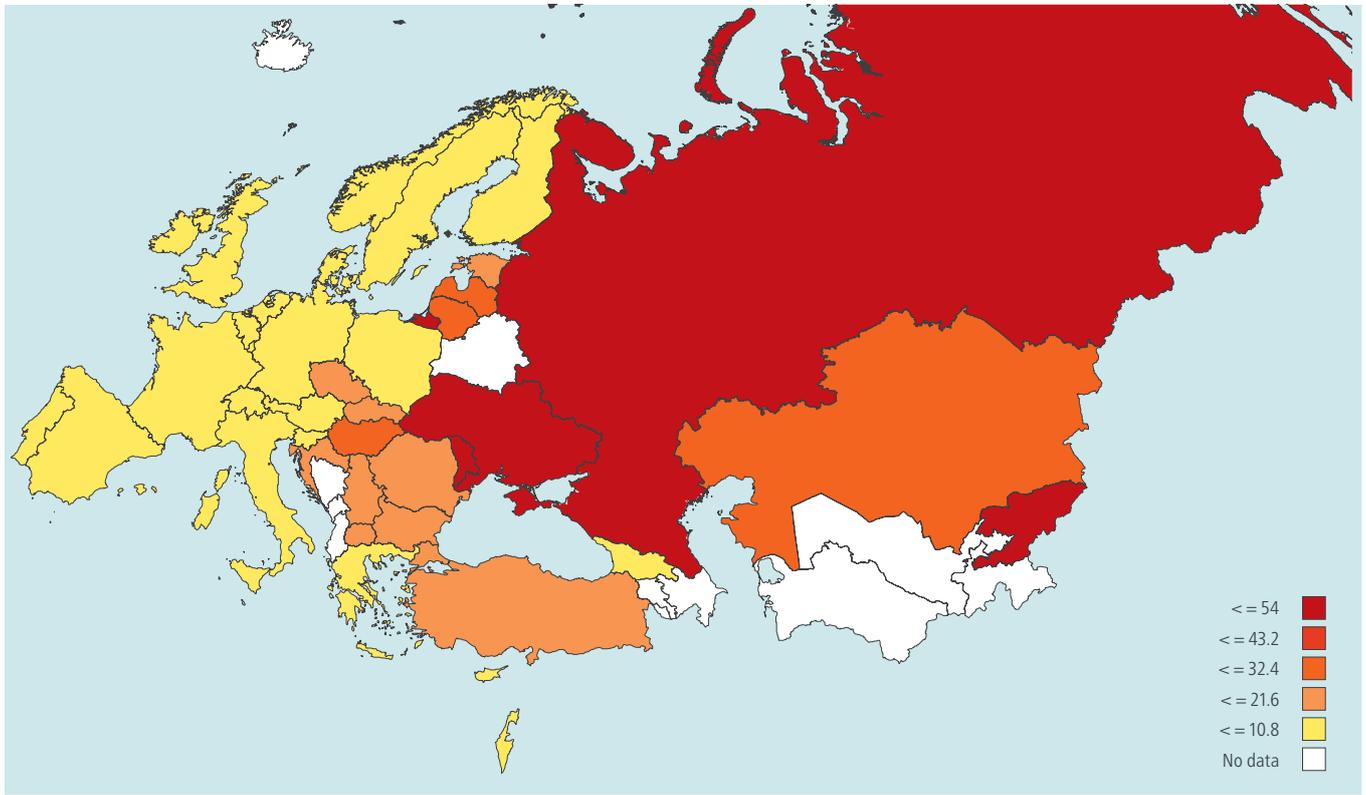


Fig. 1.6.

Source: WHO Regional Office for Europe (6).

Mortality from ischaemic heart disease per 100 000 women aged 0–64, European Region



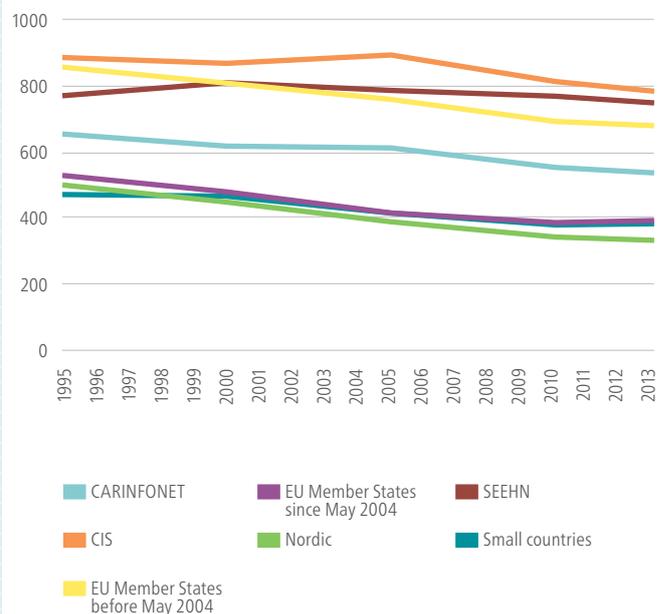
Ischaemic heart disease and stroke cause the biggest burden of death and disability in women over 65 years, but variations within the Region are large. In women aged 70 years and older, cardiovascular disease accounts for around 75% of years of life lost in the east of the Region, around 65% in central Europe, and around 40% in western. Regional differences also exist between northern and southern Europe, with cardiovascular mortality higher in the north (16).

Breast, cervical, lung and ovarian cancers pose significant burdens to the health of women in the Region. While overall cancer mortality is higher towards the west, there are large differences depending on the prevalence of risk factors and availability

Fig. 1.7.

Source: Institute for Health Metrics and Evaluation (13).

DALYs per 100 000 women due to cardiovascular disease, by subregion



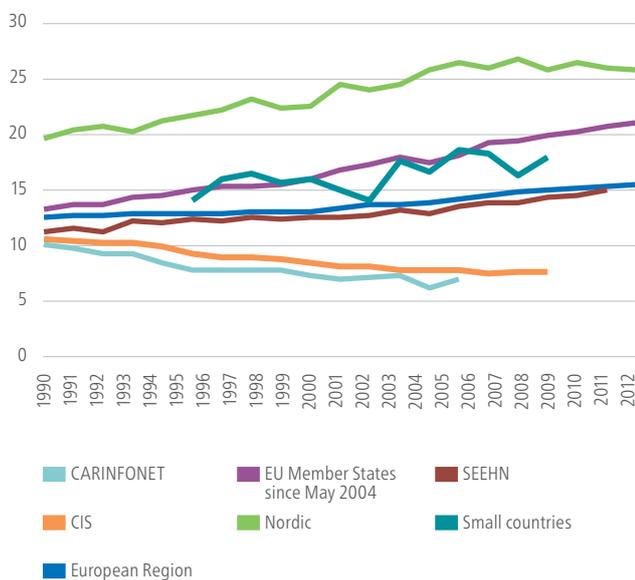
of prevention (including screening opportunities) and treatment services. Overall morbidity and mortality due to cancer for women has remained unchanged or has even decreased slightly, and advances in cancer screening and treatment have led to significant reductions in mortality in several countries. Progress has differed between countries, however, with mortality rates rising in some (17).

While lung cancer mortality in men has been decreasing since the 1980s, women in many countries in the Region continue to face a growing burden (18). The trend data in Fig. 1.8–1.9 show clearly that the highest burden of lung cancers and greatest number of deaths occur in countries towards the north of the Region, with rates much lower towards the east. Mortality rates are now rising for women in southern parts, where rates traditionally have been lower. These patterns and trends are largely ascribed to the tobacco epidemic (see discussion in the section on risk factors below (page 15)).

Fig. 1.8.

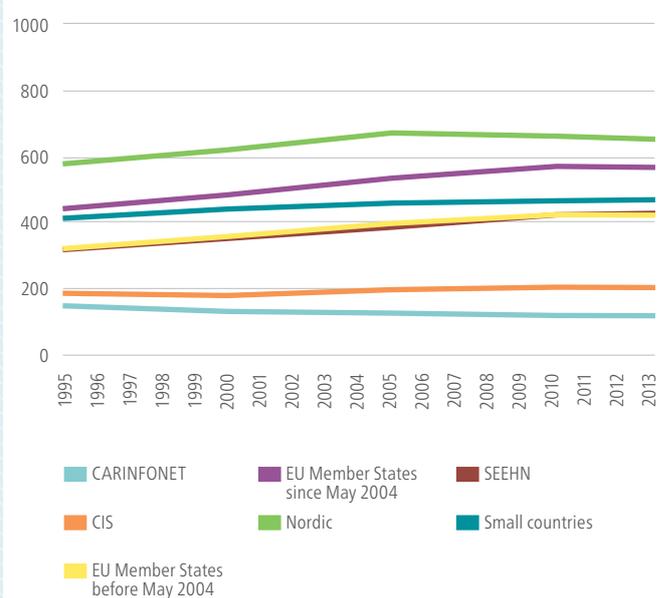
Source: WHO Regional Office for Europe (6).

Standardized death rate per 100 000 women from malignant neoplasm of larynx, trachea, bronchus and lung, European Region


Fig. 1.9.

Source: Institute for Health Metrics and Evaluation (13).

DALYs per 100 000 women due to tracheal, bronchial and lung cancer, European Region



Breast cancer still poses a great burden of disease for women in the Region. While some countries, especially those towards the north and west, have seen reduced mortality rates, this trend is not shared by countries towards the east (Fig. 1.10–1.11). Full understanding of the geographical trend confirmed by the burden of disease is limited by data availability from some subregions.

Fig. 1.10.

Source: WHO Regional Office for Europe (6).

Standardized death rate per 100 000 women from breast cancer, European Region

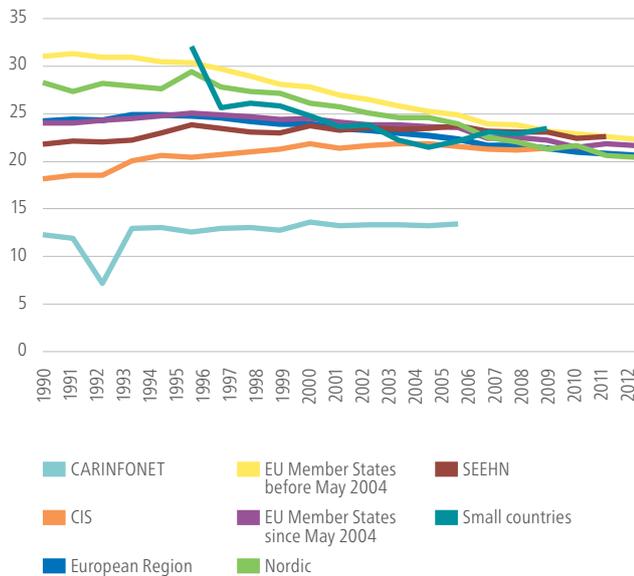
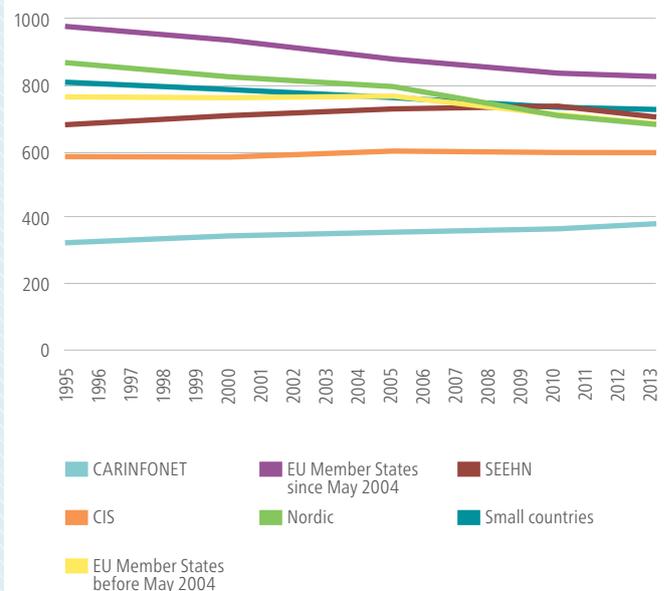


Fig. 1.11.

Source: Institute for Health Metrics and Evaluation (13).

DALYs per 100 000 women due to breast cancer, European Region



Women in the Region, specifically those in northern, central and eastern Europe, also have a high burden of respiratory disease, with chronic obstructive pulmonary disease and asthma foremost (Fig. 1.12). As is the case with lung cancer, this is closely linked with tobacco use, but is also affected by other environmental determinants such as the quality of housing and indoor air pollution (see section on environmental exposure, risks and effects in Chapter 2, page 34).

Mental health: a major concern across ages and countries

Rates of mental ill health among women are increasing in all parts of the Region and represent a significant burden from early adolescence throughout life. Evidence also emphasizes the increased level and persistence of depression among older women in all countries, although there is significant crossnational variation in the associated gender gap. In addition, evidence of the interaction between mental health and other chronic conditions during the later stages of life is increasing. Given the very varied levels of mental health service provision, it is unclear to what extent the geographic differences in the burden of mental ill health visible in Fig. 1.13 may be due to a lack of services and reporting of mental health issues.

Evidence of causes of death and burden of disease expressed through DALYs highlights that while accidents, injuries and cancers are important for girls aged 10–14, even at this early age mental ill health poses a high burden, with anxiety and depressive disorders ranking third and fourth among the top 10 causes of

Fig. 1.12. Source: Institute for Health Metrics and Evaluation (13).

DALYs per 100 000 women due to respiratory disease, European Region

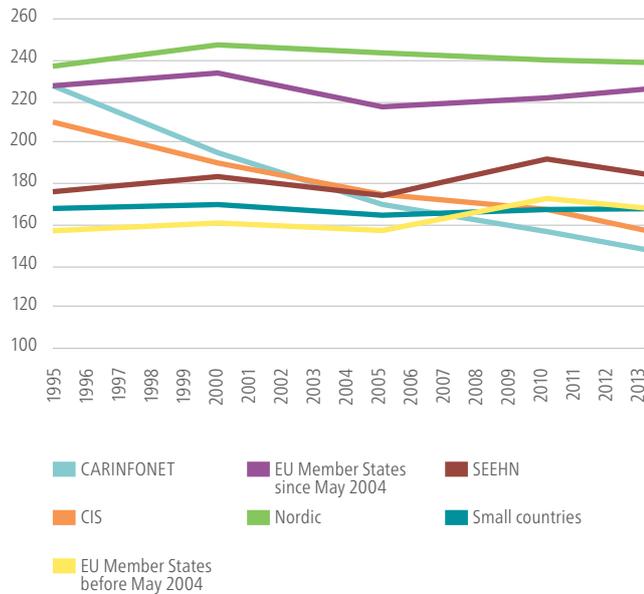
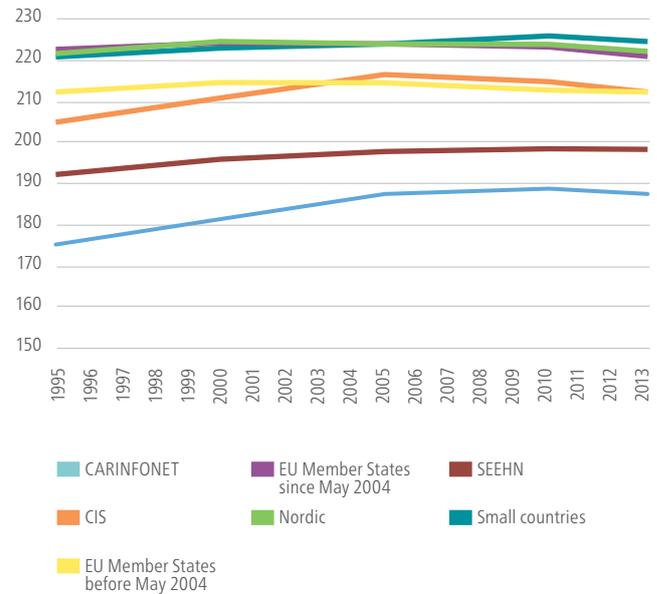


Fig. 1.13. Source: Institute for Health Metrics and Evaluation (13).

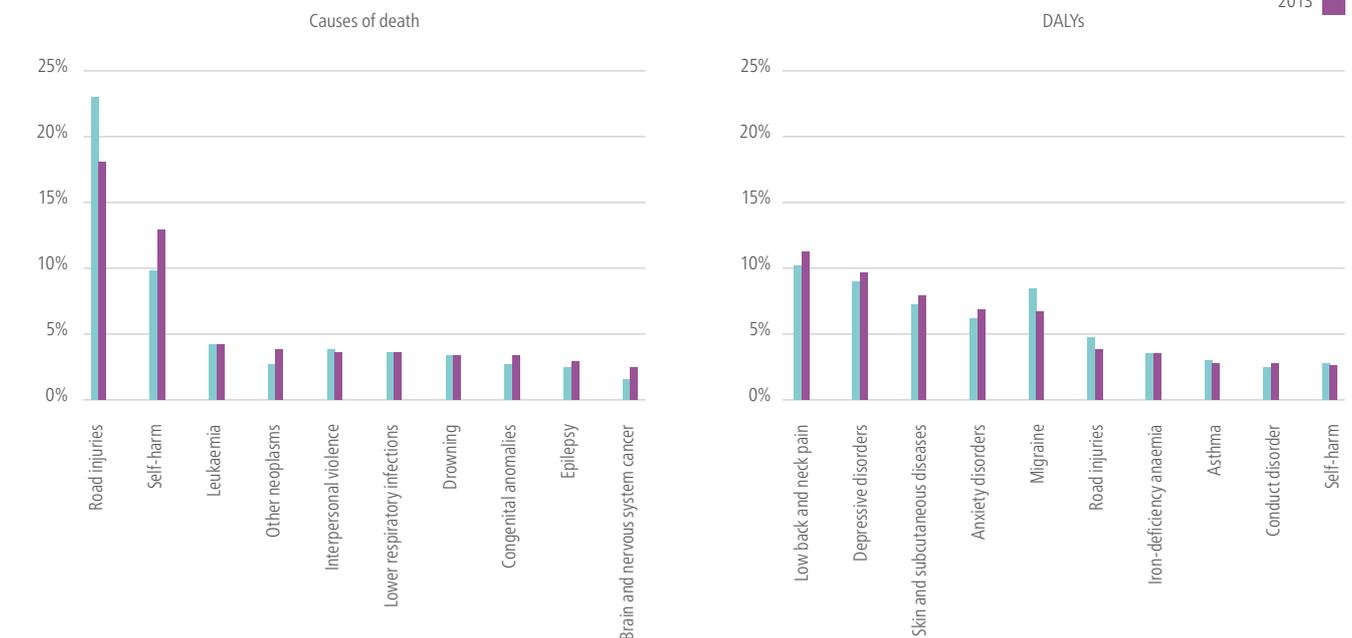
DALYs per 100 000 women due to mental and substance use disorders, European Region



DALYs (13). Self-harm ranks second among causes of death of young women aged 15–19 in the Region, and taken together, depressive and anxiety disorders account for the highest percentage of DALYs in this age group. Fig. 1.14 highlights that the burden of disease due to mental ill health increased in the Region between 1990 and 2013.

Fig. 1.14. Source: Institute for Health Metrics and Evaluation (13).

Top 10 causes of death and DALYs for young women aged 15–19, European Region



Growing risk factors for noncommunicable diseases

To understand women's pattern of disease and gain insights into likely future trends, known risk factors for mortality and morbidity must be studied. Risk has a life-course dimension through physiological factors, such as protective effects against cardiovascular disease during the reproductive years, and wider social, economic and political factors that determine women's and girls' behaviours.

Major contributors/risks for DALYs include alcohol use, tobacco-smoking, high blood pressure, high body mass index (BMI), dietary risks, low physical activity, high total cholesterol, high fasting plasma glucose, and high household air pollution and air particulate matter (13).

Examining risk factors for death and DALYs for young women and girls between 1990 and 2013 highlights the consistent role of tobacco, alcohol, intimate-partner violence (each of which is closely linked to mental ill health) and environmental factors. It also emphasizes the increase in risk factors thought to be associated with overweight, obesity and diabetes, such as low glomerular filtration rate and high fasting plasma glucose (Fig. 1.15).

These increases point to a likely growth in the burden from cardiovascular disease and cancer among women, but the lack of regional data means evidence reviews must rely on studies and surveys that involve smaller numbers of countries. The Euroaspire study, for example, which examined uptake of cardiovascular prevention strategies in selected European countries and

Fig. 1.15.

Source: Institute for Health Metrics and Evaluation (13).

Leading risks of death and DALYs for young women aged 15–19, European Region



assessed key risk factors (smoking, diabetes and obesity) in three waves of surveys between 1995/1996 and 2007, highlights the higher burden of these risk factors among younger women (19).

Smoking

Many of the current differences in burden of lung cancer in women (and the overall growing trend) are consistent with the stages of the tobacco epidemic. The Lopez curve (Fig. 1.16) models the tobacco epidemic in four stages, the last of which sees high death rates among female smokers (commonly, females are the last population group to start smoking) (20).

Evidence from Euroaspire shows that smoking rates in women under 50 in the study countries increased significantly from under 30% in 1996 to 50% in 2007 (Fig 1.17).

Alcohol

Much of the attention on harmful drinking has focused on men, but evidence of the high biological vulnerability of women to alcohol-related harm from a given level of alcohol use or a particular drinking pattern is growing.

Evidence collected in the 2014 WHO global status report for alcohol and health explains women's vulnerability due to a wide range of factors, including lower body weight, smaller capacity of the liver to metabolize alcohol and a higher proportion of body fat. Together, these contribute to women developing higher blood alcohol concentrations than men for the same alcohol intake.

Women are also affected by interpersonal violence and risky sexual behaviour as a result of the drinking problems and behaviours of male partners. Alcohol use has been shown to be a risk factor for breast cancer, and increased use among women raises major public health concerns due to its effects on neonates (21).

Regional data for alcohol consumption disaggregated by sex are not available, but as Fig. 1.15 shows, alcohol is a high risk factor for women in the Region.

Fig. 1.16.

Source: Lopez et al. (20).

A model of the tobacco epidemic (Lopez curve)

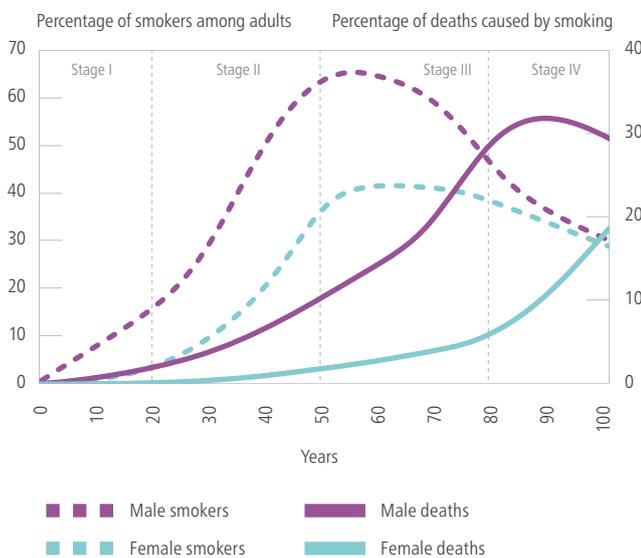
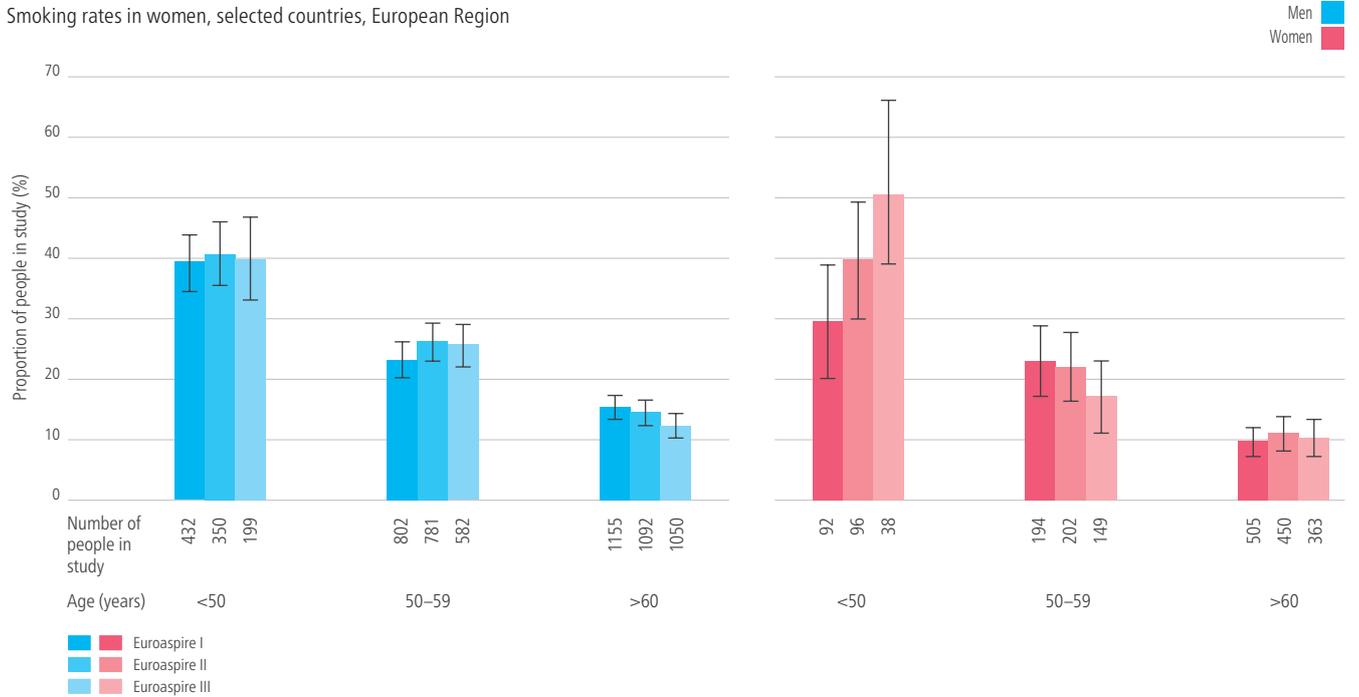


Fig. 1.17.

Source: Kotseva et al. (19).

Smoking rates in women, selected countries, European Region



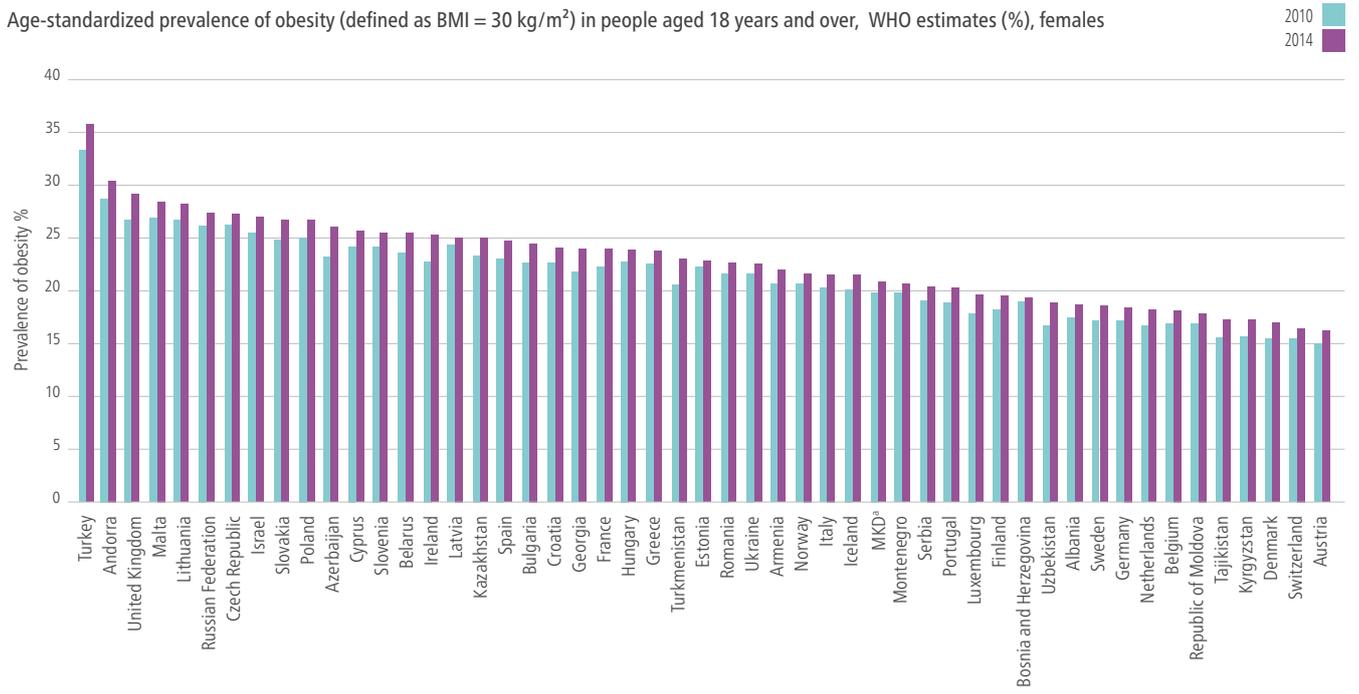
Obesity

Data on rates of obesity among women in the Region show a rapid increase over a period of just four years, between 2010 and 2014 (Fig. 1.18). While differences between countries are vast, rates increased consistently across countries in the

Fig. 1.18.

Source: WHO Regional Office for Europe (6).

Age-standardized prevalence of obesity (defined as BMI = 30 kg/m²) in people aged 18 years and over, WHO estimates (%), females



four-year period. This is particularly worrying, as obesity is a key risk factor for cardiovascular disease and diabetes.

Women are disproportionately affected by obesity-related cancers. Cancers of the endometrium, colon and breast account for almost three quarters (73%) of all cancers linked to BMI in women. Studies suggest that 10% of post-menopausal breast cancer, the most common cancer in women worldwide, could be prevented by having a healthy body weight (22). The percentage of cancer cases among women that is attributable to excess body fat is higher than the global average (5.3%) in almost all European countries: proportions in the Czech Republic, Malta and the Russian Federation are more than double the global figure.

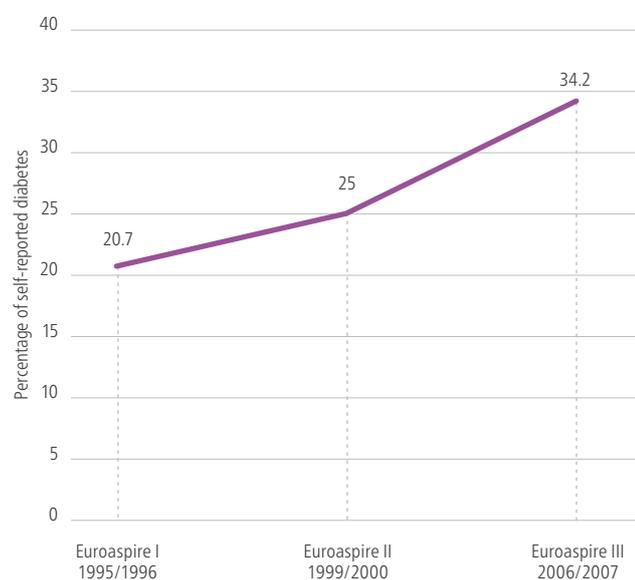
Data from the Euroaspire study (19) also highlighted the increase in diabetes among women in the study countries. Fig. 1.19 shows a rise from 20.7% in 1995 to 34.2% in 2007.

Physical inactivity

Physical inactivity is estimated to be the main cause of approximately 21–25% of breast and colon cancers, 27% of diabetes and around 30% of the ischaemic heart disease burden. The prevalence of insufficient physical activity for women aged 25–49 years in countries across the Region ranges from 16% to 76% (23). Women over 65 fall further behind on physical activity and have a higher chance of becoming obese (Josephine Jackich, WHO Regional Office for Europe, unpublished data, 2015).

Fig. 1.19. Source: Kotseva et al. (19).

Self-reported diabetes among female study participants, Euroaspire



Physical activity is important to overall well-being, functional capacity and independence. Evidence of the positive effects of increased levels of physical exercise on health and in preventing frailty, disease and death is strong. Women aged 65–80 who engage in physical exercise have been found to rely less on doctors and medication, and are more likely to try to maintain their good health through sports and positive feelings about their body. They have reported that exercise helps them to reduce stress levels and anxiety about the future, keep fit and avoid health problems (Josephine Jackich, WHO Regional Office for Europe, unpublished data, 2015).

Environmental risk

According to WHO estimates, 117 200 premature deaths in the Region in 2012 were caused by household air pollution (24). Evidence on the links between chronic exposure to household air pollution and stroke is increasing. Of the 4.3 million premature deaths worldwide each year from illness attributable to household air pollution caused by cooking with solid fuels, 34% are due to stroke, 26% ischaemic heart disease, 22% chronic obstructive pulmonary disease, 12% childhood pneumonia and 6% lung cancer (25).

Measuring women's well-being

The focus on well-being as an indicator not only of good health, but also of societal progress and quality of life at individual level, is increasing. The WHO European policy framework for health and well-being, Health 2020, recognizes well-being as an intrinsic value.

As described in the European health report 2015 (26), well-being is experienced at the subjective, individual level, but can also be described through population-level indicators such as education, income and housing. Chapter 2 explores the effect of determinants such as income and education on life expectancy; this section focuses on life satisfaction and self-reported health as a key subjective independent indicator of well-being.

A recent review of self-assessed health in 17 European countries found that while levels varied widely between countries, women had consistently worse self-reported health than men, even where levels were high. Reasons have been debated widely, but it is generally accepted as an indicator of women's greater burden of disease (27).

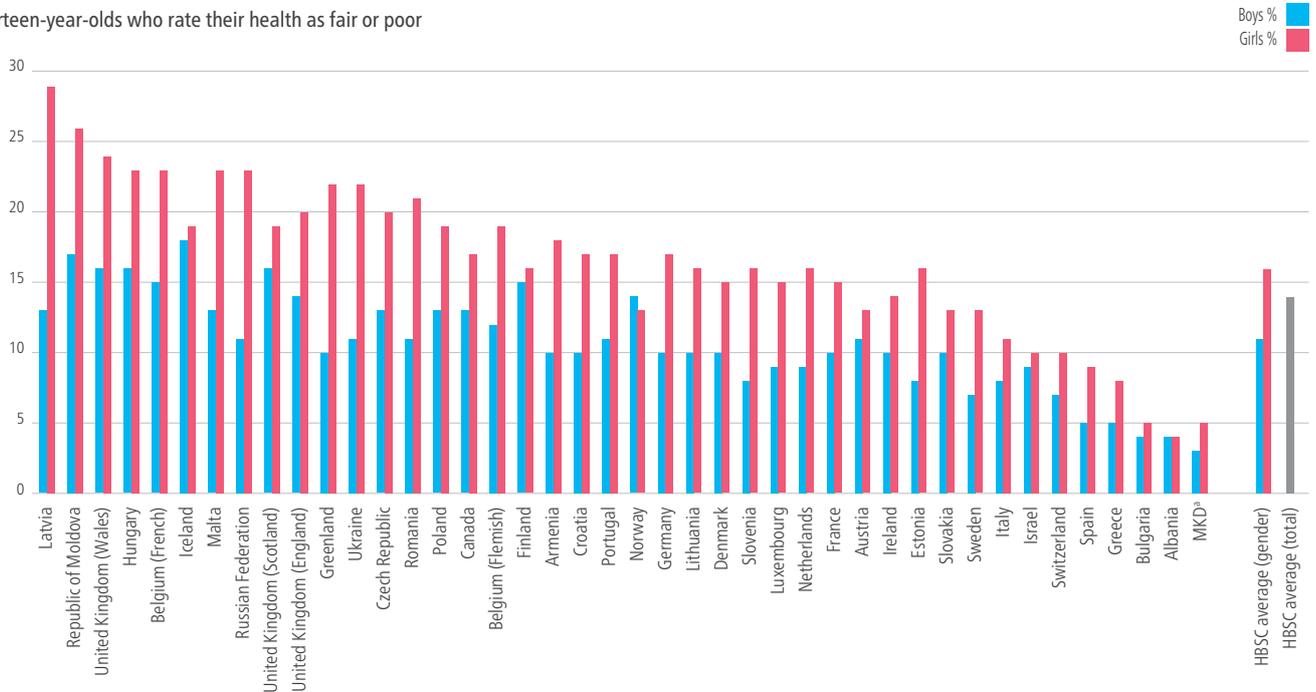
Data from the 2014 Health Behaviour in School-aged Children (HBSC) survey show that girls of 13 report far higher rates of poor or fair health than boys across three measures – self-rated health, life satisfaction and multiple health complaints – that reflect the combined effects of age, sex, gender norms and values, and socioeconomic status (Fig. 1.20) (28).

Social media use among young women requires greater analysis of its potential as a vehicle for health promotion and its effects on well-being. Recent studies on social media use report on its negative health effects, particularly among adolescent girls, which include loss of self-esteem, worrying, anxiety, difficulty relaxing and sleeping, and impaired face-to-face communication skills (29,30). These well-being effects arise mainly from negative emotions provoked by

Fig. 1.20.

Source: Inchley et al. (28).

Thirteen-year-olds who rate their health as fair or poor



* The former Yugoslav Republic of Macedonia (MKD is an abbreviation of the ISO).

constant comparisons with peers facilitated by social networking sites and the so-called fear of missing out. Social media use is also linked to social media addiction (31) and cyberbullying.

Improving well-being often requires action outside of the health sector and includes a quality element. For example, female employment being low will affect women's well-being, but the type of employment (formal and informal, and its quality) are also important factors. All well-being indices nevertheless have a health component. Health inequities are seen as a core indicator for measurement of, and an obstacle to, well-being.

As part of the increasing recognition that well-being is important and independent from traditional data on health status, mortality, risk and service utilization, greater effort has been made to capture well-being in a measurement or index. One such example is the Organisation for Economic Co-operation and Development (OECD) Better Life Index, which focuses on material conditions (income and wealth, jobs and earnings, and housing) and quality of life measured through a set of indicators (including health status, work-life balance, education and skills, social connections, civic engagement and governance, environmental quality, personal security and subjective well-being). The index recognizes the sustainability of well-being over time, considering resources such as human, social, natural and economic capital as

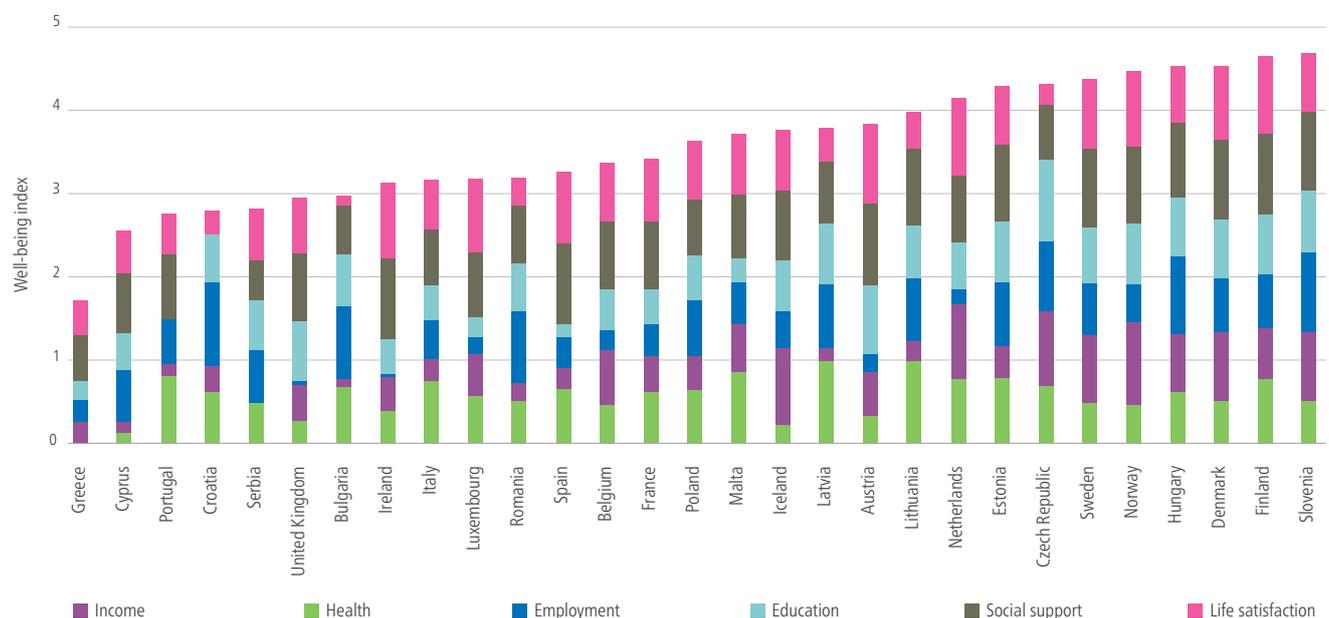
being important in securing this, and highlights the interconnectedness and complementarity of well-being dimensions.

Fig. 1.21 presents evidence from European Union statistics on income and living conditions (EU-SILC) measuring how outcomes in six well-being dimensions (income, health, employment, education, social support and life satisfaction) are distributed among women (32). The index can take values from 0 (in the case of perfect inequality in all six dimensions) to 6 (perfect equality in all six dimensions). It highlights how an index consisting of components linked to well-being might rank countries in a manner opposite to their health achievement and shows country variation in the distribution of well-being outcomes among women. Composition clearly matters: a country could rank higher for well-being with worse health than one with comparatively better health but whose other social indicators are worse.

Fig. 1.21.

Source: Eurostat (32).

Calculation of a well-being index, based on EU-SILC data



Conclusions

The available data suggest a clear pattern in terms of burden of cardiovascular disease, cancers and mental ill health for women and girls in the Region, but also great differences across ages and countries, even where overall trends are the same.

Important gaps in evidence due to the lack of sex-disaggregated data and/or comparable data that link indicators of risk such as alcohol consumption to mental health or chronic diseases continue to exist. Crosslinks between diseases and risks are also not fully understood.

Analysis of the inequitable distribution of burden of disease and exposure to risk factors determined by the interplay of determinants of health, gender and multiple forms of discrimination will be taken forward in subsequent chapters.

2 Enabling women's health and well-being: addressing gender, social and environmental determinants

Education: filling the gaps

Economic status and income: building on the gains

Social protection and family policies affect health

Environmental exposure, risks and effects

Processes and circumstances that increase vulnerability, stigma and social exclusion

Moving forward



2 Enabling women's health and well-being: addressing gender, social and environmental determinants

This chapter looks at key social, economic and environmental determinants of health and the cumulative impact of inequalities in these areas on some of the women's health issues identified in Chapter 1. Comparable data are not systematically available across the Region, but sufficient evidence exists to illustrate the relevance of these determinants to women's health and well-being.

Education: filling the gaps

Education has long been recognized as a key determinant of health and an important lever for policy action in tackling health inequities generally and among women specifically (33,34). This is clearly reflected by its effects on life expectancy (Fig. 2.1), where women with tertiary education in all countries surveyed live longer than those with a lower level of education. Overall life expectancy differs between countries, but the difference in life expectancy between levels of education is common across countries.

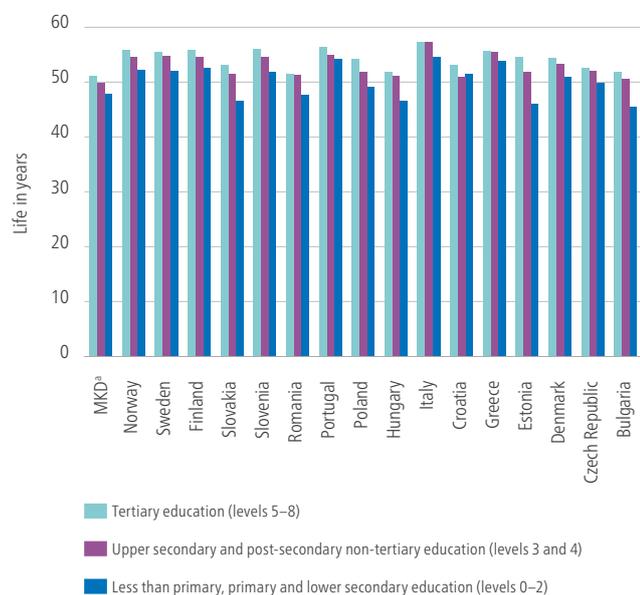
The right to education without discrimination is promoted and protected through international human rights law (36,37) and SDG4 aims to ensure inclusive and equitable education. The European review of the social determinants of health and the health divide highlights early child education and care as a key determinant of health for ensuring a good start in life (34,38).

The European Region presents a good situation for girls' education. With a few exceptions, girls and boys in Europe have equal access to pre-primary, primary and secondary education, and women outnumber men in secondary and/or tertiary education in several countries (39). The expected years of schooling have increased significantly over recent years: girls in most countries can expect to have 14 years of schooling (40), an increase compared to older generations and suggestive of fairly good opportunities to attain an education (41).

Fig. 2.1.

Source: Corsini (35).

Life expectancy of women aged 30 by level of education, selected countries, European Region



^aThe former Yugoslav Republic of Macedonia (MKD is an abbreviation of the ISO).

Gaps in access to education nevertheless continue to exist for specific groups of girls. These include barriers to secondary education for girls from ethnic minorities, those who live in remote and rural areas, and girls with a disability (42). Fig. 2.2 illustrates the significant differences between Roma and non-Roma women.

Data on educational attainment for women aged 15 and over from 31 European countries show differences based on where they live within a country. A greater percentage of women living in densely populated areas, for example, have attained tertiary education compared to those in thinly populated areas (44).

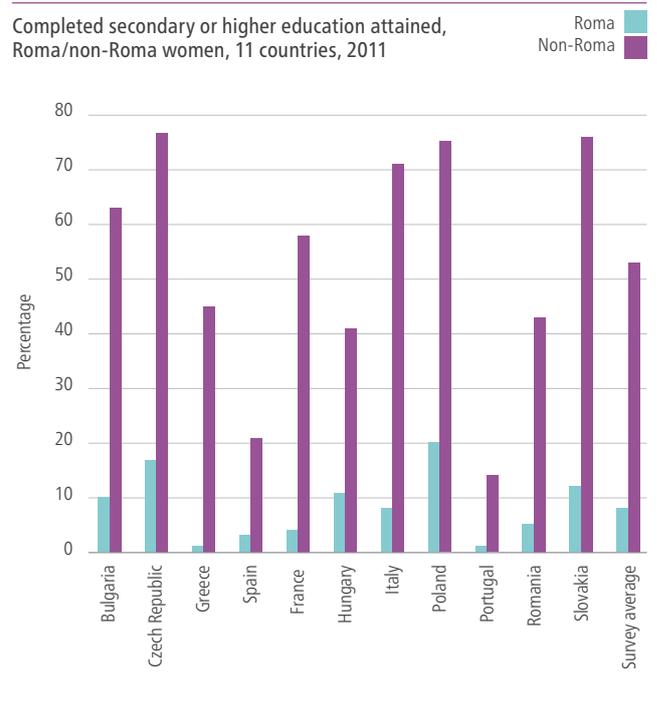
Gender stereotypes continue to limit girls' education and training choices (41), causing underrepresentation of women in areas such as science, technology, engineering and mathematics. Researchers disagree on the effect of gender bias in education on women's opportunities later in life compared to the loss of women from the workforce at various stages of their career trajectories (the so-called leaky pipeline) (45). Whatever the reason, gender segregation in education restricts women's access to better-paying jobs later in life.

Intersections between gender inequality, education and health outcomes are clearly illustrated by girls dropping out of secondary education due to early marriage and/or teenage pregnancy (see Chapter 3 for an overview of child marriage in Europe and related health issues). Women who were teenage mothers experience increased health risks, including being 30% more likely to die prematurely from any cause, almost 60% more likely to die unnaturally (suicide), and having an elevated risk of death from cervical and lung cancer (46).

Research shows lower health literacy among people with lower education levels (47). Reduced health literacy affects women's capacity for illness prevention and health promotion and their ability to access and benefit from health care and treatment: there is a significant relationship between inadequate health literacy and lower breast and cervical cancer screening rates, for example (48).

Fig. 2.2.

Source: European Union Agency for Fundamental Rights (43).



Smoking is a good illustration of the link between education and health. Studies show that educational inequalities among smokers are more pronounced in northern Europe than to the south of the Region. This is thought to be linked primarily to the stage of the tobacco epidemic (49). The link has been found for men and women, but evidence suggests it is more pronounced in women. Affluent women usually are the first to start and first to quit smoking, but in countries with the longest histories of smoking, it is now increasingly associated with low socioeconomic status. There is also evidence of higher prevalence among disadvantaged groups, such as long-term unemployed and homeless people, while differences in smoking rates among ethnic minorities and migrant communities vary across groups. These differences are mediated by gender (50).

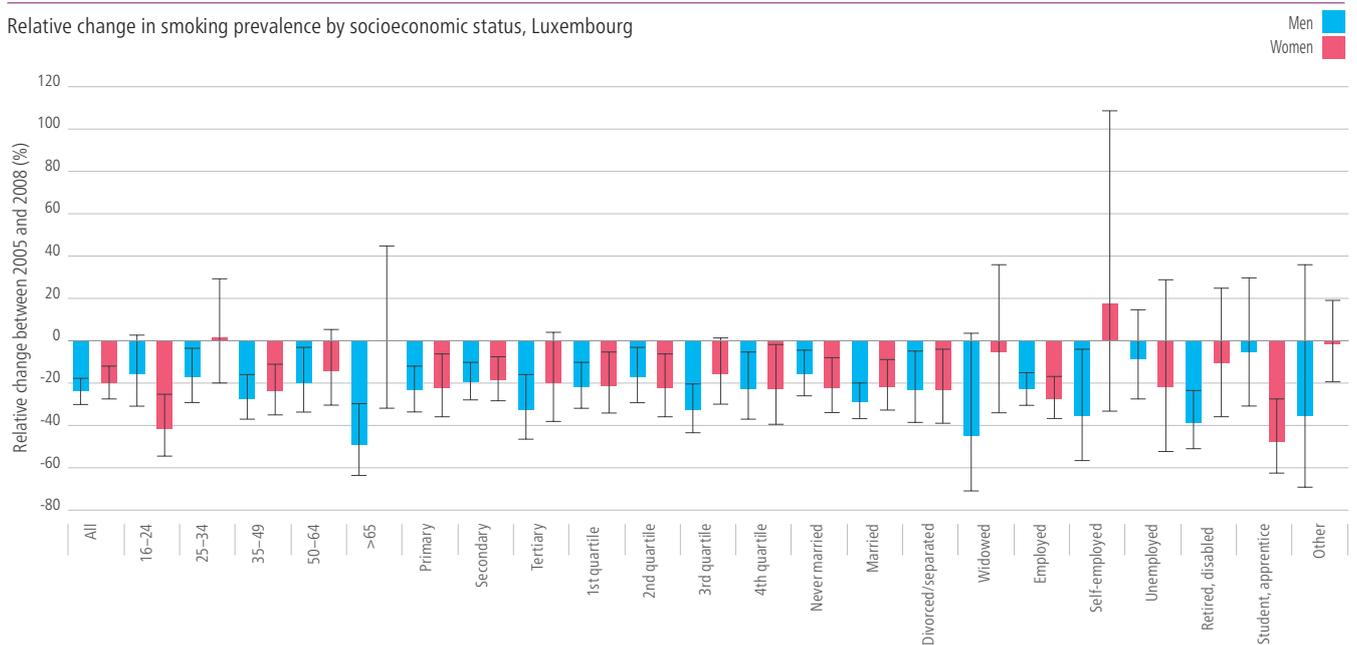
Educational inequalities in smoking initiation and cessation are less well documented than inequalities in smoking prevalence. A national population survey from the Netherlands indicates that the widening pattern in smoking initiation and cessation among women with low education is especially worrying (51). Recent research on smoking cessation in Luxembourg showed that while men with tertiary education were more likely to have stopped, the pattern was reversed for women, with women who had only primary education being more likely than those with higher levels (Fig. 2.3) (52).

Recent analysis of social inequalities in excess mortality due to alcohol consumption in 17 European countries showed that people with low education

Fig. 2.3.

Source: Tchicaya et al. (52).

Relative change in smoking prevalence by socioeconomic status, Luxembourg

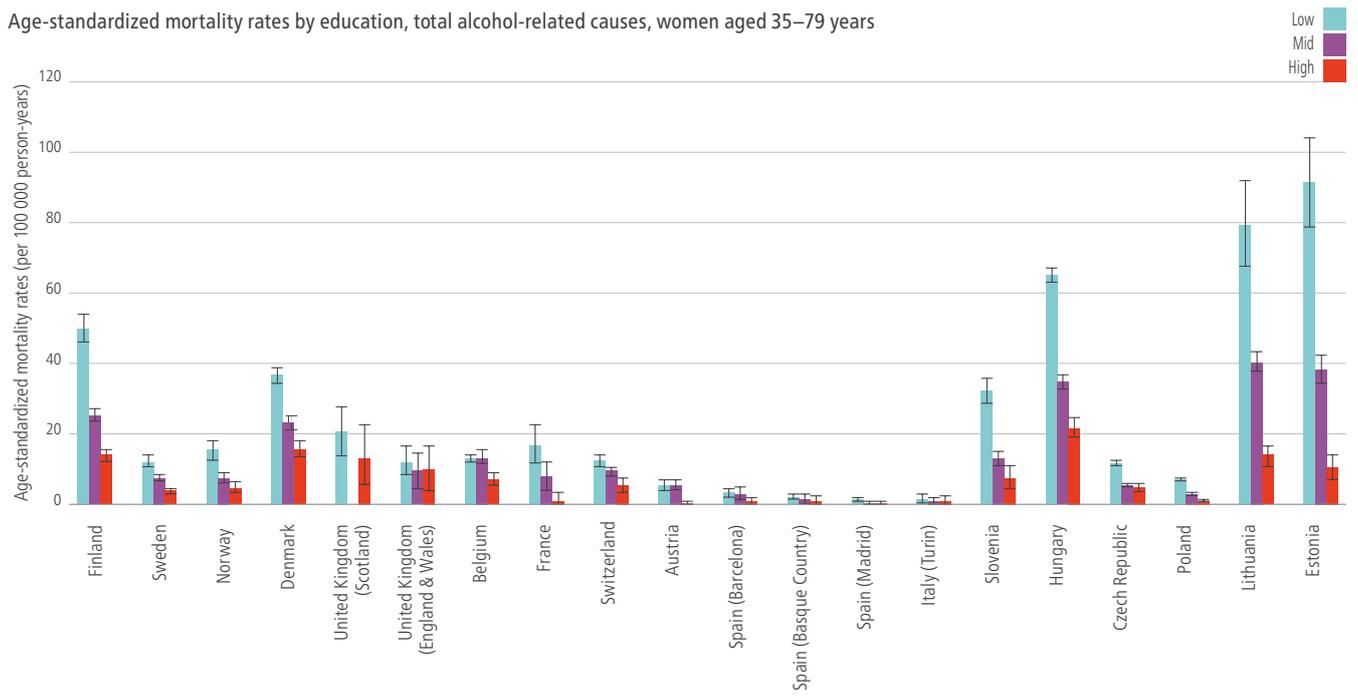


had double that of those with the highest level in most countries (53). Despite large variation among countries, the correlation between education and alcohol-related mortality in women was consistent across geographic locations (Fig. 2.4).

Fig. 2.4.

Source: Mackenbach et al. (53).

Age-standardized mortality rates by education, total alcohol-related causes, women aged 35–79 years



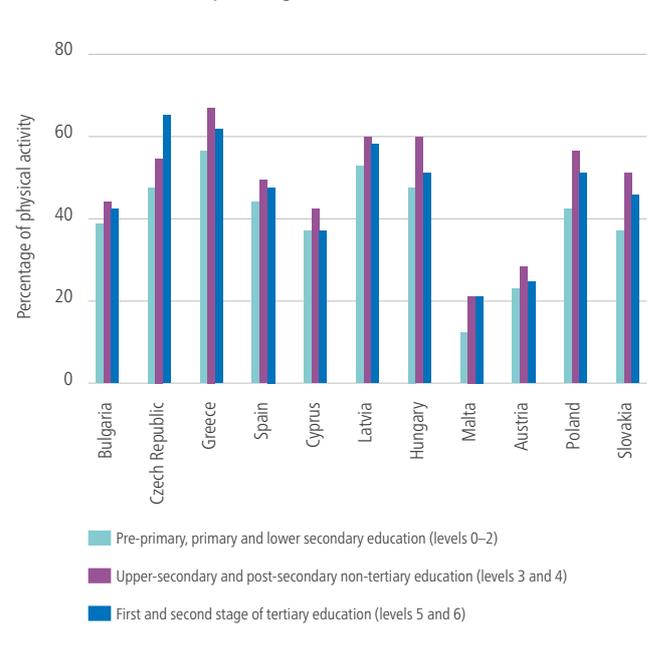
Research on physical activity in selected countries in the Region showed that women with only primary or lower-secondary education had lower rates than those with higher levels, although in many countries women with tertiary education were less physically active than those with secondary (Fig. 2.5) (54).

Men and women with low education levels and socioeconomic status are more likely to develop diabetes, but women with low education levels have higher mortality rates from diabetes than men with a similar education level. This is attributed to higher prevalence of obesity, lower physical activity and high psychosocial risks among women.

Fig. 2.5.

Source: Eurostat (54).

Practice of daily physical activity by educational attainment level, selected countries, European Region



Fifty per cent of obesity in women in the EU can be attributed to inequalities in education status (55).

Most countries in the Region show a considerable difference in women's self-perceived health based on education or income. For example, Eurostat data show that 48.8% of women aged 16–64 years with pre-primary through to lower-secondary education report good–very good health, compared to 69% of women with upper- or post-secondary education and 81.3% with tertiary. This pattern of educational inequalities continues into older age, with a higher percentage of women aged 65 years and over in EU Member States since May 2004 with tertiary education (53%) reporting good health than women with secondary (40.5%) and/or primary-level (28.1%) (54).

In general, research suggests a lower level of psychological well-being among men and women in lower-education groups. Data and studies on gender differences in social inequalities in mental health in Europe are limited, however (56,57).

Economic status and income: building on the gains

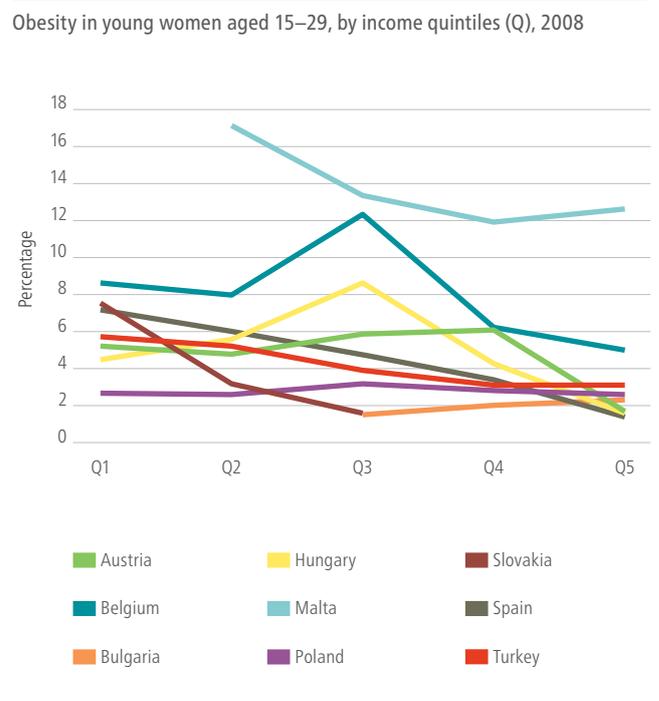
The relationship between gender equality, income and development is well established. Empowering women means more efficient use of human capital, while reducing gender inequalities has a positive effect on economic growth and development. Inequities between men and women and among women bring costs to society. Unequal access for women to economic resources such as wages, pensions and social transfers has health and social consequences (58–60).

Smoking prevalence among pregnant women is strongly related to age and socioeconomic status. The highest rates of smoking during early pregnancy in Nordic countries are observed among teenagers, while in Spain they are found in manual workers and women with low levels of education. 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 (61). While absolute inequalities in smoking-attributable mortality and the contribution of smoking to inequalities in total mortality have decreased in most countries among men, they have increased for women. Smoking remains an important determinant of socioeconomic inequalities in mortality among women, with inequalities in smoking (due to education or occupation status) being one of the most important entry points for reducing inequalities in mortality (62,63).

There is also a known link between income and overweight and obesity in the Region, with lower income being associated with higher rates of overweight in many, although not all, parts (64). Social inequalities in overweight and obesity – key risk factors for cardiovascular disease and diabetes – are consistently worse for women. Data from Eurostat for selected countries in the Region highlight rates of obesity for young women by income quintile, with quintile 1 being those with the lowest income and quintile 5 those with the highest (Fig. 2.6) (54). While data are not available for all groups and the existence of large differences between countries is recognized, the findings show that rates of obesity are lowest among those with the highest incomes. This trend may be reversed for countries towards the east of the Region, where the WHO European review of social determinants of health and the health divide (34) found higher rates of overweight children among the richest quintile; these data, however, were not sex-disaggregated.

Women in low socioeconomic circumstances are more vulnerable than men to developing obesity. Obese women are less likely to be upwardly socially mobile and more likely to be unemployed or suffer absenteeism from work due to ill health. Mothers with lower socioeconomic status are more likely to be overweight and less likely to breastfeed, given it is more difficult for obese women to breastfeed successfully due to biological and mechanical barriers (55).

Fig. 2.6. Obesity in young women aged 15–29, by income quintiles (Q), 2008 Source: Eurostat (54).



Labour force participation, and type and quality of work

Despite increases in women's labour force participation globally and in the Region, women remain disadvantaged. They continue to be engaged in the workforce less than men, are more involved in unpaid work, work in jobs that tend to be more precarious, are underrepresented in senior management and decision-making positions, earn less than men and are more likely to end their lives in poverty (58,59,65,66).

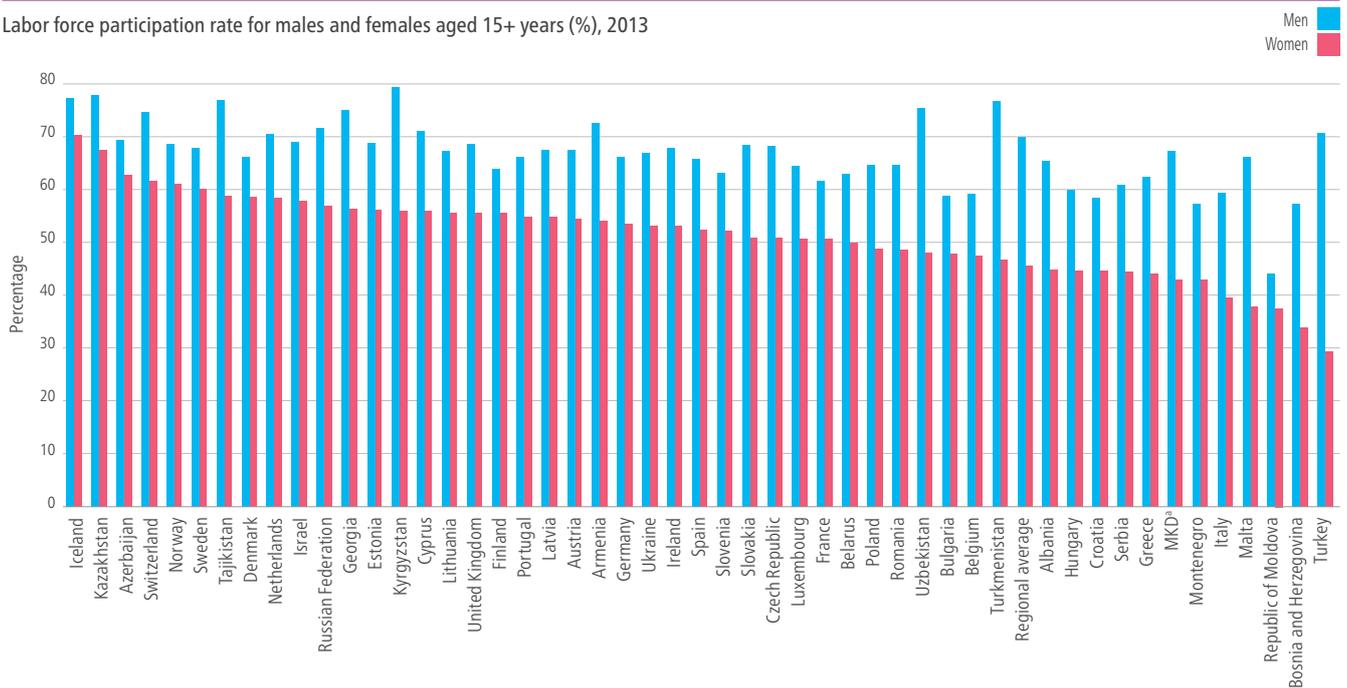
The United Nations Development Programme (UNDP) 2015 Gender Inequality Index shows that the average labour force participation in the Region was 45.6% for women (compared to 70% for men) and that only 32 countries had a women's

labour force participation greater than 50% (Fig. 2.7) (59). Data from OECD countries reveal that in 2014, 73% of men aged 15–64 years were in full-time employment, compared to 51% of women in the same age group (60). According to the European Agency for Safety and Health at Work, 80% of part-time workers in some EU countries are women (67).

Fig. 2.7.

Source: UNDP (59).

Labor force participation rate for males and females aged 15+ years (%), 2013



* The former Yugoslav Republic of Macedonia (MKD is an abbreviation of the ISO).

For many women, reduced labour force participation derives from gender inequalities in relation to family responsibilities in which they assume a higher share of unpaid domestic work and child care (66). This may further be exacerbated by family policies that provide limited formal child care and/or care for older people. Consequently, women are more likely to be in part-time or low-paid positions and less likely to hold management and leadership posts. Lack of public and private support may mean that opportunities providing sufficient flexibility for women to combine paid economic activity with unpaid household responsibilities are offered only by the informal economy (66).

The annual average unemployment rate for women aged 25–74 years in 30 European countries increased from 5.9% to 8.8% between 2007 and 2014. The annual average long-term unemployment rate also increased, from 2.8% to 4.8% (68). The unemployment rate for young women in Croatia, Greece

and Spain is exacerbated because approximately a fifth of young people in these countries are not in employment, education or training (68).¹

Job insecurity is an important social determinant of health and is found to be consistently higher among young workers, women, immigrants and manual workers (69). Inequalities linked to ethnicity, migrant status and disability are evident in employment and working conditions. Minorities face barriers to labour market access, encounter discrimination and are overrepresented in informal employment. Norway, for example, has reported lower employment rates among women from Africa and Asia (39% and 49% respectively (70)) than for other groups of women. Higher levels of unemployment and poorer working conditions (sometimes linked to lower levels of education) are reported among Roma women in some countries (71).

Research on work-related diseases does not include women to the extent that it should, although some progress has been made in relation to cancer and reproductive issues. It is often based on knowledge of male-dominated professions and male metabolism of chemicals, and excludes part-timers and occupations for which little is known about exposures. Musculoskeletal disorders and stress-related problems affect women more than men (60% and 16%, respectively). Lower-limb disorders also affect women more, but are seldom recognized as being occupation-related (67).

Women are less likely to suffer accidents at work than men, which can be explained by differences in type and amount of occupational exposure and individual behaviour and vulnerability (72). Official statistics are often not adjusted for hours worked, however, which may distort the picture (73).

Adult women consistently exhibit a higher prevalence and incidence of asthma due to the intersection of a number of factors, including genetic, hormonal, socioeconomic, environmental and behavioural (smoking) (74). Women with work-related asthma, for example, predominantly report exposure to miscellaneous chemicals, cleaning materials, indoor air pollutants and mould. Those living below the poverty line may have higher levels of exposure to agents that cause or exacerbate asthma due to poorer living and/or working circumstances. Their health and asthma may be further affected by a lack of access to, or use of, appropriate health services, such as preventive primary care (75–77).

¹ This indicator intersects with different age stages among women – students (low end) and retirees (high end) – and countries may have different statistical methodologies for calculating these figures.

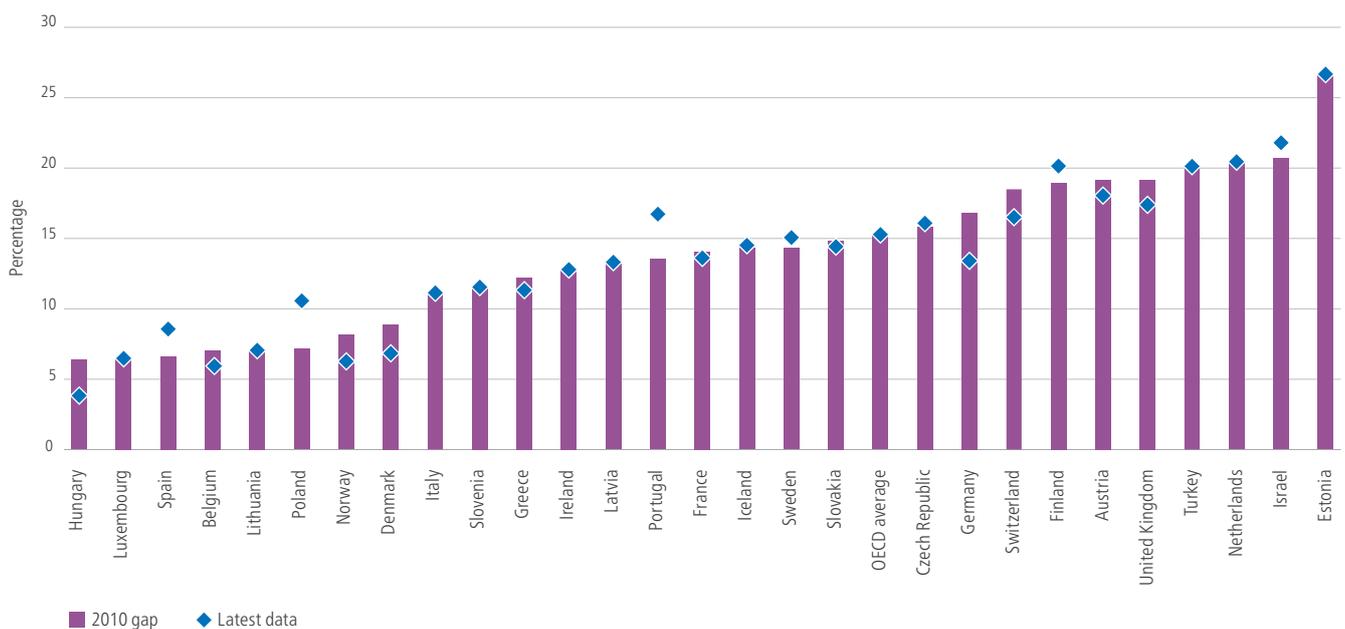
Unequal income

Although the gender pay gap has generally declined in the last decade, women in the EU earn about 16% less per hour despite their qualifications being as good as, or better than, their male counterparts (78). Typically, sectors dominated by women have lower salaries than those dominated by males (79), with the pay gap usually higher in the private sector than in the public. No country in the Region has achieved wage equality for similar work. Of the 30 worst-performing countries on wage equality in the world, 11 are from the Region (80). Fig. 2.8 shows the gender pay gap in 28 countries in the Region for 2010 and compared with the latest available data, where available (80). It underlines that the labour market in Europe continues to struggle with gender equality, with discrimination in hiring, promotion, working conditions, wages and dismissal existing in all countries.

Fig. 2.8.

Source: OECD (80).

Gender wage gap for 28 countries, European Region



The gender pay gap in working life accumulates to a gender pension gap (in terms of wealth and income) later in life (79,81). In 2012, 22% of women aged 65 and older were at risk of poverty, compared to 16% of men of the same age (80). Discriminatory laws and practices, such as earlier mandatory retirement ages for women, separate pension annuity tables for women and men based on average life expectancy (which generally is higher for women), and policies making women's pensions dependent on their husband's income and entitlements exist in many countries in the Region (82). Pension gaps for those aged 85 years and over were considerably lower, possibly due to the

effect of pensions collected by widows (83).

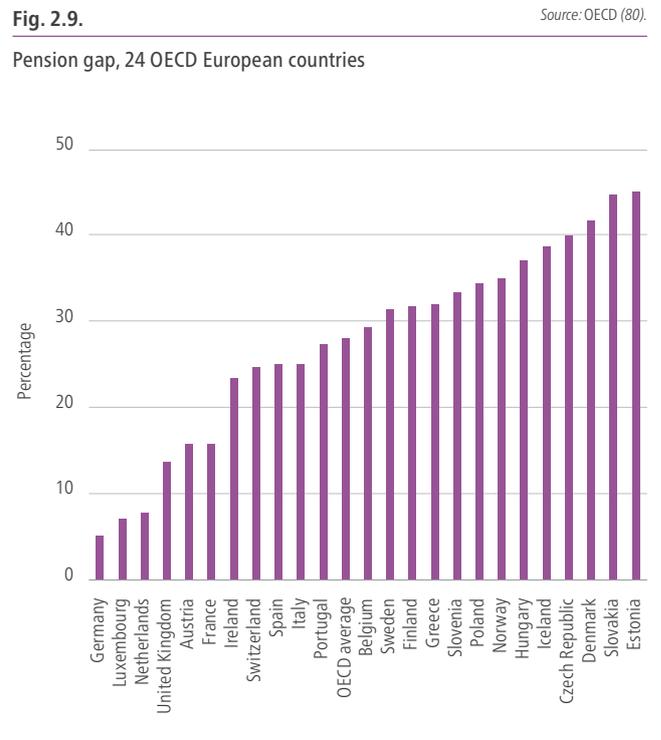
Fig. 2.9 presents data for 24 OECD European countries, highlighting that pension gaps continue (80).

The pattern is similar in other countries, such as the Republic of Moldova, where the ongoing wage gap means women across the country earn between 0% and 44% less than men. Men therefore have a pension that on average is 18% higher than that of women (84).

Social protection and family policies affect health

Social protection, particularly social protection floors and social services and transfers, are important as they may affect gender inequalities and address the structural economic disadvantages for women explained above (85). Social transfers, such as family allowances, social pensions and other cash transfers, are tools for gender empowerment by preventing deprivation throughout the life-course and supporting women in their role as carers. Social protection can be transformative by promoting women's rights through active labour market policies and linking social transfers to their productive role (86,87). Studies show that countries with higher social spending have smaller inequalities in self-rated health among men and women, higher levels of female labour force participation and more women-friendly employment conditions (88).

Women's health and well-being is affected by different types of family policy models and wider policies that either support work and family-life balance or create conflict (88,90). The European Institute for Gender Equality (EIGE) Gender Equality Index 2015 for the EU shows a 17% gap between the engagement in child care and education of working women and men, with vast differences between countries (91). The combination of unpaid with paid work has been reported as an indicator of higher stress, leading to lower quality of life and poorer health among women (92). Access to childcare services has improved (mainly among EU countries in the Region) through increased investment and the setting of specific targets. The Barcelona targets on child care are part of the 2011–2020 European Pact for Gender Equality and imply that all EU Member States should aim to provide child care to at least 90% of children between 3 years and the



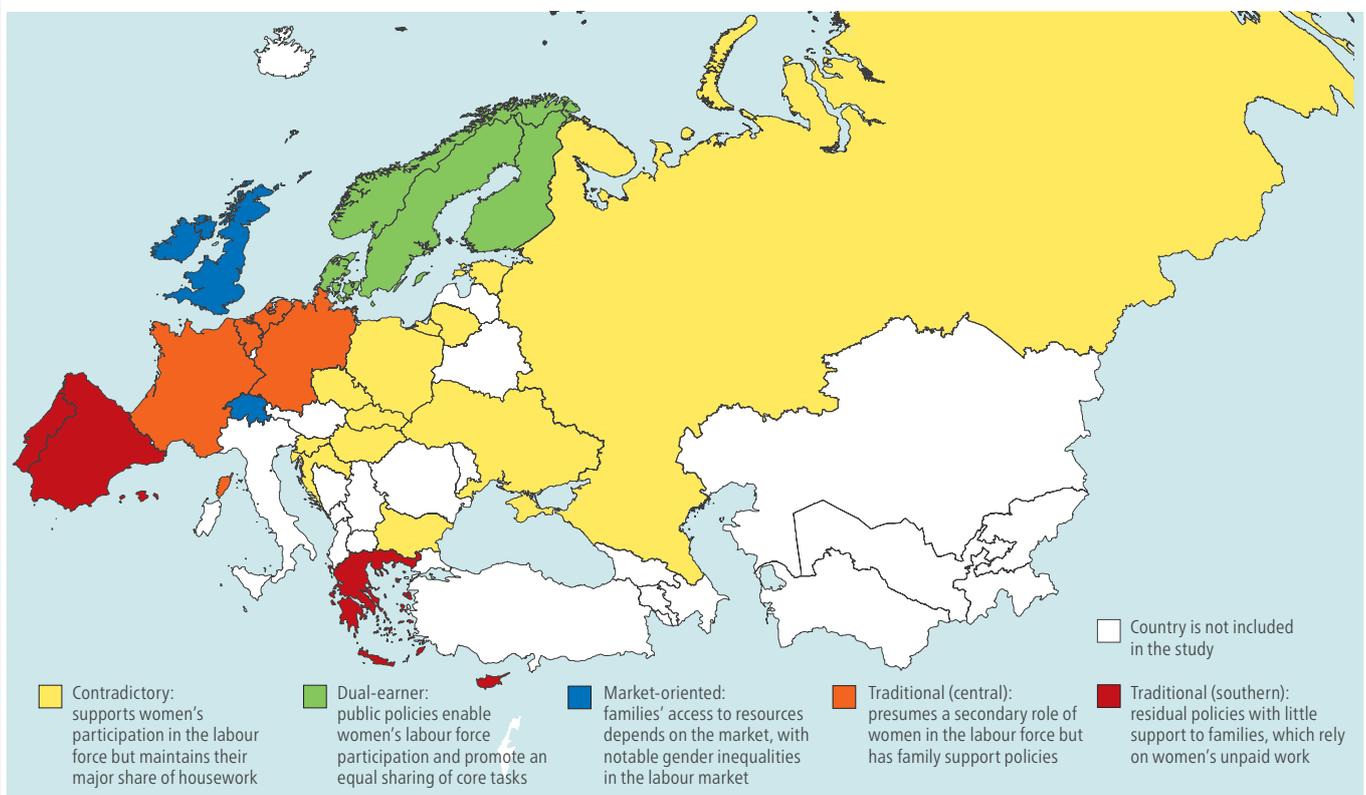
mandatory school age, and at least 33% of children under 3 years (93). Analysis in European countries shows that men's hours of workforce participation are increased by fatherhood, while women's are reduced by motherhood (94).

Research generated through the Evaluating the Impact of Structural Policies on Health Inequalities (SOPHIE) project comparing family policy models and women's self-rated health with that of men (95) shows vast differences among European countries (96) (Fig. 2.10).

Fig. 2.10.

Source: Agència de Salut Pública de Barcelona (96).

Countries included in the SOPHIE study by family model



Note: this map is a reproduction of an infographic designed by Esther Marín and Laia Palència (Consorci de Investigació Biomèdica en Red de Epidemiologia i Salut Pública and Agència de Salut Pública de Barcelona) for the SOPHIE project.

The research concluded that:

- women in countries with traditional (southern and central) and contradictory family policy models are more likely to report poorer health than men;
- gender inequalities in mental health among wage earners and across different social classes are more widespread and pronounced in market-oriented countries than in those with other economic systems; and
- the burden of combining employment and family demands seems especially harmful to the self-rated and mental health of women in traditional countries and men in market-oriented countries.

The causes of poorer health for women in traditional models appear to lie with the mix of poor working and contractual conditions, work overload and family financial stress (for those with two children or more) that drive them into the labour market. The prevalence of poor psychological well-being among women living in countries with traditional policies increases with the number of paid working hours, number of children and having a partner who is unemployed (97).

Environmental exposure, risks and effects

Many health conditions are linked to the environment and influenced by factors such as access to safe drinking-water and adequate sanitation, clean air (indoor/household and outdoor), and safe, green environments for physical activity and play. Environmental determinants of health overlap with gender and social determinants, with specific consequences for women. For example, women absorb and store environmental chemicals and metals from air, water, soil, food and consumer products in different ways to men (98–100), with life-long health consequences for themselves and/or their children. Some women are more exposed due to their socioeconomic circumstances and type of work (101,102).

Unequal access to adequate water and sanitation for children and women in the Region has adverse health and social effects. Children are particularly vulnerable due to their physiology and are less able to protect themselves from exposure. It has been estimated that about 10 people per day die from diarrhoea caused by inadequate water, sanitation and hand hygiene in low- and middle-income countries in the Region, primarily occurring in children under the age of 5 years (103). A United Nations Children's Fund (UNICEF) study conducted in Kyrgyzstan and Uzbekistan found poor water, sanitation and hygiene conditions in schools, especially in rural areas, and that equity in access was affected by gender-based inequalities (104).

Place of residence (rural and urban) intersects with other determinants to exacerbate disadvantage among some groups of women. In Kyrgyzstan, for example, only 54% of women and girls living in rural areas have access to a source of drinking-water near to their household, compared to 91% of those living in urban areas. This places an additional domestic burden on women and girls in rural areas in time taken dealing with inadequate sanitation conditions and unsafe water supplies (105,106).

Cooking and heating with solid fuels on open fires or traditional stoves results in high levels of household air pollution. Women and young children receive the highest exposure because they spend most time in or near the kitchen when the stove is alight (102).

Differences in women's exposure or vulnerability can also be seen in relation to outdoor air pollution (102). Air pollution data from France, Spain and Sweden show that women report ailments in the form of allergies and respiratory or skin hypersensitivity to a greater extent than men, with older women at greater risk (107,108).

Some of the health effects of climate change are heavily mediated by social determinants, and gender differences in health risks that are likely to be exacerbated by climate change exist. Globally, extreme weather and disasters kill more women than men. European studies have found that in relative and absolute terms, women are more at risk of dying in heatwaves (109). Women also seem to be underrepresented in climate change decision-making processes at national, European and international levels (110).

Processes and circumstances that increase vulnerability, stigma and social exclusion

Exclusion, disadvantage and vulnerability are often used to focus on the attributes of specific excluded groups rather than the processes by which they have become excluded (33). This section seeks to highlight how gender, socioeconomic, environmental and cultural determinants intersect to marginalize and exclude some groups of women in the Region.

Migration

Migrants' health issues are largely similar to those of the rest of the population, but the vulnerability of most migrants leaves them exposed to hazardous working environments, poor housing, labour exploitation and inadequate access to health care (111).

Humanitarian crises, wars, legal and illegal migration, and trafficking violations may create multiple vulnerabilities and increase risk of exposure to ill health. The impact of war and humanitarian crises is high on the European agenda (112) (Box 2.1). Girls and women on the move to and within Europe face particular challenges and risks, particularly due to gender roles and discrimination. The risks include security problems exposing them to sexual and gender-based violence, problems of accessing services, legal and protection systems that do not adequately respect, protect and fulfil their rights, and the absence of solutions (113).

Women and girls might, for example, be forced to engage in transactional sex to pay for transportation and documents to reach Europe, or be pressured into marriage to secure male protection when on the move. Women continue to be

vulnerable to rape and other forms of sexual violence once they arrive in Europe due to unsafe and inadequate transit and reception centres. Recently tightened immigration policies and restricted family reunification procedures in most European countries have left many women stranded in transit camps, in an insecure situation and further exposed. The issue of sexual violence against female refugees has generally been recognized, but response and prevention measures remain insufficient (114–119).

Box 2.1.**Refugee crisis, April 2016**

[From 1 January to 31 March 2016], 171 000 refugees and migrants had reached Europe by sea. Women and children comprised 60% of the total arrivals. Inadequate living conditions, including poor sanitation and limited or no provision for health care, mean that large numbers of migrants are affected by upper respiratory tract problems. Skin conditions such as rashes and scabies have also been reported. These could increase if living conditions do not improve. Hypothermia, burns, gastrointestinal illnesses, cardiovascular events, pregnancy- and delivery-related complications, diabetes and hypertension are the most common health conditions reported. Female refugees and migrants frequently face specific challenges, particularly in maternal, newborn and child health, sexual and reproductive health, and violence. The age and sex distribution of the population arriving in 2016 suggests an increase in specific health needs and the necessity of tailored responses.

Source: WHO Regional Office for Europe (112).

Economic crises and austerity policies

Economic crises and subsequent austerity measures have been shown to pose a risk to population health. Available data on the ongoing crisis suggest that the health effects are gendered and inequitable (120,121). Austerity measures, such as redundancies in public sector employment and reductions in budgets for care facilities, unemployment benefits, income maintenance and pensions, disproportionately affect women. The economic crisis may have further affected not only the availability of work and employment for girls and women, but also the quality and working conditions for women and, in turn, their health and well-being (122). Research emphasizes the important role of social protection floors in cushioning the disadvantage that austerity measures create for women, including effects on their health and well-being (85).

Rises in unemployment and precarious employment with resultant financial insecurity, which are the most direct results of economic crisis, increase the risk of mental health problems. Evidence from a number of countries in the Region suggests that while overall deterioration of mental health has been observed for women and men, women's mental health has been affected more strongly by the current crisis (123). Rises in male unemployment and the financial and

psychological strain experienced by families in a number of countries have been linked to increased levels of domestic violence, the primary victims of which are women (124). Public spending on health per person post-2008 fell at some point in most countries of the Region, including reduced coverage (123,125). Cuts in the public sector primarily affect women, who comprise most of the workforce: in the United Kingdom, for example, 75% of workers in local government, 77% in health, 80% in adult social care and 82% in education are women. Many cuts have affected women specifically: in Greece, for instance, obstetricians reported a 32% rise in stillbirths between 2008 and 2010 as fewer pregnant women had access to antenatal care services (123). Similarly, women's use of antenatal care in other countries in the Region has been affected by socioeconomic status.

Moving forward

There are significant gaps in evidence and a need to improve availability and use of sex-disaggregated data that can be crosslinked to social factors.

Key challenges for women that lie outside the health sector, such as the pensions gap, social protection mechanisms and gender segregation in education and the labour market, need to be understood to enable them to achieve their full health potential.

There is a need to better understand patterns of inequities and how different determinants, such as gender, disability, education, employment and ethnicity, intersect. Knowledge gaps in relation to mental health and well-being are particularly large. Significant gaps in knowledge about health inequities among women in relation to the effects of determinants and gender on mental health and well-being continue to exist.

Considerations identified as important for tackling differential exposure and vulnerability to ill health caused by the interaction between gender and other social and environmental determinants of health include:

- a. giving visibility in political agendas to women facing multiple vulnerabilities and severe exclusion;
- b. improving the circumstances, environments and specific settings that influence girls' and women's health, with particular attention to housing, health care and education facilities, the workplace and environmental hazards;

- c. analysing and addressing intersections between biology, gender and social determinants of mental health and well-being of girls and women from childhood to older age;
- d. strengthening intersectoral mechanisms among health, social welfare and labour sectors to reduce the negative effects on health and well-being of precarious employment and working conditions experienced by many women in the Region; and
- e. ensuring that women's work is not only valued, but valued equally with that of men, and that women's paid and unpaid contributions as care providers are recognized, valued and compensated.

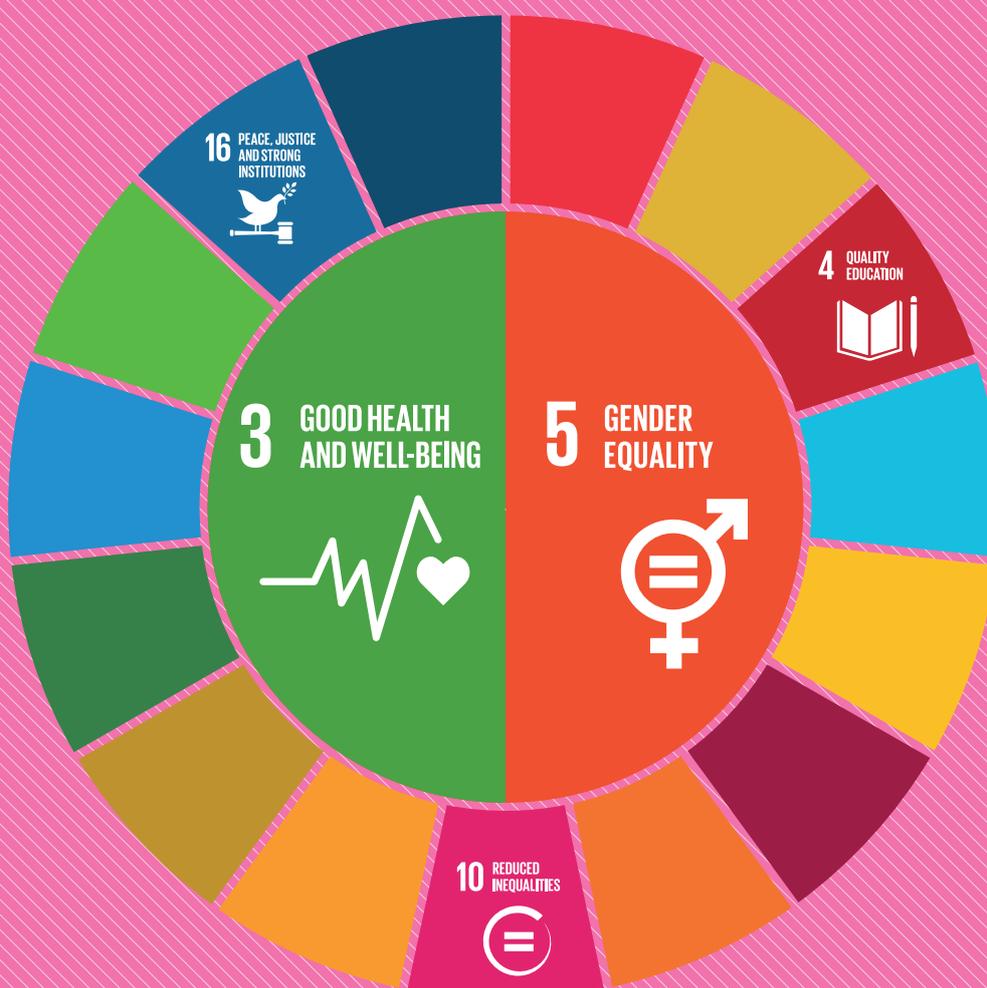
3 The impact of discriminatory values, norms and practices on women's health and well-being

Unequal power leads to unequal health

Links between gender inequality and other forms of discrimination

Current gender discriminatory values, norms and practices in the Region

Moving forward



3 The impact of discriminatory values, norms and practices on women's health and well-being

Gender equality refers to equal chances or opportunities for women and men to access and control social, economic and political resources (126). It means equal visibility, empowerment, responsibility and participation for women and men in all spheres of public and private life.

Gender equality is at the heart of human rights promotion and protection and countries are responsible under international law for ensuring equal rights for men and women. Despite this, women in the European Region continue to experience discrimination on the basis of their sex, with some being subject to multiple forms due to factors such as their age, ethnicity, disability, socioeconomic status, sexual orientation and gender identity (126). This is the conclusion drawn from measures of gender equality, including the World Economic Forum (WEF) Global Gender Gap Index, the UNDP Gender Inequality Index and the EIGE Gender Equality Index (81,91,127–129).

Unequal power leads to unequal health

The WEF Global Gender Gap Index benchmarks national gender gaps using four subindices – economic, political, education and health – to provide country rankings that allow for comparisons across regions and income groups in 47 of the Region's countries. Fig. 3.1 shows the results for 2015 for all countries from which data were available.

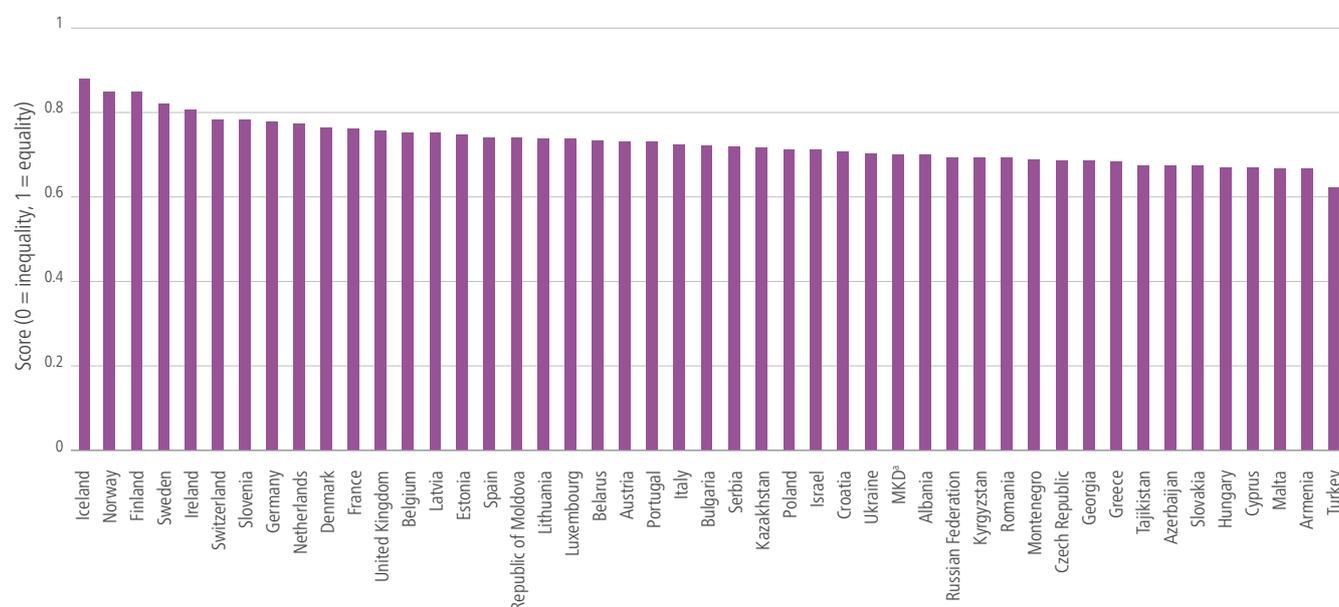
From a global perspective, European countries generally rank high, with the top five countries all being in Europe. Iceland has the smallest gender gap in the world according to this index, and Turkey ranks lowest among countries in the Region (globally ranking 130th of 145 countries). Looking at trends over time, the Region shows progression towards closing the gender gap. Most progress has been achieved in France and Slovenia.

Unequal treatment of women and men may have negative health consequences and is discriminatory in many instances. The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) definition includes direct and indirect discrimination in law or practice in all aspects of public and private life. Article 1 of CEDAW defines discrimination against women as (130):

Fig. 3.1.

Source: WEF (81).

Gender Gap Index



^a The former Yugoslav Republic of Macedonia (MKD is an abbreviation of the ISO).

... any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.

Direct discrimination is intentional and constitutes apparent exclusion, distinction or restriction of women's rights compared to men (131). Examples include sex-selective abortions or restricting women's access to contraception, both of which are discussed below. Examples with potential health consequences include unequal pay for equal work or less favourable treatment of an employee due to pregnancy.

Indirect discrimination occurs when apparently neutral legal standards or policies that do not seek to discriminate lead to consequences that, without justification, affect the enjoyment of rights by women disproportionately simply because they are women (131). The health system providing care based on a male standard, for example, may not appropriately address women's health needs (see Chapter 4 for further discussion on this). An example of indirect discrimination that affects women's health is the legal age of marriage. While it is 18 years in a majority of European countries, most of those same countries also allow for exceptions to the rule under defined circumstances, exceptions that

disproportionately affect women. Child marriage in the Region and its health effects are discussed below.

The principle of non-discrimination is at the core of all human rights protection and promotion and is regulated in international law. All Member States have ratified human rights treaties, committing them to eliminate discrimination in their national contexts. While most have enacted laws prohibiting discrimination in access to health care, many do not specifically recognize, or have practices for dealing with, discrimination on a range of grounds (such as sex, age, disability, religion or belief, race or ethnic origin, sexual orientation or gender identity) – what is referred to as multiple discrimination (132).

Links between gender inequality and other forms of discrimination

European research has shown that people with certain combined characteristics, such as women who are older and also from an ethnic minority background, may face specific and complex challenges in accessing health systems and receiving equal treatment. Some of these challenges may amount to discrimination. Key structural barriers include lack of translation and interpretation services, lack of communication support, specific financial, organizational, cultural and psychological barriers, and stereotyping by health care providers (132).

Gender inequality can intersect with other forms of oppression (such as gender identity, sexual orientation, ethnicity or disability) at different life stages, leading to specific and complex challenges in accessing health systems and receiving equal treatment (133). Without aiming to address all the intersections between different forms of discrimination, special attention is given below to how gender interacts with gender identity and sexual orientation and disability and ageing affect women's health and well-being. It is recognized that these interactions also affect men and men's health (133), but the focus is on women's health and well-being.

Gender identity and sexual orientation

Lesbian, gay, bisexual, trans and intersex (LGBTI) people are usually grouped for various purposes, but represent a very diverse population who face different challenges. A common concern, however, is the stigmatization and discrimination they face in everyday life (often referred to as minority stress) (134). Sexual minorities in European countries report substantially worse physical and mental health than their same-gendered heterosexual counterparts (135–138). Direct exposure to sexuality-based discrimination has been shown to be inversely linked to self-rated health and subjective well-being among same-sex couples in

Europe (139). Women in same-sex couples also seem to have greater risk for fatal breast cancer (140) and face mortality rates that are significantly higher than for women with a male partner (141,142). Mortality rates for transsexual people are about three times higher compared to controls, and transsexual women have around 10 times greater risk for suicide attempts compared to cisgender controls (143).

Many women in Europe undergo nonconsensual sterilization and genital operations. This includes trans women who are forced to undergo sterilization to have their gender legally recognized (see page 52 for examples of laws restricting sexual and reproductive health and rights in the European Region). So-called sex-normalizing surgical interventions on intersex babies occur in at least 21 EU Member States (144). Lesbian and bisexual women may also face barriers to receiving fertility treatment and experience discrimination during pregnancy (145,146).

Disability

The purpose of the Convention on the Rights of Persons with Disabilities is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and promote respect for their inherent dignity, including the right to attain the highest standard of health care without discrimination (147). People with disabilities report seeking more health care than those without and have greater unmet needs, with health promotion and prevention activities seldom targeting them. Women with disabilities, for example, receive less screening for breast and cervical cancer than those without (148).

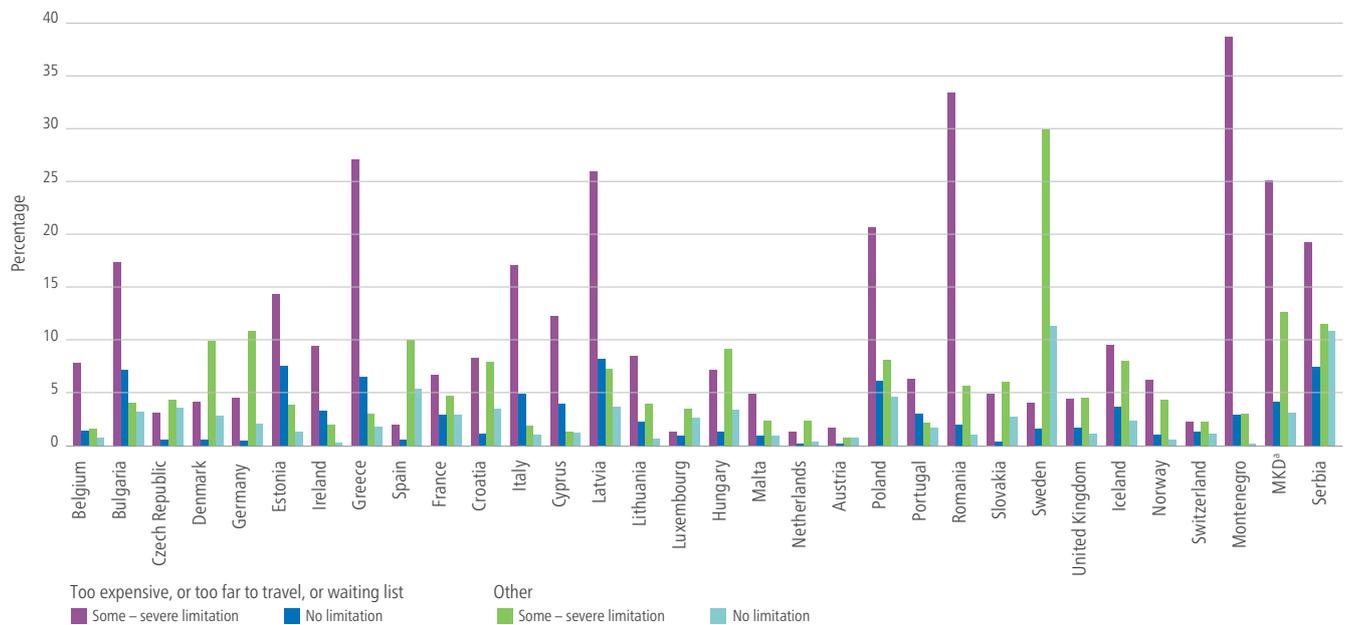
Fig. 3.2 presents differences among women aged 16–64 years in EU Member States in 2013 who reported unmet needs for medical examination because it was too expensive, too far to travel or because of a waiting list (149). Young women aged 18–24 in the EU in 2011 who had difficulties in basic activities were twice as likely to be early leavers from education and training than those with no difficulties. The employment rate for women aged 15–64 with difficulties in basic activities was 43.9%, compared to 60.7% for women with no difficulties (149). Data from the rest of the Region are difficult to find.

Ageing

Women comprise most of the older population, with the proportion being even higher for those aged 80 and older (150). EU data from 2013 show that older women in nearly all countries face a higher risk of poverty than older men (151). This reflects a legacy of wage and pension inequality in earlier years, social policies on pensions and family policies (65).

Fig. 3.2.

Source: Eurostat (149).

Women with disability and unmet need, 2013


^a The former Yugoslav Republic of Macedonia (MKD is an abbreviation of the ISO).

The risk of poverty is far higher for women in some countries: more than one third of poor older households in EU and European Free Trade Association countries, for example, are made up of women who live alone (ranging from 22% in Greece and the Netherlands to 81% in Norway) (151). On average, one third of older female single households are at risk of poverty, compared to one fifth for males; older people living in couple households have a lower risk of poverty than the average in most countries.

Women's quality of life, health and well-being later in life is a culmination of the earlier phases in life, possibly marked by gender stereotyping in girlhood and education, precarious and informal labour, costs of caring, interrupted career patterns and the motherhood pay gap, which measures the pay gap between mothers and non-mothers (the latter being defined in most econometric studies as women without dependent children). It also measures the pay gap between mothers and fathers. This is different from the gender pay gap, which measures the pay gap between all women and all men in the workforce (152).

Ageing is also associated with increasing prevalence of disability, with a steep increase seen in people aged 80 years and over, and functional limitations are higher in women in all older age groups. Between 25% and 50% have functional limitations affecting activities of daily living and instrumental activities of daily living, with the risk of falls increasing. Health effects and social consequences

of ageing are different for women: women's increased risk of low income in older age, for example, means they are more likely to live in unsafe places, reside alone and have less potential to adapt their homes to enable their independence (153–157). Women aged over 65 with lower educational attainment have shown increased risk of worsening in frailty state (weakness, weight loss, exhaustion, slowness and low activity) (158–160).

Current gender discriminatory values, norms and practices in the Region

This section focuses on specific forms of discrimination that exist throughout the Region and their effects on the health and well-being of women across the life-course.

Valuing girls

The first years are considered by many as the most critical period for a healthy life. While boys and girls need to be equally supported, girls' development and empowerment have clear consequences in breaking intergenerational cycles of inequities.

Governments are obliged as part of their human rights duties under the Convention on the Rights of the Child, Article 7 (37), to register all births and provide every new-born child with a birth certificate. Registering children at birth is the first step to securing their recognition in law and safeguarding their future rights in areas such as access to health care and education. Despite this, UNICEF estimates that in 2013, at least 700 000 under-5s in the Region did not have their births registered (161). There were no significant differences between boys and girls, although the proportion of non-registered girls was slightly higher.

A preference for sons is present in several European countries. This is one of the clearest manifestations of gender discrimination based on the different value given by society to girls and boys. The International Conference on Population and Development Programme of Action from 1994 (paragraph 4.16) called for the elimination of all forms of discrimination against the girl child and the root causes of son preference, which result in harmful and unethical practices regarding female infanticide and prenatal sex selection (162).

Although data on sex ratio at birth are fairly limited (163), the 2014 International Conference on Population and Development review found skewed ratios in Albania, Armenia, Azerbaijan, Georgia, Montenegro and Tajikistan (164). Sex ratio at birth is one of the variables used to generate the WEF Global Gender Gap Index health and survival score: 12 of the 20 lowest-ranking countries on this indicator globally are from the Region (81).

Patriarchal family systems nurture son-preference. Although the modernization of reproductive technologies has compounded the problem of gender-biased sex selection, it has not caused it (163). The United Nations interagency statement on preventing gender-biased sex selection provides an important basis for collaborative action in the Region, emphasizing an informed and systematic approach to addressing root causes (163).

Consistent differences in feeding practices between boys and girls at an early stage in life are observed in some parts of the Region. Boys in Kyrgyzstan, for example, are more likely to be breastfed until they are 2 years old (46% of boys against 8% of girls), as is the case in Tajikistan (41% of boys, 27% of girls). In Montenegro, 37% of boys are still breastfed after one year opposed to only 14% of girls. Differences in timing the introduction of solid and semi-solid foods in infants are also seen to favour boys in Kyrgyzstan and Tajikistan (165).

Child marriage

Child or early marriage is defined as a union, official or not, of two people, at least one of whom is under 18 years. It is a gendered phenomenon that affects girls and boys in different ways and is more prevalent among girls (166). Links between child and forced marriage – those in which at least one of the parties does not consent to the marriage – are strong.

Girls' right to be protected from child marriage is upheld in international instruments such as the Convention on the Rights of the Child and CEDAW, each of which calls for countries to legislate for a minimum marriage age of 18. Most countries in the Region have amended their legislation to reflect the Convention and CEDAW standards, but effective enforcement remains a challenge (130). A landmark resolution calling for a ban on child marriage was adopted by the United Nations General Assembly in 2014 (167).

A map illustrating the legal age of marriage in the Region is shown in **Fig. 3.3**.

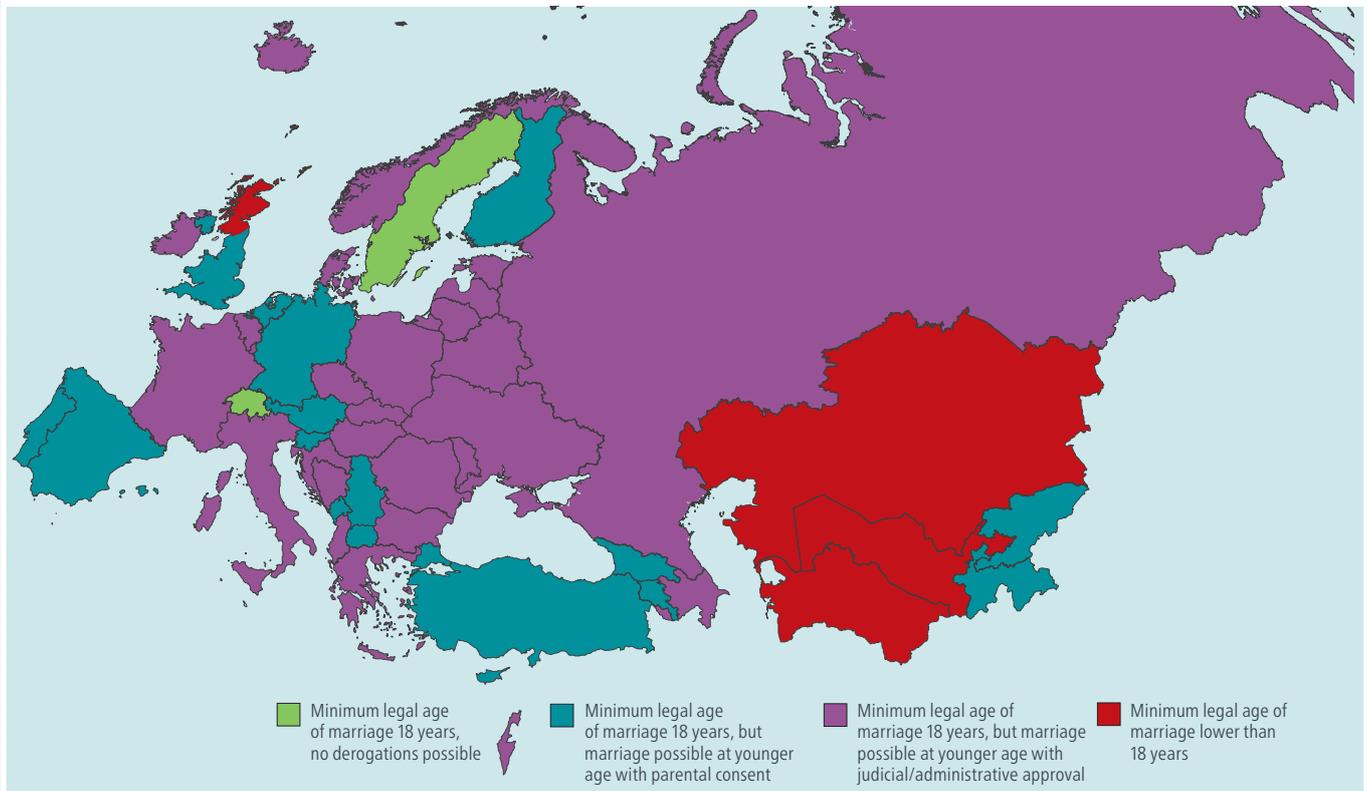
Estimates suggest that child marriage has been increasing in some parts of the Region (such as countries in central Asia and south Caucasus) since the political transition (166). Current data indicate that 10% of girls in eastern Europe and central Asia are married before the age of 18. The scope of child marriage is not fully known due to limited or outdated data in many countries (169–171).

Child marriage rates vary widely in the Region (19% in the Republic of Moldova, 14% in Azerbaijan and Georgia, 5% in Serbia) (169–171). Practice also varies among social groups within countries. Girls living in rural areas and in lower wealth quintiles, for instance, are more likely to be married before 18 (169) and some

Fig. 3.3.

Source: UN Women (130); United Nations Statistics Division (168).

Marriageable age, European Region



migrant communities, Roma and travellers are known to have higher rates of child marriage than the general population (170). Research suggests that among Serbian Roma, for example, 44% of 15–19-year-old girls are married or in a union, with 14% being married before they were 15 (169).

From a rights perspective, a number of serious concerns about child marriage for girls arise. These include restrictions on personal freedom and development, reduced educational opportunities and limitations to girls' right to health, including reproductive health and psychological well-being.

Child marriage for girls has a number of negative health impacts (170,171), including:

- being more likely to be forced into sexual intercourse;
- being more likely to experience domestic violence and abuse perpetrated by the husband and/or husband's family members and less likely to take action against the abuse;
- having poor psychological well-being through being denied an appropriate childhood and adolescence;

- being vulnerable to poorer sexual and reproductive health: for instance, girls in child marriages face an increased probability of early pregnancy and sexually transmitted infections, including HIV, as they often lack the status and knowledge to negotiate safe sex and contraceptive practices with their older partner;
- being more likely to face complications from pregnancy and childbearing; and
- having no access to adequate health and contraceptive services due to geographic location or the oppressive conditions of their lifestyle.

Sexual and reproductive health and rights are at the very core of gender equality

Women and men need to be empowered to make free and informed choices about their sexuality and sexual and reproductive health to attain the highest standards of health. Human rights relevant to sexual and reproductive health are defined in international legal treaties and implementation is monitored at national and international levels.

WHO defines sexual health as (172):

a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

Sexual and reproductive rights are human rights related to sexuality and are derived from a number of human rights principles – particularly the principle of non-discrimination – affirming the freedom, equality and dignity of all people. As provided through international human rights treaty monitoring mechanisms and European case law, these principles include the right to: equality and non-discrimination; life, liberty and security of the person; autonomy, bodily integrity and informed consent; freedom from torture and cruel, inhuman or degrading treatment or punishment; privacy; the highest attainable standard of health; information; education; marry and found a family; the equal right (of women) in deciding freely and responsibly on the number and spacing of their children (and having access to the information, education and means to enable them to exercise these rights); freedom of thought, opinion and expression; freedom of association and peaceful assembly; participation in public and political life; recognition as a person before the law; and a fair trial.

Specifically, CEDAW requires countries to ensure that men and women have the same rights to decide freely and responsibly on the number and spacing of their children, and to have access to information, education and means to enable them to exercise these rights (130).

Many Member States have made substantial progress in improving key sexual and reproductive health indicators over the past 15 years. The average perinatal mortality rate for the Region, for instance, declined by nearly a quarter, from 9.5 perinatal deaths per 1000 births in 2000 to fewer than 7.4 in 2013. The average estimated maternal mortality ratio decreased by more than half, from 33 maternal deaths per 100 000 live births in 2000 to 16 in 2015. The contraceptive prevalence rate, using modern methods, increased slightly from 55.6% in 2000 to 61.2% in 2015, mostly as a result of increases in eastern and southern Europe (173). The abortion ratio in the Region fell from 431 per 1000 live births in 2000 to 234 in 2013.

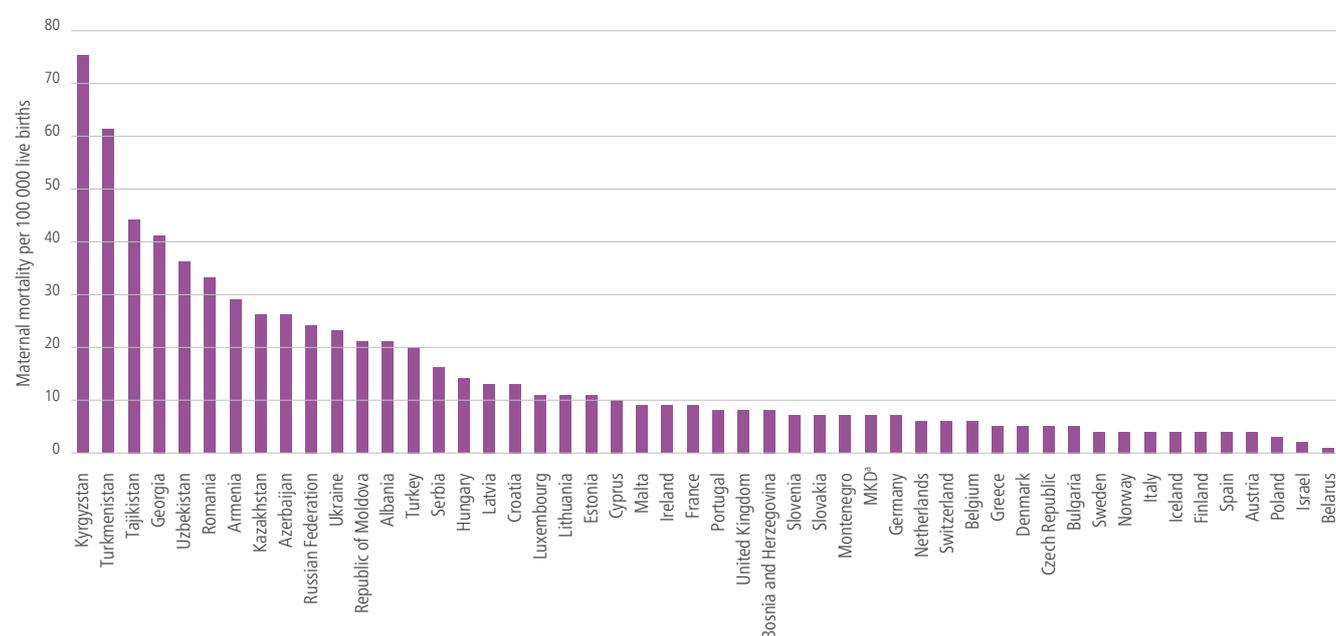
Although the overall picture is generally positive, caution should be exercised when interpreting data, since the regional averages frequently hide substantial variations within and between countries. The estimated maternal mortality ratio, for example, is 25 times greater in some countries of the Region than others, and perinatal mortality is up to 10 times higher (6).

While the rate of maternal mortality in Nordic countries is 4.19 deaths per 100 000 live births, it is almost tenfold higher in the CARINFONET group at 40.9 (Fig. 3.4).

Fig. 3.4.

Source: WHO Regional Office for Europe (6).

Maternal mortality per 100 000 live births, European Region



* The former Yugoslav Republic of Macedonia (MKD is an abbreviation of the ISO).

This difference means that a risk of death during pregnancy, labour and birth that has almost been eliminated in some countries in the Region remains a threat to women's lives in others. Unmet family planning needs in Member States, based on the latest year available, ranges from 5% to nearly 23% (6).

Data on within-country variation usually show disparities in relation to place of residence (urban versus rural), wealth quintile, level of education and ethnicity.

Little or no systematic information is available for several important aspects of sexual and reproductive health, such as the prevalence of infertility and sexually transmitted infections, access to and quality of services, and methods for measuring the as yet ill-defined concept of sexuality-related well-being. Examples of laws restricting sexual and reproductive health and rights in the Region are shown in [Box 3.1](#).

Box 3.1.
Laws restricting sexual and reproductive health and rights in the European Region

Same-sex relations are illegal in Turkmenistan and Uzbekistan (between men only), while Lithuania and the Russian Federation have adopted laws penalizing so-called anti-homosexuality propaganda. In 2013, Belarus, Georgia, Latvia, Kazakhstan and Ukraine considered calls or proposals for such laws (none of which has as yet come to pass), while the parliaments in Armenia, Hungary and the Republic of Moldova rejected such propositions. Currently, a similar law is being considered by the parliament in Kyrgyzstan.

Abortion is illegal in Andorra, Malta, Ireland and San Marino, but may be permitted to save a woman's life in all of these countries except Malta. Abortion is only permitted under some restricted circumstances in Monaco and Poland.

Legal gender recognition, represented through documents reflecting a person's gender identity, is important for protection, dignity and health. Many countries in Europe impose a number of conditions on changing documents, including the requirement to undergo sterilization. Procedures for legally changing gender in Austria, Belarus, Estonia, Denmark, Germany, Iceland, Ireland, Italy, Malta, the Netherlands, Poland, Portugal, Spain, Sweden and the United Kingdom do not request sterilization.

Sources: Carroll & Itaborahy (174); Center for Reproductive Rights (175); Transgender Europe (176,177).

Gender stereotypes and conservative norms regarding the acceptability of sexual activity, particularly among young people, determine social expectations and behaviour and have an effect on health. Stereotypes include young men being sexually free, gaining experiences and being in control, while young women are expected to protect their virginity and be controlled. Heterosexuality is taken for granted for both sexes (178).

The health impact of these gender stereotypes include girls' later initiation of sexual intercourse (179) and expectations that women and girls should take

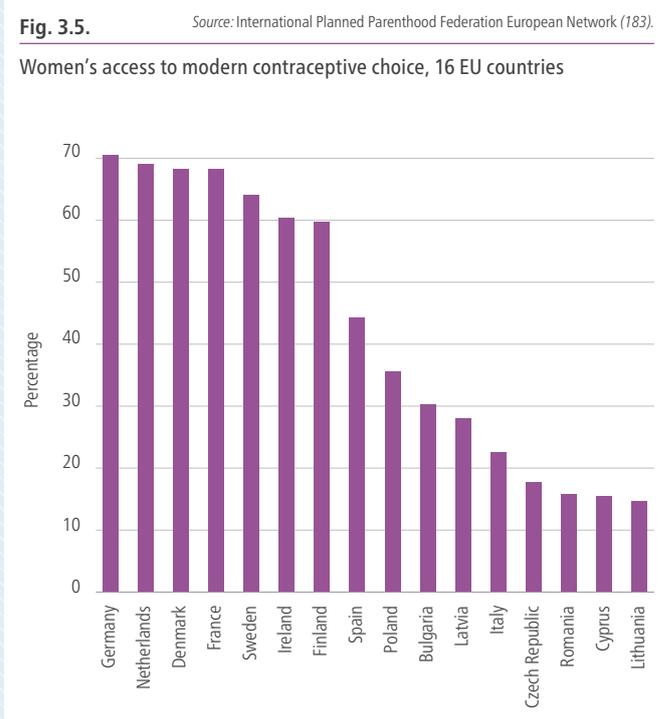
responsibility for contraception (178). The high value placed on virginity in some countries and cultures can make it difficult for adolescent girls to access information and services. Fear of stigma, gender-based violence (such as forced early marriage or rape) and concerns about provider confidentiality can also impede adolescents from seeking help and using sexual and reproductive health services (180,181). Abortion rates among adolescents can partially reflect girls' limited ability to access and negotiate the use of contraception due to gender inequalities (182).

A study undertaken in 16 EU countries looked at women's access to modern contraceptive choice from a gender equality and human rights perspective (183). The study rated countries across eight policy benchmarks: policy-making and strategy; general awareness of sexual and reproductive health and rights and modern contraceptive choice; education on sexual and reproductive health and modern contraceptive choice for young people and young adults; education and training of health care professionals and service providers; provision of individualized counselling and quality services; existence of reimbursement schemes; prevention of discrimination; and empowering women through access to modern contraceptive choice. Fig. 3.5 shows the results of this study, indicating significant differences among countries in the Region on how women's access to contraception is approached and implemented.

Eliminating gender-based violence against women

Gender-based violence against women remains one of the most pervasive human rights violations of current times. It affects society as a whole, has major public health consequences and constitutes an obstacle to women's active participation in society.

The European Convention on Preventing and Combating Violence against Women and Domestic Violence defines violence against women as a violation of human rights and a form of discrimination. The definition includes all acts of gender-based violence that result in, or are likely to result in, physical, sexual, psychological or economic harm or suffering to women, including threats of such acts, whether occurring in public or private life. Examples of situations under this definition include psychological violence,



stalking, physical and sexual violence (including rape), forced marriage (and its civil consequences), female genital mutilation, forced abortion and sterilization, sexual harassment and unacceptable justifications for crimes, including so-called honour crimes (184).

WHO estimates that one in four women in the Region will experience violence on the basis of gender at one point in their lives at least. This estimate covers the lifetime prevalence of physical and/or sexual intimate-partner violence for ever-partnered women from the age of 15 in the Region, which ranges between 23.2% and 25.4% (185).

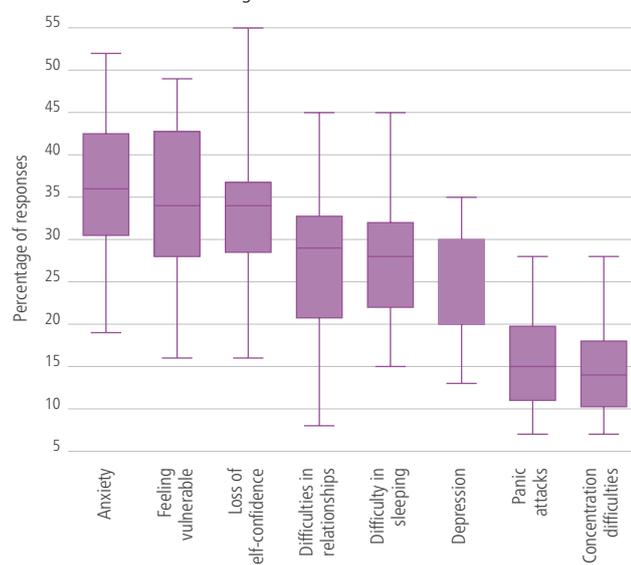
Violence has serious effects on women's physical and mental health, leading to physical trauma and injury, death, disability and poor maternal and perinatal health outcomes, and psychological trauma, stress and depression. Analyses show that intimate-partner violence is a major contributor to women's mental health problems, with women who have experienced it being almost twice as likely to develop depression than those who have not and having almost double the risk of alcohol-use problems (185). The longer-term health and psychological consequences of interpersonal violence match some of the conditions identified in this report as broad causes of DALYs among women, including depression, anxiety, feeling vulnerable and difficulty sleeping (Fig. 3.6) (186).

Gendered social and cultural norms (including beliefs that men have the right to control women and girls and that violence is a private family matter) and

harmful traditional practices may lead to girls experiencing maltreatment and violence from an early age. Maltreatment and other adverse experiences in childhood have far-reaching consequences on mental, reproductive and physical health and social outcomes for girls. Maltreatment is very common, with 13.4% of women reporting having been sexually abused when under 18 years and the prevalence of physical and emotional abuse being 22.9% and 29.1% respectively. Gender-based violence against women starts early in life and there is growing evidence of the intergenerational transmission of violence, with victims being more likely to drift into abusive relationships as women and perpetrate maltreatment on their children (187).

Fig. 3.6. Source: European Union Agency for Fundamental Rights (186).

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



While violence against women happens in all settings, is irrespective of age, socioeconomic status or educational background and occurs across religious and cultural groups, important differences relating to the characteristics of girls and women experiencing and perpetrating violence continue to exist (186). Risk factors include social isolation, harmful alcohol use, being a victim of child maltreatment, and unfavourable gender and violence norms and attitudes (188). Women's education, membership of the formal workforce, property ownership rights for women and strong legal frameworks against violence are protective factors (189). Gender-based violence is not limited to any age group and therefore does not stop once people reach a certain age. A study of violence among women aged 60 and over showed that 23.6% faced emotional abuse, 2.5% physical abuse, 3.1% sexual abuse and 28.1% any form of abuse (190).

A survey of women in the EU (186) produced the following findings relating to socioeconomic differences and violence.

- Women aged 18–29 reported the highest prevalence rates of intimate-partner (6%) and non-partner violence (9%) over the previous 12 months.
- Differences in education levels of victims/survivors of intimate-partner violence were not significant, but the partner's education level was associated with prevalence, increasing from 6% among women whose partner had tertiary education to 16% where the partner had not finished primary education.
- A large difference in reported prevalence of non-partner violence was found among women of different occupations. The highest level (28–30%) was for professionals, managers, directors and supervisors; rates were lower among those doing skilled manual work (17%) or who have never had paid work (13%).
- The reported prevalence of intimate-partner violence differed across urban/rural settings, with the highest prevalence (27%) found among women in suburban areas and the lowest (18%) in those living in the countryside. This pattern was also found for non-partner violence, with 31% for women in suburban areas and 17% in the countryside.

These and other characteristics, such as belonging to a minority group, may also lead to lower health-seeking behaviours after experiencing violence. A general lack of contact with health systems among some minority groups (such as Roma) creates challenges in measuring and addressing the problems of violence among women in these groups. Cultural differences, gender-biased attitudes within the health care system and possibly the lack of health insurance or documentation, coupled with an associated fear of stigmatization and deportation, may create barriers to accessing health systems (191).

Specific forms of gender-based violence against women are summarized in [Box 3.2](#).

Box 3.2.**Specific forms of gender-based violence against women****Female genital mutilation**

While female genital mutilation is practised mainly in specific countries in Africa and the Middle East, women in Europe with roots in these countries are either living with, or at risk of being subjected to, the practice. National reports are available for some European countries, but there is at present no comparable data for estimating prevalence and risk at European level. The most common health consequences are severe pain, shock, haemorrhage, oedema and infections. In the longer term, it can cause repeated urinary tract infections, painful menstruation and abscesses.

Sources: WHO (192); EIGE (193).

Forced or coerced sterilization

European human rights bodies continue to investigate reported cases of forced or coerced sterilization of women in the Region. The cases mainly concern poor women, those from ethnic minorities (particularly Roma) and women with intellectual disabilities. Forcefully ending a woman's reproductive capacity may lead to social isolation, abandonment, fear of health professionals and lifelong grief.

Source: Open Society Foundations (194).

So-called honour killings

Murders in the name of so-called honour is a specific form of femicide increasingly debated in the European context. Certain cultural norms and beliefs are causal factors and perpetrators often view it as a way to protect family reputations, follow tradition or adhere to wrongly interpreted religious requirements. Crimes committed in the name of honour are also linked to other forms of family violence. They are usually committed by male family members as a means of controlling women's sexual choices and limiting their freedom of movement.

Source: WHO (195).

Bride kidnapping

Marriage by abduction, although illegal, continues as a traditional practice in some parts of the Region, particularly in central Asia, and within some minority groups. The marriages are usually forced and involve girls under 18 years marrying an adult man. Forced or servile marriages are considered a contemporary form of slavery under international law.

Sources: United Nations Population Fund Eastern Europe and Central Asia Regional Office (166); Girls Not Brides (196); United Nations (197).

Trafficking in women

Victims of trafficking in the Region are predominantly adult women (62% in western and central Europe and 77% in eastern Europe and central Asia), with trafficking in girls less frequent. Most detected victims of trafficking in the Region are subjected to sexual exploitation. Health and other effects of trafficking include mental health problems, physical and/or sexual abuse, forced or coerced use of drugs or alcohol, social restrictions and stigma, economic exploitation and legal insecurities.

Sources: United Nations Office on Drugs and Crime (198); WHO (199).

Linking gender stereotypes, discrimination and health

Gender stereotyping is the practice of ascribing to an individual woman or man specific attributes, characteristics or roles by reason only of her or his membership of the social group of women or men (200). It begins early and has lifelong implications for girls' health in relation to expectations and opportunities. Recent research suggests that adults attribute degrees of femininity and masculinity to babies solely by the pitch of their cries (201). This is reflected throughout childhood in how children dress, play and learn, including the hobbies and interests they are encouraged to pursue.

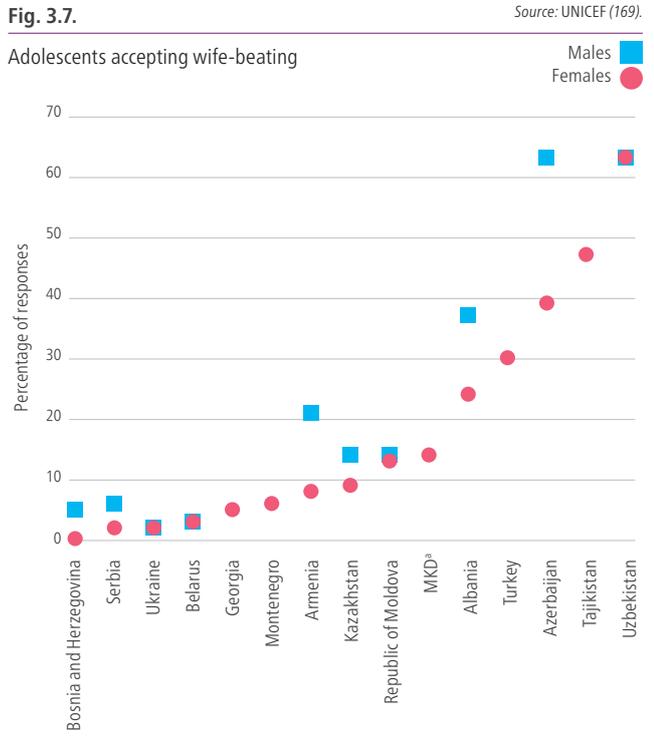
Gender stereotypes are simplistic generalizations about gender attributes, differences and the roles of individuals and/or groups. They can be positive or negative but affect the life expectations, opportunities and experiences of both women and men in education, work, relationships, social status and health and well-being (202).

The regional review of progress for Beijing +20 identifies discrimination and gender stereotypes as a stubborn issue requiring ongoing attention and action (42).

Gender stereotypes usually attributed to women include being emotional, irrational, gentle, dutiful, weak and not smart, while men are seen as rational, factual, ambitious, strong, disciplined and responsible. Stereotypical traits for girls emphasize obedience, diligence, calmness and creativity, while boys are seen as being naughty, playful, disorderly and lazy. In general, women and girls are expected to care more for their physical appearance than men (203).

Gender stereotypes have many effects on women's social and economic lives. They have negative consequences on health in terms of self-confidence and well-being, particularly in relation to worries about physical appearance, which may cause girls and young women to develop eating disorders and other mental health problems such as depression and anxiety. Stereotypes and sexism also pave the way for certain forms of oppression, such as sexual harassment and gender-based violence (204), and can affect health system responses through under- and overdiagnosis of some conditions, affecting health outcomes for women and men (205).

Gender stereotypes of masculine and feminine identities underpin attitudes towards violence. Fig. 3.7 shows the percentage of boys and girls aged 15–19 years who consider a husband to be justified in hitting or beating his wife for at least one of the following reasons: if she burns the food; argues with him; goes out without telling him; neglects the children; and refuses sexual relations. The study from which these figures emerge provides important insights into the potential health effects of negative and discriminatory attitudes towards women, including the acceptability of such attitudes among women (169).



*The former Yugoslav Republic of Macedonia (MKD is an abbreviation of the ISO).

EU survey data on sexual harassment reported higher prevalence rates in countries where the gender gap is smaller. On average, 55% of women in the EU have experienced sexual harassment since the age of 15, ranging from 81% in Sweden (80% in Denmark and 75% in France) to 32% in Poland and Romania and 24% in Bulgaria (186).

School settings, including pre-school, are important contexts for the construction of gender stereotypes through children's interactions with teachers and peers. Contributing factors in education practice include the curriculum, school reading materials, school organization and management, teacher attitudes, assessments, co-education and single-sex settings.

Gender differences among teachers are also important: a large majority of teachers in primary and lower-secondary education in EU countries are women, but the proportion in upper-secondary education settings decreases noticeably. In higher-level education, male teachers predominate in all EU countries (206).

The impact of early gendered stereotypes is reflected in adolescent girls' educational choices and opportunities. They may, for instance, choose general education and humanities rather than sciences, and legislation in some countries limits young women's vocational training in male-dominated professions (42). The disproportionate participation of women in caring roles (paid and unpaid) is influenced by traditional stereotypes attributing the caring role in families and societies to women.

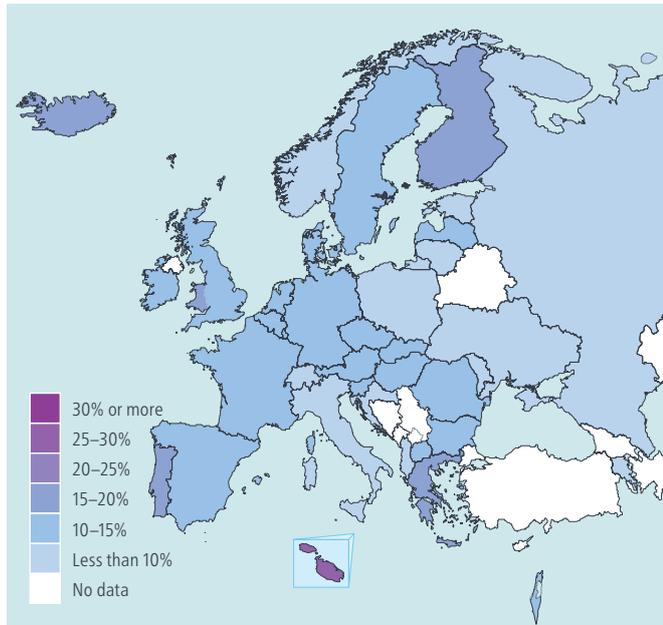
The HBSC survey concludes that gender stereotypes drive girls in all countries surveyed to think they are too fat, a finding that increases with age from 11 to 15 years. Forty-three per cent of 15-year-old girls in the 2014 HBSC survey were unsatisfied with their bodies – almost double the rate for boys in the same age category – and 26% reported being on a diet, even though only 13% were overweight (compared to 11% of boys being on a diet and 22% being overweight) (Fig. 3.8). Attempts to lose weight are a common feature of girls' lifestyles by the time they are 13 and increase with age (28).

Fig. 3.8.

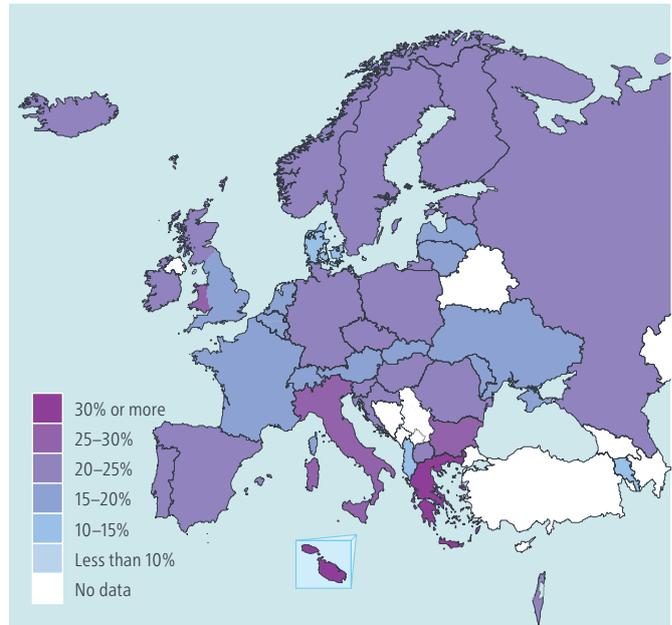
Source: Inchley et al. (28).

Body image

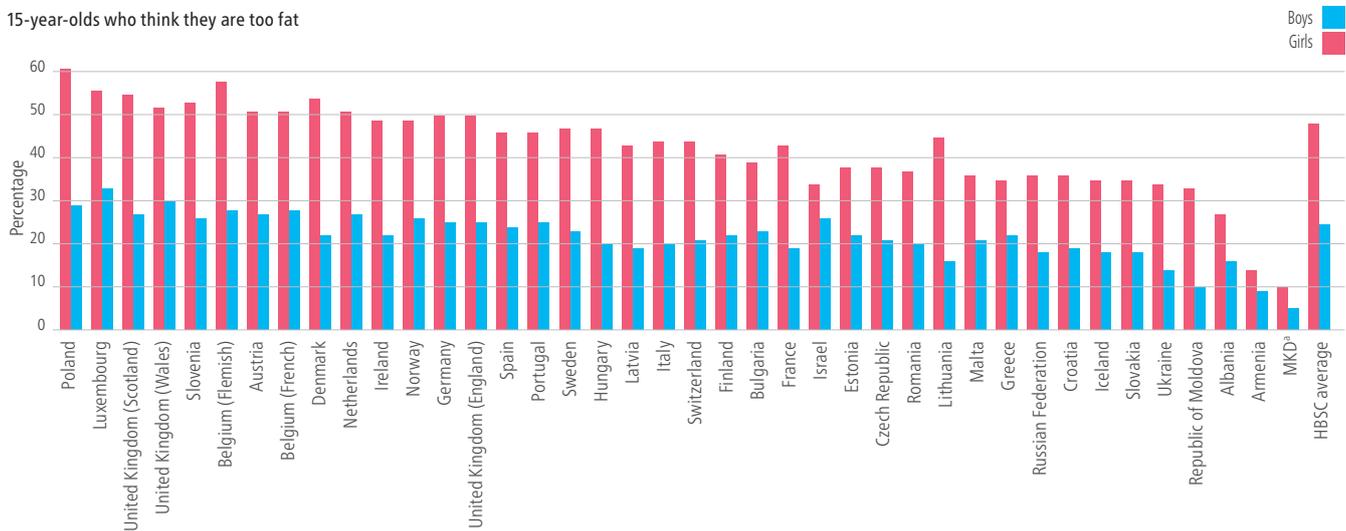
15-year-old girls who are overweight or obese



15-year-old boys who are overweight or obese



15-year-olds who think they are too fat



*The former Yugoslav Republic of Macedonia (MKD is an abbreviation of the ISO).

Eating disorders among adolescents is an important public health concern and a cause of much anxiety for families and friends. Anorexia nervosa has a prevalence rate of 0.3% among young women and a high mortality, but only 30% of young women with anorexia are treated by the health system. Bulimia has a prevalence of 1% in this group (207).

Links between gender stereotypes and reduction of physical activity are worth exploring. Physical activity levels begin to decrease significantly between ages 11 and 15 in most European countries. The decrease for girls between 11 and 13 is steeper than it is from 13 to 15. Boys continue to be significantly more active (28), suggesting that opportunities to participate in physical activity may be gender-biased in favour of boys. Traditional gender norms about teenage girls and women not participating in organized physical activity may act as a barrier (55).

Moving forward

Gender-biased values and social and cultural norms and stereotypes that are discriminatory and/or harmful translate into practices that affect girls' and women's health and well-being. These include boys being valued over girls, beliefs that men have the right to control women and girls, harmful traditional practices, violence, limits being placed on women's education and occupation choices and opportunities, gender-based stereotypes, and institutional biases that may perpetuate discriminatory values, norms and practices.

Actions that can be identified as important in addressing these challenges and moving forward to develop strategies and action plans relevant to women's health in Europe include:

- a. developing and implementing multisectoral policies that promote the value of girls and women and eliminate harmful practices and gender-based violence;
- b. increasing health service providers' capacity to eliminate practices that damage girls' and women's health and violate their human rights;
- c. implementing health promotion interventions that project a positive and strong self-image for all girls and women;
- d. developing innovative and rights-based programmes aimed at transforming gender norms and empowering girls and women through comprehensive sexuality education; and
- e. identifying and addressing institutional biases that may perpetuate gender-based discrimination (intended and unintended) in areas such as education, employment, social protection mechanisms, pension schemes and health insurance policies.

4 People-centred health systems responding to women's health: what do they entail?

Moving towards gender-balanced evidence on health system responses

Meeting women's needs through gender-transformative health services

Rethinking women's access to safe and appropriate medicines

A gender-balanced workforce in formal and informal care

Gender-sensitive financing mechanisms

Moving forward



4 People-centred health systems responding to women's health: what do they entail?

Evidence on burden of disease presented in Chapter 1 shows that women in the Region are largely affected by cardiovascular disease, cancers and mental ill health. Previous chapters demonstrate that many determinants of women's health lie outside health systems and therefore require intersectoral action.

Health systems are nevertheless essential to improving women's health and well-being. Evidence from the global Commission on Social Determinants of Health highlighted that health systems can have a positive effect on population health beyond treatment and prevention of disease and, importantly, can promote health equity (34). The gender framework underpinning this report identifies biases in health systems as a determinant of health.

Universal health coverage is at the centre of the 2030 Agenda. Women's biological and gender-based needs, access to resources and the impact of their role as carers makes it important for policy-makers to incorporate women's health needs into universal health coverage goals (208).

People-centred health systems that respond to women's health needs should address comprehensively the links between biology, gender and social determinants throughout the life-course. They should reflect issues such as participatory governance, sustainable financing, the availability and acceptability of services, upskilling of the workforce, appropriate exemptions and entitlement policies, responsible use of medicines and technologies, and research priorities that are gender-responsive rather than gender-biased.

Equally important is ensuring that health systems are not gender-blind, but are designed to promote gender equity in the health sector, particularly among carers (formal and informal). In doing so, they will serve as examples to other sectors and extend their role in addressing women's health needs beyond enabling nondiscriminatory access to services.

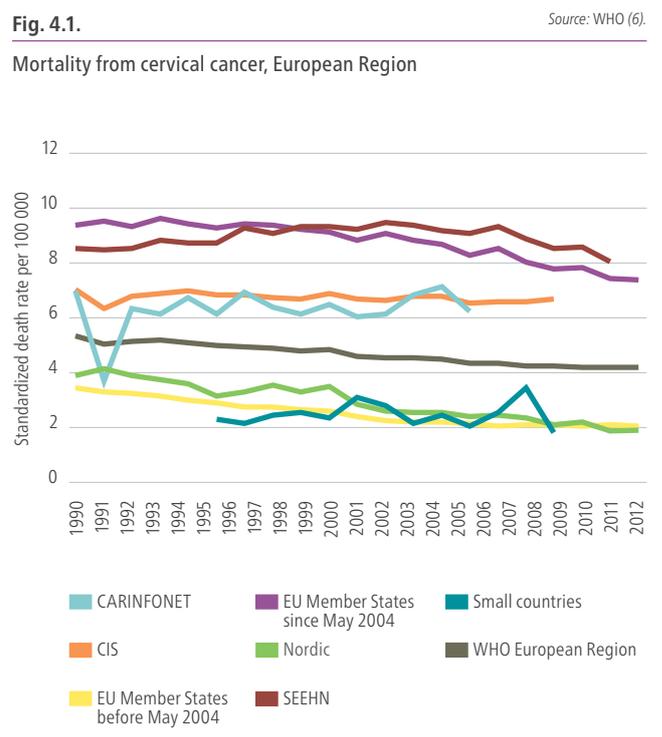
Health systems should also address the broad continuum of the life-course of women, as recognized by the Minsk Declaration: a life-course approach for health and well-being builds on the interaction of multiple promotive, protective and risk factors throughout people's lives (209). Addressing women's health through a life-course approach is important not just for women, but also for their children through the intergenerational effect of women's health.

Moving towards gender-balanced evidence on health system responses

Services still have a long way to go to meet women's biologically specific health needs. As reflected in Chapter 3, discriminatory values and gender inequities contribute to considerable differences across the Region in access to contraception, rates of maternal mortality and prevalence of gender-based violence. Disparities in health service responses to women's conditions were illustrated in Chapter 1, which emphasized the differences in mortality from breast cancer; they can further be illustrated by differences in survival rates for cervical cancer, despite widespread cervical screening and improvements in treatment (Fig 4.1). Women in south-eastern Europe show an almost four times higher risk of dying as a result of cancer of the cervix and uterus than those in Nordic countries, mainly because of the relative lack of effective prevention and early detection and treatment programmes, and unequal access to those that do exist (210).

Attention to women's differential physiological risk profiles and consequently to specificities required for therapeutic approaches has been gaining interest, with growing demand for gender analysis. The perception of risk for cardiovascular disease in women, for example, is low, despite it being the main cause of mortality for women in the Region (see Chapter 1). A recent review of risk and outcomes of adult cardiovascular surgery highlighted that women, especially those over 55 years, have higher risks for postoperative morbidity and mortality (211). Some of the underlying reasons remain incompletely understood, but the authors noted that women present with different symptoms to men and that diagnostic guidelines are neither gender-sensitive nor reflective of these differences. Women are also at greater risk of diabetes complications than men, with a 50% higher risk of mortality. The authors conclude that being a woman is an independent risk factor following heart surgery and highlight the importance of research that explicitly examines biological and gender differences relating to cardiovascular disease.

Recent data examining incidence of, and mortality from, stroke in the Region highlighted some gender specificity in survival rates that was not linked to incidence and could not be explained by other determinants (212).



The evidence points at least in part to health system responses to women's health, with study results suggesting that poorer survival of women in the north of Sweden may be due to the provision of hospital services.

This evidence highlights the extent to which assumptions on women's health guide research agendas, diagnosis, therapy and, consequently, therapeutic outcomes. Health systems appear to respond inadequately to women's health needs by failing to recognize changing risks over the life-course, such as the disappearance of the protective effect against cardiovascular disease after menopause (15).

Somewhat more (but still not enough) is known about the way in which biological features determine difference in the effects of risk factors such as alcohol and tobacco on men and women (213). Evidence shows that women may experience more severe signs of nicotine withdrawal and nicotine replacement therapy is less effective with female smokers (214).

Research in France showed that older women's ability to access effective treatment for breast cancer depended on the characteristics of the treating physicians, such as specialty, sex and perception of the age at which patients become elderly (215). Variation in treatment due to physician perceptions highlights the lack of age- and gender-specific guidelines on treatment of noncommunicable diseases, specifically cardiovascular disease, cancers and mental health disorders.

Recognizing this shortcoming, the Standing Committee of European Doctors adopted a policy on sex and gender in medicine in April 2016 (216). The policy states that: "currently medical research and healthcare fail to appropriately take into account the specificities of men and women to diagnose and treat patients." It points to considerable differences in cardiovascular disease between men and women that have not been taken into account.

Meeting women's needs through gender-transformative health services

The WHO Gender-responsive Assessment Scale (217) describes gender-transformative actions and policies as those that address the causes of gender-based health inequities by including ways to transform harmful gender norms, roles and relations. The objective of such programmes is often to promote gender equality and foster progressive changes in power relationships between women and men.

Gender roles, including power relations between men and women, shape the type of responses and experiences of women (and men) as health service users (218). Women's needs for health services are determined by their specific

biology, how this is shaped and determined by gender relations and roles, and its interaction with social determinants. Interactions between these factors change across the life-course, meaning that needs for, and use of, health services differ substantially between women and men from childhood, through adolescence and the reproductive years, into older age. The selection, design, organization and management of health and social services should therefore take into account gender norms, roles, power relations and cultures to respond to the health needs of women, including and beyond maternal health.

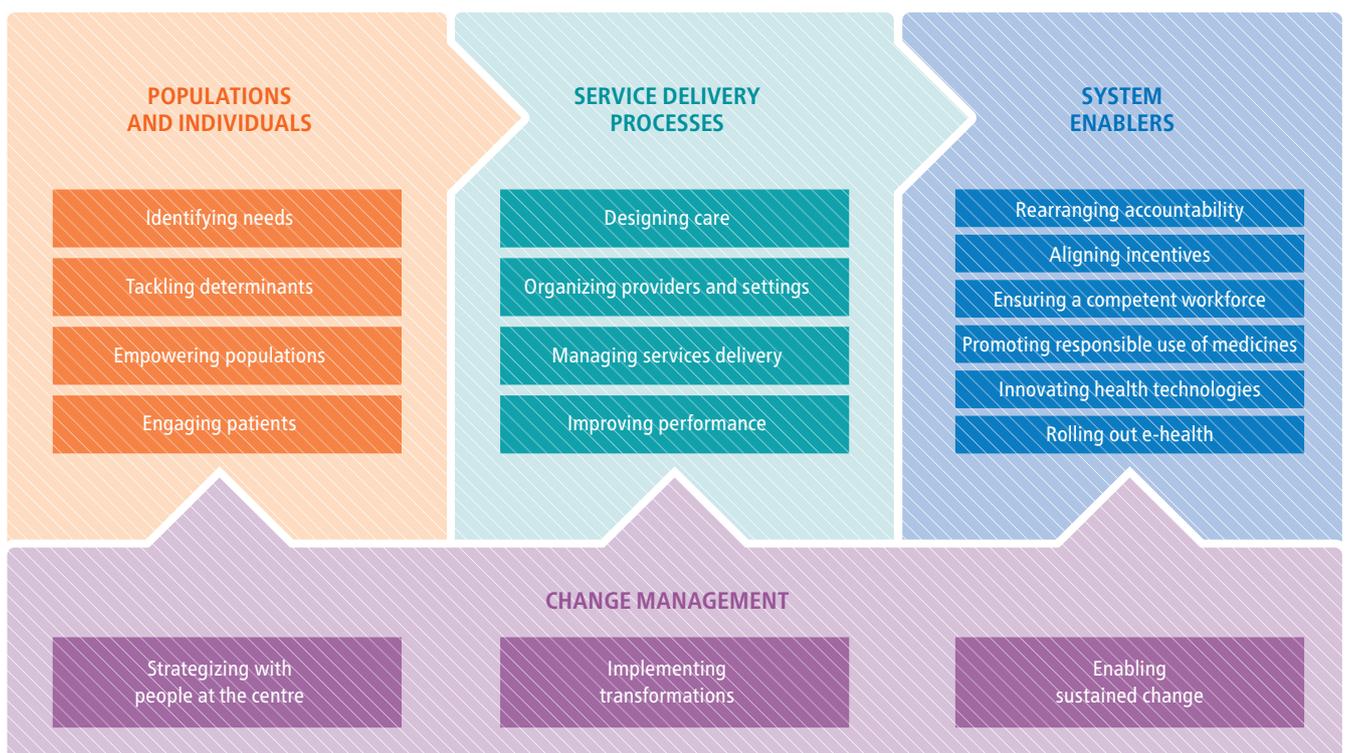
WHO's new framework for action on integrated health services delivery in Europe places people at the centre (Fig. 4.2) (219). It recognizes the importance of tackling determinants, empowering populations and engaging patients (220). Engaging women to ensure their needs and perspectives as users, patients and carers are at the centre of health service delivery needs to be an essential part of realizing this vision.

The framework recognizes that the delivery of health services should take direction from, and be developed on, identified health needs. Applying a gender analysis (218) through the framework ensures that services take into consideration women's access to resources, the impact of division of labour, social norms and the decision-making process.

Fig. 4.2.

Source: WHO Regional Office for Europe (219).

Overview of the European framework for action on integrated health services delivery



A full gender analysis of health services delivery is beyond the scope of this report, but an area that needs to be highlighted (due to limited attention being paid to it to date) is health promotion. A review of tobacco and alcohol interventions targeting girls and women (221) found limited understanding of a gender-sensitive approach. Health promotion materials rely in many instances on gendered norms by, for example, perceiving women as carers or perpetuating gender stereotypes in which women are portrayed as being concerned primarily with their body image. Anti-alcohol and anti-tobacco campaigns that target women commonly highlight the links between the risk factor and issues such as weight and appearance: campaigns to reduce female drinking, for example, often highlight the calorie intake linked to alcohol (222), while anti-smoking campaigns tend to explicitly link tobacco to skin ageing. They may also ignore the interaction between gender and social and economic determinants of individual behaviour: campaigns targeting drinking during pregnancy, for instance, may place the sole responsibility on women or take a judgemental approach.

Transformative health promotion builds on understanding gender as a determinant of health and outlines a continuum of actions that address gender and health by recognizing women's rights and realities. It also tackles gender roles at societal, and not solely individual, level (223).

Health services can become more gender-sensitive by ensuring that the frontline health workforce is competent in recognizing individual needs and social circumstances. The competencies identified by Langins & Borgemans (224) call for a health workforce that equally advocates for patients, communicates effectively, works with people and teams, and continuously updates and develops its knowledge and expertise to deliver people-centred services. Accessing health services involves social interactions between patients and health workers in which societal power relations and the interplay of ideas (such as gender) shape patients' experiences (225). The health workforce must therefore be prepared appropriately to take social and cultural complexities into consideration if it is to deliver safe and appropriate care, which means considering gender, sexuality, the life-course, health and socioeconomic status, education level and gender identity. A health workforce prepared by services to pay special attention to gender roles, including the power relations between men and women, can not only shape the type of responses and experiences of women (and men) as recipients of care (218), but also help ensure greater responsiveness and better health outcomes (226).

Rethinking women's access to safe and appropriate medicines

In addition to poor clinical decision-making around treatment and the inability to diagnose and address complexities in women's health, women's lack of

participation in research affects their access to safe and appropriate medicines. Medicinal products are safer and more effective when clinical research includes diverse population groups, but women remain underrepresented in clinical trials (227,228).

A review of clinical trials in Europe focusing on cardiovascular disease and risk factors highlights the smaller percentage of women enrolled in studies (less than 35% on average) and that few trials report results by sex (229).

Participation in clinical trials affects women across the life-course (including during pregnancy). Women use more gender-specific and more general drugs; this may be influenced by differential prescribing by medical practitioners. Women are also 1.5 times more likely to develop adverse reactions to medication due to differences in female and male responses (230).

Guidelines from the International Conference on Harmonization, which promotes regulatory standards for clinical trials, address women's inclusion in clinical trials, but no consolidated guidelines for the investigation of medicinal products in women exist. EU Clinical Trial Regulation No 536/2014 aims to create an environment in Europe that is favourable to conducting clinical trials with the highest standards of ethical and safety protection for participants. Results will need to be analysed according to gender and age, and reasons for exclusion will have to be justified. The regulation defines the conditions under which pregnant and breastfeeding women can participate in clinical trials. Most medicines are contraindicated during pregnancy, consequently limiting access to treatment for women with chronic conditions such as asthma or diabetes.

A gender-balanced workforce in formal and informal care

Strengthening the competences of the health workforce to reflect a deep understanding of women's needs and their demands of health services is important, but it is equally important to reflect on the health system as an employer that can promote gender equity within the sector (220). This requires consideration of the gender composition, recruitment strategies and employment conditions of the health workforce to maximize its capacity to meet current and future health care needs (231,232).

A gender analysis of human resources for health reveals that health systems can replicate many existing gender biases and social inequalities across and within health occupations (233). Some countries in the Region are experiencing an increase in women entering medicine, but full integration of female medical

professionals is still lacking (234). Notable differences between male and female physicians are seen in relation to specialty choice (horizontal segregation), with women underrepresented in high-prestige leadership roles and highly remunerated specialties such as surgery (235). Gender segregation is also evident within the medical hierarchy (vertical segregation): women are often overrepresented in nursing and midwifery services and care professions, while men are overrepresented in generally higher-wage professions such as medicine and dentistry.

Evidence suggests that family commitments restrict women more than men. Several studies highlight the multiple demands of work and family facing female physicians that potentially interfere with their careers (236). As a result, women tend to be overrepresented in family-friendly working situations with flexible hours (such as general practice and paediatrics), which are characterized by lower remuneration and less prestige among peers. A review of health workforce wage data in 16 OECD countries found that women not only receive lower wages than men in general, but also receive lower wages for doing the same or similar jobs as men within the same occupational group (237).

The gender dynamics of health professional mobility also present cause for concern. A high proportion of health professionals in the Region leave their country to seek better and more lucrative employment elsewhere. A survey of 12 countries found that migrant care workers predominantly were female (150). They tended to have a higher level of education than was required for their profession, but were increasingly likely to lose status, face difficulties in progressing along a career pathway, carry large family burdens and be exposed to violence upon arriving in recipient countries (238). This highlights the extent to which employment is less secure for women. In addition, it is important to ensure that the burden created by the exodus of health professionals from countries does not fall negatively on the shoulders of those who choose to remain.

Proposed solutions include paying greater attention to how the health workforce (male and female) is attracted and retained, encouraging clearer career pathways and career progression, promoting work–life balance through policies such as paternity and maternity leave and day care, protecting employees from workplace violence, discrimination and biases, and developing flexible and accommodating workplace policies (233,239).

All this has implications for the whole of society. A recent OECD report about how less inequality benefits everyone recommends as one of four main areas for policy action an increase in women's participation in economic life through eliminating unequal treatment, removing barriers to female employment and

career progression, and improving the earnings potential of women on low salaries (240). This will become an increasing challenge if barriers such as lack of formal care options are not addressed and, more importantly, if women are unable to continue working in older age because of poorer health and well-being status. Negative effects of gender discrimination and positive effects of equal opportunity are summarized in [Table 4.1](#) (231).

Table 4.1.

Negative effects of gender discrimination and inequality and positive effects of equal opportunity and gender equality

Negative effects	Positive effects
<ul style="list-style-type: none"> • Entry into health occupations impeded 	<ul style="list-style-type: none"> • Equal access to professional education, requisite skills and knowledge
<ul style="list-style-type: none"> • Clogged health worker education pipeline 	<ul style="list-style-type: none"> • Increased health worker pipeline
<ul style="list-style-type: none"> • Workers' career progression impeded 	<ul style="list-style-type: none"> • Equal chance of being hired and fairly paid, and enjoying equal treatment and advancement opportunities
<ul style="list-style-type: none"> • Workers experience work/family conflict, low morale, stress, lower productivity 	<ul style="list-style-type: none"> • Female health workers better able to juggle life events
<ul style="list-style-type: none"> • Recruitment bottlenecks 	<ul style="list-style-type: none"> • Better work–life integration for all health workers, with less stress
<ul style="list-style-type: none"> • Worker maldistribution 	<ul style="list-style-type: none"> • Better morale and productivity
<ul style="list-style-type: none"> • Workplaces experience absenteeism and attrition 	<ul style="list-style-type: none"> • Increased retention
<ul style="list-style-type: none"> • Limited pool of motivated health workers to deal with today's health challenges 	<ul style="list-style-type: none"> • More health workers
	<ul style="list-style-type: none"> • More health services

Source: Newman (231).

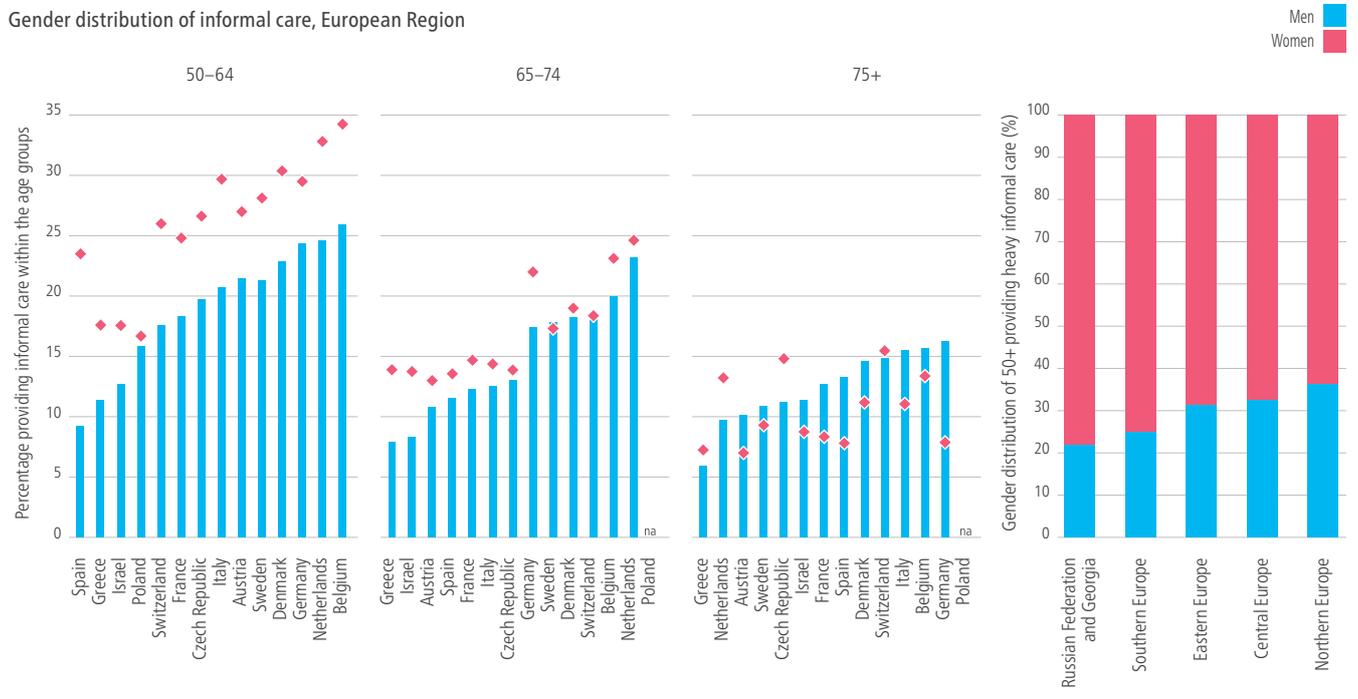
The unbalanced gender composition evident in informal caregiving also demands attention. [Fig 4.3](#) shows the distribution across European countries of the burden of informal care for children and older people (150). The charts to the left show the share of women and men providing informal care by age grouping in specific countries, as proportions of the total populations of men and women. The bar chart on the right shows the gender distribution of people aged 50 and over in subregions of Europe providing heavy informal care (defined as 20 hours per week or more) to someone outside the household.

Strong social norms and economic imperatives mean that policy options for formal care alternatives in many countries are few; those that do exist may not

Fig. 4.3.

Source: Rodrigues et al. (150).

Gender distribution of informal care, European Region



be accessible, affordable or of high quality. This creates pressure on women of all ages through the high expectation that they will provide intergenerational support. Mothers and grandmothers are affected, creating what is known as the sandwich generation, where the combined effect of increased longevity and delayed fertility means women provide care to the younger and older generations in the family (241).

Women assume most informal care responsibilities for older age groups in nearly all countries, but the proportion of male carers increases with age. In most countries, men are more likely to adopt informal caring roles for the oldest age group (75 years and older): while more than one in five women are informal carers for people aged 50-64 years, compared to one in 10 men, the pattern reverses with age.

Variations in gender inequalities of caring across countries are also seen. The usual pattern of women having a higher probability of receiving care services (at home or in an institution) compared to men is reversed in Armenia, Estonia and Lithuania (men in Armenia and Lithuania are more likely to receive care services in institutions and those in Estonia to be recipients of home care (150)).

Older women living alone are often less able to afford long-term care out of their own pocket while simultaneously having increased needs for formal care due to lack of support from close relatives (242). Data from Slovenia and the United

Kingdom suggest that older women are the social group most sensitive to changes in publicly available health services, which usually have a greater effect because of their traditional role as caregivers. As Mirjana (243) notes: “in terms of their health, older women, next to migrant women and Roma women, are the most vulnerable groups in Slovenia. By reducing pensions and social transfers, these groups will become even more vulnerable”.

Gender-sensitive financing mechanisms

A gender analysis of health financing can positively influence the development of equitable financing mechanisms. It would help, for instance, to develop understanding of how women and men are differently affected by user fees and out-of-pocket expenditures, identify which services should be included in insurance packages, recognize the extent to which services provided by female and male workers are included in performance-based incentive programmes, and define what health insurance is available to informal care workers (218).

The evidence that out-of-pocket health expenditure acts as a deterrent to seeking and accessing services for those with lower incomes is significant (242). Out-of-pocket expenditure on health care is normally measured per household, which masks gender differentials in expenditure. Data from a study of people over 50 in selected countries in the Region nevertheless showed that women paid more out of pocket than their male counterparts in all countries surveyed (244). Family planning services, for example, are usually not included in essential benefit packages. Women's antenatal care and support is often affected when essential services are cut or fees introduced. Evidence from Greece suggests that child and maternal health has worsened significantly since the economic crisis (245).

Given the trend across the Region over the past decade towards health insurance funds, much greater attention to gender-sensitive health budgeting is required (see Chapter 5). Key to this will be better understanding of the effects of health expenditure on women at household and national levels.

Moving forward

The following actions can ensure health systems are responsive to women's health:

- a. ensuring the collection, analysis and use of data disaggregated by sex and age and cross-sections with other variables, such as income, education, and urban or rural residence;

- b. promoting a people-centred approach that responds to all women's needs for health promotion, protection, prevention, diagnosis, treatment and acute and palliative care throughout the life-course, avoiding stereotypes of women as reproductive agents;
- c. supporting gender-transformative policies that guarantee care for carers and ensure sustainable models of care that avoid placing pressure on women and putting them at risk of social exclusion (examples include policies that increase men's participation in caring for their families through paternity leave and other measures);
- d. adopting gender-transformative policies in working conditions for the health workforce that demonstrate health sector leadership in promoting gender equity in the workplace;
- e. strengthening the knowledge and competences of the health workforce in addressing: interactions between biology, gender and other social determinants of health and their effect on women's health and well-being; and gender stereotypes that may result in direct or indirect discrimination against women in accessing health and health care services;
- f. promoting research and innovation that eliminates sex and gender bias in the use of medicines, service delivery and health promotion and identify and disseminate good practices;
- g. supporting gender-based medicine to improve detection, diagnosis and treatment of the most common noncommunicable diseases and their risk factors, with an emphasis on conditions that are specific to women, and on cardiovascular disease, mental health disorders, cancers and chronic obstructive pulmonary disease;
- h. increasing women's participation in clinical trials by performing a gender analysis of data, increasing women's awareness of cardiovascular disease and building professionals' capacity;
- i. ensuring policy and service responses that put an end to the acceptance and tolerance of all forms of violence against women and girls, and strengthen the role of health services and the capacity of health professionals to identify and care for women experiencing intimate-partner violence by building on WHO guidelines and protocols; and
- j. improving health literacy among women and engage women as patients to ensure they have the opportunity to make informed, evidence-based, health-conscious and self-determined decisions and choices on health issues.

5 Strengthening governance for women's health and well-being

Ensuring policy coherence and intersectoral action towards gender equity

Improving women's participation

Allocating resources to commitments: gender budgeting

Monitoring progress and accountability for results: collecting and using the right evidence

Moving forward



5 Strengthening governance for women's health and well-being

The Health 2020 framework acknowledges that leadership and participatory governance for health need to improve (3). The WHO European strategy for women's health and well-being recognizes that changes in governance for health that integrate women's lifelong needs into health policies, health-in-all-policies approaches and intersectoral action are needed. Governance reflects how governments and other social organizations interact, how they relate to citizens and how decisions are taken.

The strategy supports countries to implement the 2030 Agenda and the global strategy for women's, children's and adolescents' health (2), the operational framework of which highlights country leadership as the overarching means for driving implementation. It also states that while governments have the leadership and stewardship role for planning and implementation, true country ownership occurs when governments work with other stakeholders within and beyond government. This is what Health 2020 calls whole-of-government and whole-of-society approaches.

This chapter highlights some of the mechanisms that support the implementation of global and regional frameworks relevant to improving women's health and well-being at country level. This includes promoting intersectoral action as a shared responsibility that needs to be sustained through engagement of all sectors of government and all segments of society. It also requires policy coherence at national, subnational and international levels, with close interconnections between gender equality and other human rights principles, as described in previous chapters.

Ensuring policy coherence and intersectoral action towards gender equity

Gender equity means more than just formal equality of opportunity. It refers to the different needs, preferences and interests of women and men. Gender equality relates to equal chances or opportunities for groups of women and men to access and control social, economic and political resources, including protection under the law (such as health services, education and voting rights). It is also known as equality of opportunity, or formal equality (217).

Gender mainstreaming is the process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, in all areas and at all levels. It is a strategy for making women's, as well as men's,

concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres so that women and men benefit equally and inequality is not perpetuated (217).

Gender mainstreaming is a global policy paradigm that aims to institutionalize gender equality across sectors. While focusing historically on women, it is intended to benefit women and men (217). Most countries in Europe have committed formally to gender mainstreaming, but progress in health has been slow (246): while the formal definition of gender mainstreaming has been relatively consistent, the ways in which gender is mainstreamed in practice are variable and contextual. The focus in relation to health has been women and reproductive health, missing the complex interaction between sex, gender and the social determinants of health.

Horizontal (across policy areas) mainstreaming has been undertaken in many countries through national-level interministerial structures that coordinate gender mainstreaming across ministries in support of implementation of the Beijing Platform for Action. These have different forms and resources, but their impact has not been thoroughly evaluated across the Region (42).

The regional review of the Beijing Platform for Action recognizes progress in developing legislation on gender equality and women's rights, setting up national gender mechanisms and ensuring increased collaboration with civil society organizations on gender issues. It also highlights, however, the limited capacity of most national mechanisms to implement, coordinate and monitor gender-equality policies and hold others to account. These mechanisms have been merged with child protection and family affairs in some countries which, from a health perspective, reinforces the parallels between women's and maternal health. Cuts in government spending in a few countries have reduced or eliminated national resources to promote gender equality (42).

WHO acknowledges that if the process of intersectoral action is to be successful, optimal ways to include gender, equity and human rights considerations in the design, development, implementation and evaluation of intersectoral policies need to be identified (247). Policy needs to be gender-responsive to respond to women's (and men's) health needs. This means fulfilling two basic criteria (217): gender norms, roles and relations are considered; and measures are taken to actively reduce their harmful effects.

WHO has developed a scale that can be used to assess the level of gender-responsiveness across policies (Fig. 5.1).

Fig. 5.1.

Source: adapted from WHO (217).

WHO Gender Responsive Assessment Scale (adapted)

Gender-unequal

Perpetuates gender inequality by reinforcing unbalanced norms, roles and relations

- Privileges men over women (or vice versa)
- Often leads to one sex enjoying more rights and opportunities than the other

Gender-blind

Ignores gender norms, roles and relationships

- Often reinforces gender-based discrimination
- Ignores differences in opportunities and resource allocation for women and men
- Often constructed based on the principle of being fair by treating everyone the same

Gender-sensitive

Considers norms, roles and relations BUT:

- does not address inequality generated by unequal norms, roles or relations
- no remedial action is developed

Gender-specific

Considers women's and men's specific needs

- Considers how norms, roles and relations affect access to, and control over, resources
- Intentionally targets and benefits a specific group of men and women
- Makes it easier for women and men to fulfill duties that are ascribed to them based on their gender roles

Gender-transformative

Fosters progressive changes in power relationships between women and men

- Addresses the causes of gender-based health inequities
- Includes ways to transform harmful gender norms, roles and relations
- The objective is often to promote gender equality

According to the framework, a policy must be at least gender-specific to be considered gender-responsive. The WHO European strategy for women's health and well-being is promoting gender-transformative policies that decrease the burden of care responsibilities on women and secure greater involvement of men, challenge gender stereotypes that promote negative health outcomes for men and women, and promote gender equity.

Many, such as those aimed at improving the quality of women's employment, promoting wage transparency and equal pay, encouraging women's enrolment in sciences, eliminating gender stereotypes in education and increasing women's participation in decision-making in politics and in the workplace, lie outside the health sector (248). They nevertheless have implications for the health of women and girls and are crucial to how health systems address workforce gender equity and reduce health inequities.

Gender-equality policies promote equality between men and women. They include family policies but also those promoting equal opportunities in the labour market and equal political representation. Few studies have investigated the effects of gender policies on women's health (249).

Policy coherence also applies at global level. The SDGs and global strategy on women's, children's and adolescent's health for 2016–2030 provide a common framework for countries to address gender equity in national health policies. The global strategy includes a prioritized list of key policies and interventions across different sectors that correspond to many of the SDG targets (2).

Improving women's participation

The relationship between gender equality, income and development is well established. It supports the ideas that empowering women means more efficient use of human capital, and reducing gender inequality has a positive effect on economic growth and development. It recognizes that inequities among men and women and between women create costs to society (34). Women's unequal access to economic resources, such as wages, pensions and social transfers, have health and social consequences.

While progress has been made in closing the gaps between women and men in education, the gender gap in economic participation and political empowerment in most of the Region remains wide (81). This suggests an untapped pool of educated girls and women who for different reasons are not represented in political governance or do not participate in the cash economy. The education sector is crucial in breaking gender stereotypes that drive women towards traditional roles and career paths. Building capacity among teachers to challenge these stereotypes and promoting policies to increase women's enrolment into sciences, technology, engineering and mathematics are identified as actions to improve women's participation in better-paid work and decision-making positions (248).

Initiatives such as the *Voices and profiles* page on the Beijing Platform for Action Turns 20 website (250) are key, providing positive images and messages that challenge gender stereotypes. It is important to represent the diversity of girls and women in the Region in their own words.

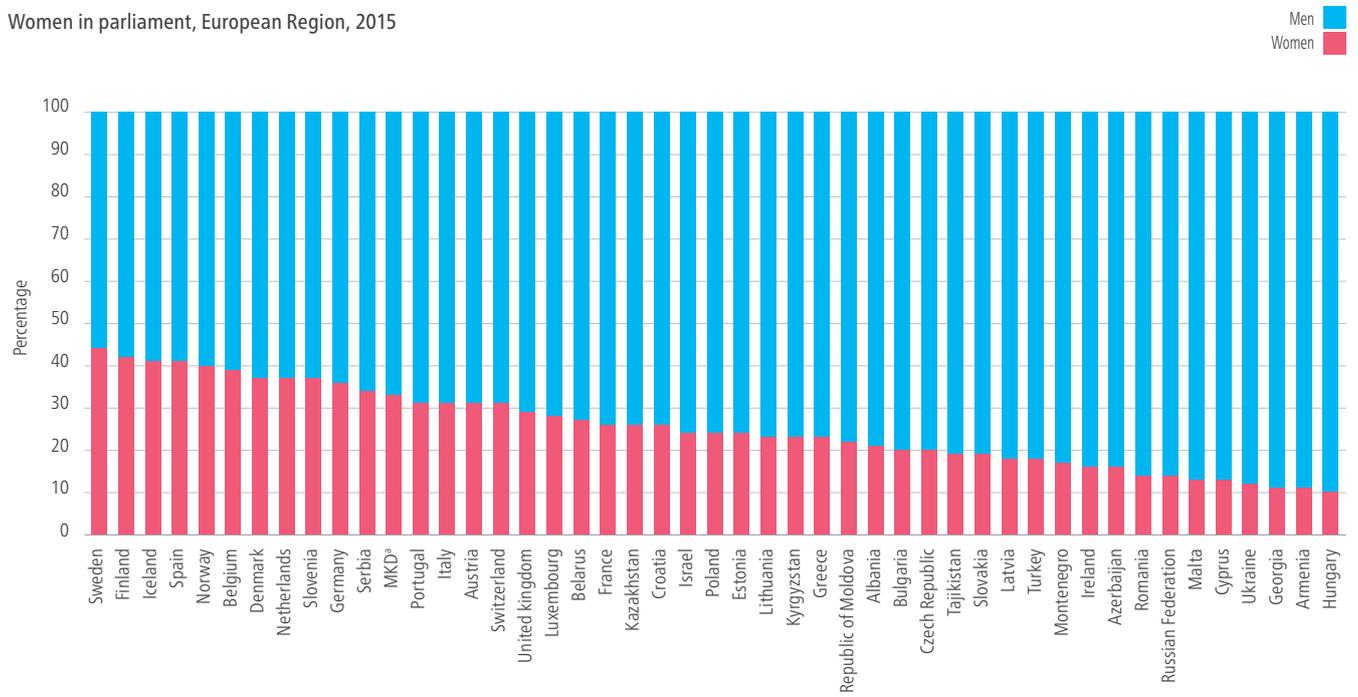
Advancing gender equality requires balanced participation of women and men in political and public decision-making. Fig. 5.2 shows striking differences in women's participation in parliaments among the 47 countries from the Region ranked in the WEF 2015 Global Gender Gap Index (81).

Much of the debate about gender equality is narrowly focused on women at the top. 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

Source: World Economic Forum (81).

Fig. 5.2.

Women in parliament, European Region, 2015



*The former Yugoslav Republic of Macedonia (MKD is an abbreviation of the ISO).

different backgrounds, and on how they can be involved in shaping the world in which they live. A gender-transformative approach is less about how women can succeed in a man's world, and more about how to change the rules of the game for men and women (251).

Leadership needs to ensure a diversity of ways, spaces and opportunities for girls and women to be heard and lead the way, learning from and improving existing mechanisms such as institutional gender mainstreaming, participation quotas, legislative changes, transformative measures like paternity leave and new ways of looking at evidence. As new forms of participation appear, leadership becomes increasingly consultative and democratized. Women's movements have been cited as examples of social movements that increase participation (252).

The SDG agenda provides a renewed framework to strengthen women's participation. Engagement of women to ensure they are at the centre of change is a defining factor for success that has been recognized in Member States' commitments to undertake a series of measures to end discrimination against women in all forms (130).

An important aspect of women's future empowerment highlighted as a target under SDG5 is closing the digital gender gap and strengthening women's access and capacities to use information and communication technologies.

Women's equal and meaningful participation in the digital society is seen as being integral to the realization of women's rights in the 21st century (253). Information and communication technology access is considered important for gender equality because it can enable women to achieve greater independence and autonomy, providing them with new economic and social opportunities, including employment and access to resources (254). An international action plan to close the digital gender gap was launched in 2015 (253), with women's health included in relation to strengthening data collection and research, improving the use of technology to challenge inequalities that affect women and their health (including gender stereotypes and discrimination), and using technology to promote and protect women's and others' health through, for example, better access to e-health services.

Allocating resources to commitments: gender budgeting

Gender budgeting is a process of planning, executing and auditing budgets in a gender-sensitive way. It enables analysis of how public money is raised and spent with the aim of strengthening gender equality in decision-making about public resource allocation, distribution and its benefits and burdens, and provides a tool for monitoring policy implementation in relation to commitments (255).

Gender budgeting is recognized as an instrument for improving national and subnational programmes' transparency and accountability. It is based on the premises that budgets are not gender-neutral, and that they require the participation of a broad range of stakeholders to enable better targeting. The Council of Europe gender equality glossary defines it as follows (256):

Gender budgeting is an application of gender mainstreaming in the budgetary process. It means a gender based assessment of budgets, incorporating a gender perspective at all levels of the budgetary process and restructuring revenues and expenditures in order to promote gender equality.

It also serves to identify biases that mask inequalities in distribution of resources critical to health outcomes. A budget analysis of the application of the law on social services in one country detected that de facto, social services assumed the head of the household to be a man. Women, unlike their male counterparts, had to prove they occupied this status through producing specific documentation. The analysis recommended that the law should target individuals and, within this, their dependants.

Gender budgeting is unevenly used throughout the Region and across sectors, but recorded experiences from the United Nations Development Fund for Women,

the OECD and Council of Europe (among others) identify learning from, and challenges in, progressing the process in Europe. When applied to health issues, it shows a clear reproductive-health focus and misses other critical areas (257).

The economic crisis has had an unequal effect on populations. Analysis of budgets from a gender perspective allows identification of areas that may require targeted support, such as those identified in previous chapters.

Monitoring progress and accountability for results: collecting and using the right evidence

Disaggregation and analysis of data is a precondition for improving accountability, transparency and participation of women in governance mechanisms. Without accountability, commitments may not be converted into action. It is a central feature of human rights protection and promotion through governments' legal obligations to explain actions and provide remedies. Put simply, accountability is the process that allows communities to understand how governments have discharged their obligations and provides an opportunity for governments to explain what they have done and why. Where mistakes have been made, accountability requires redress (258).

Strengthening accountability for women's health requires systematic collection and analysis of data and information disaggregated by sex, age and other stratifiers to track progress, identify and close knowledge gaps, and implement and evaluate appropriate policies (2). Specific areas for attention include moving beyond describing differences between men and women to how gender intersects with other social factors to create inequities among women, and moving beyond socioeconomic determinants to the more complex intersection between gender, socioeconomic and cultural factors for all age stages (133). This evidence needs to be used for analysis, action, monitoring and evaluation.

Previous chapters have shown gaps and challenges in finding and analysing relevant data. Several international initiatives mapping gender data gaps, particularly around monitoring of the SDGs, are underway. In parallel, new technologies and data collection methods, including big data, present opportunities for the future.

Studies on inequities among adults may consider men and women, but do not commonly present data separately. Even where disaggregated data are presented, the analysis often extends only to noting a difference between men and women without proper gender analysis, such as how the differences might reflect

sex/biological differences and their interaction with gendered factors not considered in the study (45).

Disaggregation of data is a prerequisite for gender indicators. Gender-responsive and -sensitive indicators measure gender-related changes over time, including quantitative changes based on sex-disaggregated statistical data of qualitative changes, such as attitudes towards gender stereotypes or violence against women.

Despite strong advances and efforts, as reflected in disaggregation in the European Health for All database and Eurostat and OECD statistics, this remains a challenge at country and regional levels, including in high-income countries. Available evidence for all 53 Member States is limited, particularly in relation to age- and sex-disaggregated data that can be crosslinked with key social determinants such as education, employment and working conditions, income, place of residence and ethnicity. Early child education, for example, is recognized as a key health determinant for ensuring a good start in life, but sex- and age-disaggregated data that can easily be linked with socioeconomic status and composition of families are limited. This issue has been raised in several documents and is included in recommendations from the global and European reviews of social determinants and equity for ensuring minimum health equity surveillance (34).

The EIGE Gender Equality Index (259) recognizes constraints in the availability of data. At the time the index was developed in 2012, it could measure only two of the three subdomains of health status, health behaviour and access, as indicators related to health behaviours were either not disaggregated by sex or not available in all countries. There were also important constraints in measuring access.

Active and informed participation is essential at all stages of an accountability process, from setting the agenda for discussion, to implementing and evaluating policy choices. Effective participation requires institutional mechanisms that encourage people's participation and build capacity for participation among policy-makers and civil society. Mechanisms such as the Beijing +20 review process, the Millennium Development Goals and SDGs, human rights treaties such as the Convention on Elimination of All Forms of Discrimination and the monitoring of Health 2020 provide important international frameworks that can be used to build accountability around women's health.

The SDGs represent a step forward in recognizing the importance of gender equality for sustainable development. UN Women (the United Nations organization dedicated to gender equality and the empowerment of women) has proposed a framework that monitors the gender dimensions of poverty, hunger,

health, education, water and sanitation, employment, safe cities, and peace and security across the 17 SDGs and 169 targets (260). The global strategy for women's, children's and adolescents' health selected 60 indicators that align with 34 from the SDGs. It is important that these efforts to monitor women's health reflect the key issues described in previous chapters and do not focus exclusively on women's reproductive health or impacts on the health of neonates and children.

Moving forward

The following actions can improve governance for women's health and well-being:

- a. collecting and using disaggregated data to inform policies and programmes – disaggregation by age and sex needs to be complemented by disaggregation on grounds of disability, ethnic origin, level of education, place of residence, sexual orientation and gender identity so policies can address gender inequities and inequities among women;
- b. improving transparency and accountability on how priorities are set, data are collected and research funding is allocated;
- c. improving financing to address women's health priorities and integrating gender budgeting across health policies and programmes;
- d. assessing the impact on women's health of national strategies and action plans within and outside the health sector to identify critical actions;
- e. including gender perspectives in initiatives addressing the social, economic, environmental and cultural determinants of health and health equity;
- f. strengthening opportunities and building capacity for women's participation as citizens, carers, service users and patients in leading and managing health policy and health system actions;
- g. strengthening intersectoral mechanisms between the health and education sectors to eliminate gender stereotypes in primary, secondary and tertiary education, and integrate gender into health workforce education;
- h. strengthening collaboration and partnership between the health sector and civil society, particularly with organizations active in women's rights and health;
- i. building on existing policy frameworks and commitments, such as those taken by Member States under the European Environment and Health Process; and

- j. strengthening monitoring frameworks for women's health at national, subnational and local levels that are in line with the targets and indicators of regional and global mechanisms.

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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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Women's health and well-being in Europe: beyond the mortality advantage

Women's health is at a crossroads. Global efforts to advance women's health have been endorsed by countries through the adoption of the 2030 Agenda for Sustainable Development and are being taken forward through the Sustainable Development Goals and the global strategy for women's, children's and adolescents' health. To strengthen action as part of progressing the Health 2020 agenda, a strategy on women's health and well-being in the WHO European Region 2017–2021 will be considered by the 66th session of the WHO Regional Committee for Europe in September 2016. This report provides background to the strategy. It presents a snapshot of women's health in the Region, discusses the social, economic and environmental factors that determine women's health and well-being, brings into focus the impact of gender-based discrimination and gender stereotypes, considers what the concept of people-centred health systems would need to entail to respond to women's needs, and considers perspectives important for the international and national frameworks that govern women's health and well-being in Europe.

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