



EUROPE

**How health systems can
accelerate progress towards
Millennium Development
Goals 4 and 5 on
child and maternal health
by promoting gender equity**

**Briefing on policy issues produced through the
WHO/European Commission equity project**

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Acronyms and abbreviations

CE	Council of Europe
CEDAW	Convention to Eliminate All Forms of Discrimination Against Women
CRC	Convention on the Rights of the Child
CSDH	WHO Commission on Social Determinants of Health
EC	European Commission
ECOSOC	United Nations Economic and Social Council
EmOC	emergency obstetric care
EU	European Union
GDI	Gender-related Development Index
GPs	general practitioners
HDI	Human Development Index
HSKN	Health Systems Knowledge Network
ICPD	International Conference on Population and Development
MCH	maternal and child health
MDGs	Millennium Development Goals
MPI	Multidimensional Poverty Index
NIS	newly independent states
OPHDI	Oxford Poverty and Human Development Initiative
PAC	post-abortion care
PHC	primary health care
PSIA	poverty and social impact analysis
QIS	quality improvement systems
SEKN	WHO Social Exclusion Knowledge Network
SEP	socioeconomic position
STI	sexually transmitted infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WGEKN	WHO Women and Gender Equity Knowledge Network

Executive summary and key messages

The United Nations Millennium Declaration embraces a vision of a world in which countries work in partnership for the betterment of all, particularly the most disadvantaged. This vision is expressed in the eight Millennium Development Goals (MDGs). With only five years left until 2015, the deadline for meeting the MDGs, progress is blighted by unacceptable inequities. Despite advances, the 53 countries in the WHO European Region are not immune to these inequities.

MDG 4 aims to reduce child mortality and MDG 5 aims to improve maternal health. Although averages show that most countries in the European Region have improved maternal and child health, large inequities continue to exist among and within countries. This briefing highlights how gender inequities limit progress to achieving these two MDGs by describing what is known and what health systems can do.

Although the determinants of the health of women and children are multifaceted, well-functioning health systems are a prerequisite to achieving maternal, neonatal and child health. The Tallinn Charter: "Health Systems for Health and Wealth" (WHO Regional Office for Europe, 2008a), endorsed by Member States of the European Region, outlines policy consensus on four key health system functions:

1. delivering health services
2. financing
3. resource generation
4. stewardship.

Lack of resources and fragmentation of services, weak stewardship capacity of ministries of health and shortcomings in supply and distribution of the health workforce all cause failures in good maternal and child health, particularly within the most deprived populations.

However, the root causes of maternal and child ill health cannot be solely addressed by health systems. Low income, inadequate schooling, food insecurity, unsafe water supplies, inadequate sanitation, lack of good transport and security concerns are key factors for poor maternal, newborn and child health outcomes. Gender inequities crosscut through all these factors, increasing women's risk and children's vulnerability.

This briefing aims to show how health systems can address gender inequities to reduce inequities in maternal and child health outcomes. Main recommendations are summarized below, structured around the four health systems functions.

Addressing gender inequities in the provision of services

- Strengthening health systems through applying a primary health care approach entails collaboration within health system actors and between the health sector and other sectors.
- In some countries and among some population groups, women have limited control over when and how to go to health services. Gender inequity and its intersection with other inequities, such as socioeconomic position and place of living, may have a direct link to physical accessibility to services.
- Responding to men and women's needs requires health systems to provide culturally sensitive services. This is especially relevant in the case of reproductive health services, as norms and values around sexuality are culturally specific.
- Health services need to respond to the needs of women who are victims of gender-based violence and to interact with social and judiciary services that should provide support and protection to these women.

Making financing systems gender equitable

- Universal health and social protection systems support gender equity. Universalism entails providing services to all who require them, including the creation of specific measures for groups experiencing social exclusion who may otherwise fall through the cracks of universal services. In the context of maternal

and child health, ensuring optimal human resource coverage and training is key to facilitating universal access to health services in underserved areas.

- It is necessary to support specific interventions that increase economic accessibility of women to maternal and child health services.
- Equitable distribution of resources throughout the health system can be achieved by using specific financing and budgeting tools, such as gender budgeting.

Promoting gender equity within health system resources

- Gender equity can be promoted within the resource generation function by:
 - ensuring the availability of skilled health personnel to assist at births with a quality medical infrastructure in rural/remote and disadvantaged areas to address the specific health needs of women;
 - making confidential information (delivered in a non-punitive manner) accessible so that women and men can make informed choices about sexual and reproductive health and the care of children;
 - investing in the capacity of health workers to provide gender-responsive services that aim to empower women, and involving men in reproductive, maternal and child health; and
 - ensuring that there is no gender discrimination in the health sector workforce and that institutional policies support working conditions for pregnant women and child care.

Addressing gender equity through health system stewardship

- Gender equity can be addressed within the stewardship function by:
 - promoting gender equity in policies and programmes inside and outside of the health sector that impact on MDGs 4 and 5;
 - using gender mainstreaming as a strategy to ensure that services are gender responsive (operational mainstreaming) and that health systems address the ways in which institutions may perpetuate gender inequalities (institutional mainstreaming);
 - viewing MDGs 3, 4 and 5 as protecting universally recognized human rights, consequently anchoring health service delivery, financing, resource generation and stewardship in a system of entitlements and obligations established by international law (existing negative gender norms and values that impact on health, such as gender-based violence and early marriage, need to be challenged by the health sector); and
 - collecting and using data disaggregated by sex, age, socioeconomic status and rural/urban living and other variables so that gender inequities and the intersectionality of determinants can be better understood and addressed.
- Establishing accountability mechanisms for addressing gender and other inequities is an underlying principle for action on MDGs 4 and 5 and is essential for delivering health services and effective financing. Internal accountability systems can include gender audits, gender impact assessments, evaluation tools and other guidance to review gender and social equity within the health system.
- Ensuring equal participation of women and men in decision-making, design and financing of health systems is important.
- Additional research is needed, particularly for the collection of programme implementation data to better document successful ways of transforming gender norms, and the collection of qualitative data relating to the individuals whose health needs are not being successfully met by the health system. It is also needed to assess the accuracy of maternal and child morbidity and mortality data at health-facility and national levels.

1. Introduction

Health systems play a vital role in addressing maternal and child health (MCH), in promoting gender equity and in empowering women. Effective primary health care (PHC) is essential in reducing maternal and infant mortality and in ensuring referral for complications for mothers and babies. Health systems are critical to realizing women's sexual and reproductive rights and their right to health. Leadership from health systems and ministries of health is required to empower women by ensuring gender equity in access to services and health outcomes and, importantly, by promoting equity through their practices and processes (Freedman et al., 2005). Health systems are often large employers in their own right and can further contribute to gender equity and the empowerment of women through their employment practices and by ensuring a gender-sensitive workplace. Health systems can act as a vehicle for active citizenship and the realization of rights (United Nations Millennium Project, 2005).

Gender inequity shapes health status for women, men and children (Sen, Östlin & George, 2007:1). The concept of gender is not the same as biological sex. Gender differences between men and women are socially constructed (EC, 2008). Because they are social phenomena rather than biological attributes, gender differences "have been learned, are changeable over time [and] have wide variations both within and between cultures" (EC, 2008). Gender inequity can be defined as systematic differences in the "distribution of benefits, power, resources and responsibilities between women and men" (WHO Regional Office for Europe, 2001a). Gender hierarchies permeate all aspects of life, governing how people live (Sen, Östlin & George, 2007:12).

Sex and gender influence health status via two major pathways. First, biological differences between women and men lead to some health inequalities. Second, gender as a social determinant further shapes health status, leading to health inequities that are both modifiable and unfair. Upstream determinants of health, such as wealth, working conditions, water and sanitation, freedom of movement, education and access to health care, may be differentially distributed between men and women. It is important to emphasize that gender inequity impacts negatively on all individuals, including men. Addressing all gender-linked inequities is key to promoting gender and health equity. Combating gender inequity is especially pertinent to improving MCH, and persistent gender inequity undermines progress in these areas.

Health systems are gendered institutions (Box 1); they can perpetuate or lessen the impact of gender inequity on health. Health systems are (WHO Regional Office for Europe, 2008a):

the ensemble of all public and private organizations, institutions and resources mandated to improve, maintain or restore health. Health systems encompass both personal and population services as well as activities to influence the policies and actions of other sectors to address the social, environmental and economic determinants of health.

As such, health systems should address the biologically-specific health needs of all individuals across the life-course. Effective, sustainable health systems also promote gender equity within the health sector and contribute to policies that address gender inequity outside the health sector.

Box 1. Gendered institutions

The concept of "gendered institutions" is apt in examining how gender inequity produces ill health and on how gender inequity is reproduced in health systems. "Gendered institutions" refers to the fact that entire institutions are patterned by gender (Andersen & Taylor, 2006:314), with the term "institution" understood as comprising the "rules of the game in a society" (North, 1990:3). Family structures, cultural norms and economic arrangements are gendered, as are health and social protection systems.

This briefing highlights key health systems policy implications for policy-makers in the European Region as we enter the final five-year period to the 2015 target year to achieve the Millennium Development Goals (MDGs), particularly the two related to MCH (see Box 2 for the specific MDGs addressed in this briefing). Discussion focuses on the actions that health systems should take to address gender inequity within and beyond the health sector.

Box 2. MDGs 3, 4 and 5

The MDGs addressed in this briefing are:

- **MDG 3:** to promote gender equality and empower women
- **MDG 4:** to reduce the under-five mortality rate by two thirds.
- **MDG 5:** to reduce the maternal mortality ratio by three quarters, and achieve universal access to reproductive health.

The primary audience for the briefing is health policy-makers, but since intersectoral action is required to meet the MDGs, gender, social protection, education and other policy-makers are also target audiences. The briefing aims to be accessible to health policy-makers unfamiliar with gender policy literature and to gender specialists unfamiliar with health policy literature. Relevant findings from the WHO Commission on Social Determinants of Health (CSDH) and the CSDH Women and Gender Equity Knowledge Network (WGEKN) (Sen, Östlin & George, 2007), and policy guidance from the European Union (EU), Council of Europe (CE), WHO and other sources are noted (see Box 3 for more information on the mandate of the CSDH).

Box 3. CSDH

WHO established the CSDH in 2005 to encourage debate on the opportunities for policy and action on the social determinants of health. Social determinants are responsible for the majority of health inequities, which are the unfair and modifiable differences in health within and among countries. Gender inequity is a key social determinant of health inequities.

The briefing contributes to follow-up to World Health Assembly resolution 63.15 on monitoring of the achievement of the health-related MDGs. The resolution urges Member States to renew their commitment to prevent and eliminate maternal, newborn and child mortality and morbidity. It states that measures to achieve this include health systems strengthening and integrated strategies and programmes to address root causes of gender inequities and lack of access to adequate care and reproductive health (World Health Assembly, 2010). The briefing is also written in support of follow-up to the European Commission (EC) communication on reducing health inequalities in the EU (EC, 2009) and supports World Health Assembly resolution 60.25 on integrating gender analysis in the work of WHO, which urges Member States to formulate national strategies for addressing gender issues in national health policies (WHO, 2007a).

Gender relations of power and health systems are not homogenous in the European Region,² a diverse region with 53 Member States. As will be shown, certain policy challenges and options are more or less relevant in particular countries, but there are some commonalities. Most importantly, gender inequity remains a paramount determinant of MCH throughout the European Region.

To be effective, programmes and services intended to reduce maternal and child morbidity and mortality must be implemented within a framework that promotes gender equity and women's empowerment within and beyond the health sector (Türmen, 2009). Failing to address gender inequities and discrimination will compromise service efficacy and make achieving MDGs 4 and 5 and, indeed, all other MDGs much more difficult (Grown et al., 2005). In contrast to some countries in other parts of the world, countries in the European Region generally have the governance capacity to actively tackle the social, economic and cultural barriers that perpetuate gender inequity.

In recognition of the importance of gender equity for development, the United Nations Economic and Social Council (ECOSOC) made the subject of the 2010 annual ministerial review of progress towards the MDGs implementing the internationally agreed goals and commitments in regard to gender equality and empowerment of women (ECOSOC, 2010). The resulting ministerial declaration expressed concern about the unevenness of progress in achieving the MDGs and reaffirmed that gender equality and empowerment of women is an essential component in achievement of the MDGs (ECOSOC, 2010).

2. Current status of MDGs 3, 4 and 5 – challenges in the European Region

This section provides an overview of progress towards MDGs 3, 4, and 5 in the European Region (see Table 1 for the goals and indicators), highlighting the challenges faced. The United Nations emphasizes that indicators should be disaggregated by sex and by urban/rural living as much as possible. Increasingly, the need to disaggregate them by socioeconomic status is also being acknowledged. As will be shown, the European Region still shows unacceptable disparities in MCH both between and within countries (WHO Regional Office for Europe, 2007a).

² Countries included in the WHO European Region are: Albania, Andorra, Armenia, Austria, Azerbaijan, Belarus, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, the Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Luxembourg, Malta, Monaco, Montenegro, the Netherlands, Norway, Poland, Portugal, the Republic of Moldova, Romania, the Russian Federation, San Marino, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Tajikistan, the former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine, United Kingdom and Uzbekistan (see: <http://www.who.int/about/regions/euro/en/index.html>).

Table 1. Targets and indicators of MDGs 3, 4 and 5

Goal		Target	Indicator
3	Promote gender equality and empower women	Target 3.A: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015	3.1 Ratio of girls to boys in primary, secondary and tertiary education
			3.2 Share of women in wage employment in the non-agricultural sector
			3.3 Proportion of seats held by women in national parliament
4	Reduce child mortality	Target 4.A: Reduce by two thirds, between 1990 and 2015, the under-five mortality rate	4.1 Under-five mortality rate
			4.2 Infant mortality rate
			4.3 Proportion of one-year-old children immunized against measles
5	Improve maternal health	Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio	5.1 Maternal mortality ratio
			5.2 Proportion of births attended by skilled health personnel
		Target 5.B: Achieve, by 2015, universal access to reproductive health	5.3 Contraceptive prevalence rate
			5.4 Adolescent birth rate
			5.5 Antenatal care coverage (at least one visit and at least four visits)
			5.6 Unmet need for family planning

Source: United Nations, official MDG indicators (<http://unstats.un.org/unsd/mdg/Host.aspx?Content=Indicators/OfficialList.htm>).

Monitoring and data

Discerning progress on MDGs 4 and 5 is difficult due, in part, to data inconsistencies and challenges in the European Region. Lack of robust, reliable data constitutes a major obstacle to achieving the MDGs. As highlighted in a recent report by the United Nations Secretary-General on progress toward the MDGs, rigorous monitoring and data are essential for effective and appropriate policy and programme design and for ensuring accountability between health systems and the people they serve (United Nations, 2010a:16).

In some countries of the European Region, historical definitions for events such as “live birth” may differ from the WHO definition, causing reporting discrepancies. Use of the earlier definition of live birth leads to undercounting of infant deaths occurring in the first seven days of life and creates several disincentives for health personnel to actively care for preterm or low-birth-weight infants (UNICEF Innocenti Research Centre, 2009:115). Even when there is no confusion regarding definitions, deaths and other adverse events may be underreported because a mother gave birth at home, medical staff misreported an event, or fees for birth registration discouraged families from registering births (World Bank, 2005; WHO Regional Office for Europe 2010a; Elebro et al., 2007). In some contexts, intense pressure to minimize “bad outcomes” means that health care professionals take deliberate steps to misrecord or hide morbidity and mortality (Médecins Sans Frontières, 2010).

Weak information systems and disruptions in reporting in countries of central and eastern Europe during the baseline year for the MDGs – 1990 – deepen data challenges in the European Region (WHO Regional Office for Europe, 2010a:9). The impact on data quality is substantial. A comparison of administrative versus survey data for infant mortality reveals marked discrepancies in several countries. While it cannot be expected that the two different sources will produce identical estimates, the differences are not marked in countries where the quality of the data from the vital registration system is better (UNICEF Innocenti Research Centre, 2009:115).

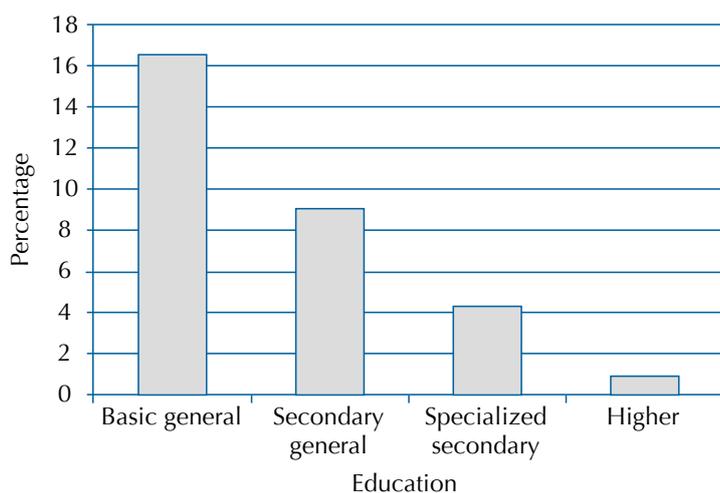
The data presented in the following paragraphs should be read with these caveats regarding data quality in mind. Despite data weaknesses, looking at indicators as collected is illustrative of overall trends.

Challenges to gender equity – MDG 3

While the prospects of reaching MDG 3 are greater in the European Region than elsewhere in the world, much remains to be done.

MDG indicator 3.1 relates to education. Level of education is widely known to relate to maternal health (Sen, Östlin & George, 2007:14–15). Available data show that the use of maternal health care has been correlated with maternal education in several countries of the European Region (Fan & Habibov, 2009:954; Cammu et al., 2010). The example of Armenia is presented in Fig. 1, showing that less-educated women are more likely to have received no antenatal care. Education has also been causally related to the likelihood of delayed childbearing and improved birth spacing (Türmen, 2009).

Fig. 1. Percentage of women receiving no antenatal care, by education, Armenia (2005)



Source: WHO Regional Office for Europe (2010).

While educational attainment is relatively high in the European Region, pockets of deprivation persist, and the education level among migrants from outside the European Region can be lower (Carus, 2009:22). Some countries still have discrepancies in the ratio of females to males at primary, secondary and tertiary levels of school (MDG indicator 3.1) (WHO Regional Office for Europe, 2010a:34). For example, in 2008, the ratio of females to males in primary education in Turkey was 0.97 (United Nations Statistics Division, 2010). In some countries, female enrolment in tertiary education is far greater than male enrolment, while in other countries, male enrolment is higher. For example, in 2008 in the Republic of Moldova, the ratio of females to males in tertiary education was 1.45, while it was 0.83 in Azerbaijan (United Nations Statistics Division, 2010).

MDG indicator 3.2 relates to the percentage of women in wage employment in the non-agricultural sector. This is a proxy measure of women's economic and social empowerment and of their ability to make decisions within the household, including the decision to seek health care. Data are less consistently collected for this indicator, so identifying regional trends is difficult. In many countries of the European Region, women comprise between 40% and 50% of the non-agricultural wage employment sector, while in several countries, they comprise over 50% (United Nations Statistics Division, 2010). The countries with lower rates of female participation include Turkey (22.4%) and Malta (35.1%) (United Nations Statistics Division, 2010).

However, even if women are almost equally represented in wage employment in the non-agricultural sector, their employment may be less stable. Casual employment is more prevalent among women, bringing with it little control over employment tenure, salaries and working conditions and the double burden of child care and household management (Sen, Östlin & George, 2007:18; UNIFEM, 2009:7; Scherer, 2009; EMCONET, 2007). The number of people with insecure employment has increased over the past 20 years: globalizing markets and the transition in eastern Europe have contributed to increased insecure employment and migration within the European Region and to increased migration from other regions to the European Region.

Women's participation in government and decision-making is a useful measure of women's political and social voice. Progress on women's participation in the highest levels of government (MDG 3, indicator 3.3) has been slow throughout the European Region. Participation is higher in the Scandinavian countries, but it is difficult to generalize. In 2008, for example, women held 31.8% of the seats in the Belarusian parliament, while they held

18.9% of all seats in France and 12.5% of all seats in Cyprus (United Nations Statistics Division, 2010). Similarly, greater participation of women in health service decision-making processes, design and financing arrangements is pivotal to ensuring that health systems are sensitive to their needs.

In addition to the indicators included in MDG 3, there are other manifestations of gender inequity that are relevant and, in some cases, specific to countries or groups. A full discussion of gender inequity in the European Region is beyond the scope of this briefing, but a few examples are illustrative. The media has reported that sex-selective abortion (son preference) is increasing in countries of the Caucasus and the western Balkans (The Economist, 2010). In countries of central Asia, there has been a resurgence of more patriarchal norms that seek to return women to the home (UNIFEM, 2009:8). Certain Roma communities throughout the European Region may place a high value on virginity and early marriage (Surdu & Surdu, 2006:34; UNDP, 2003:27). Additional manifestations of gender inequity are highlighted in the next section on health systems and the gendered social determinants of MCH.

There are composite indices that, although not part of the MDG indicators, may capture additional gender and social dynamics (see Box 4).

Box 4. Gender-related Development Index (GDI) and the Gender Empowerment Measure

The United Nations Development Programme (UNDP) has developed the GDI and the Gender Empowerment Measure. The GDI is a composite index that includes the same indicators as the Human Development Index (HDI) but adjusts for gender inequality (UNDP, 2009a). There are substantial discrepancies between the HDI and GDI of some countries in the European Region. Ireland, for example, is ranked 5 in the HDI and 10 in the GDI. Similarly, Austria is ranked 14 in the HDI and 23 in the GDI. Other countries, particularly those in eastern Europe and central Asia, show the opposite trend. For example, Kazakhstan's HDI ranking is 82 and its GDI ranking is 66, and the Republic of Moldova's HDI ranking is 117 while its GDI ranking is 97 (UNDP, 2009a). The Gender Empowerment Measure includes inequality indicators related to women's political participation, economic participation and control over economic resources. As in the case of the GDI, comparing the Gender Empowerment Measure with the HDI can be instructive regarding the degree of overall human development and gender empowerment (UNDP, 2009b).

Reducing child mortality – MDG 4

Progress towards MDGs 4 and 5 are intrinsically linked. As WHO emphasized in the 2005 world health report, reproductive and sexual health are closely tied to child health outcomes, particularly for children under the age of five (WHO, 2006). Maternal health in the antenatal period is particularly important to child survival: the two are biologically linked. However, women's health throughout the life-cycle is biologically and socially related to child health: focusing only on mothers' health during pregnancy, childbirth and lactation is insufficient to ensure child health (United Nations Millennium Project, 2005:55). There are many significant, nonbiological links between maternal and child health. These include sick mothers being less able to care for their children, women who are unable to seek health care for themselves perhaps being unable to do so for their children, and barriers to accessing health services affecting the entire household.

Despite the interconnectedness of MCH, it is important to point out that maternal health and child health also merit separate analyses and interventions where appropriate. Indeed, focusing on mothers as determinants of child health rather than as human beings deserving interventions in their own right may further promote gender inequity.

Action on social determinants needed to address under-5 mortality

Estimated under-5 mortality rates (number of deaths of children under five years per 1000 live births) have consistently decreased throughout the European Region, from an average of 32 in 1990 to 14 in 2008 (WHO Regional Office for Europe, 2010a:9).

Neonatal deaths comprise almost half of all under-5 deaths in the European Region as a whole (WHO Regional Office for Europe, 2010a:9). However, the importance of neonatal deaths in the under-5 mortality rate varies substantially by country. Key proximate causes of neonatal deaths include low birth weight and prematurity, birth asphyxia and birth trauma, and neonatal infections (WHO Regional Office for Europe, 2010a:9). Hypothermia is an important underlying cause of many of these deaths (WHO Regional Office for Europe, 2005a). Deaths occurring after the neonatal period are frequently caused by acute respiratory infections, diarrhoeal diseases and noncommunicable diseases (WHO Regional Office for Europe, 2007b, 2010:9). Diarrhoeal disease attributable to water, sanitation and hygiene in the European Region for children 0–14 years accounts for over 13 000 deaths

(WHO Regional Office for Europe, 2010b). In this context reaching the MDG target on water and sanitation – part of MDG 7 on environmental responsibility (see also below) – is critical to reducing child mortality.

Despite progress, disparities in child mortality persist among and within countries. The average under-5 mortality rate in central Asia is 42, while it is 26 in the European countries of the former Soviet Union (United Nations, 2009:24), and 6 in the countries of western and eastern Europe and Israel (United Nations Statistics Division, 2010). A WHO review of the MDGs in the European Region presented data showing the under-5 mortality rate and its relationship to place of residence and wealth quintile for the countries shown in Table 2, revealing significant differences. In some countries, under-5 mortality is more concentrated in rural areas and within the lowest wealth quintile. These data strongly underline the need to focus on social determinants of health such as income and place of residence to address child mortality in Europe. Health systems and ministries of health have a vital role to play in providing leadership and influencing the policies of other sectors and ministries.

Table 2. Estimated under-five mortality rates in 10 countries by place of residence and wealth quintile

Country	Year	Under-5 mortality rate					
		Place of residence			Wealth quintile		
		Rural	Urban	Ratio	Lowest	Highest	Ratio
Albania	2005	19	20	1.0	...	...	...
Armenia	2005	42	26	1.6	52	23	2.3
Azerbaijan	2006	64	52	1.2	...	...	...
Georgia	2005	45	24	1.9	...	...	...
Kazakhstan	2006	43	30	1.4	...	...	...
Kyrgyzstan	2006	50	35	1.4	...	...	...
Republic of Moldova	2005	30	20	1.5	29	17	1.7
Tajikistan	2005	83	70	1.2	...	...	...
The former Yugoslav Republic of Macedonia	2005/2006	26	10	2.6	...	...	...
Uzbekistan	2006	59	51	1.2	72	42	1.7

Note: Ratios cover rural–urban and lowest–highest wealth quintile. Data for Albania, Georgia, Kazakhstan, Kyrgyzstan, Tajikistan, the former Yugoslav Republic of Macedonia and Uzbekistan are derived from multiple indicator cluster surveys (MICS, round 3) that were extracted from country reports available on the UNICEF web site (http://www.childinfo.org/mics_available.html).

Source: WHO Regional Office for Europe (2010:10).

For the European Region as a whole, infant mortality rates, defined as the number of deaths of children under the age of one year per 1000 live births, have steadily declined since 1990. The estimated regional average went from 27 in 1990 to 12 in 2008 (WHO Regional Office for Europe, 2010a:9). However, differences between countries remain. As of 2008, the countries with the highest estimated infant mortality rates were: Tajikistan (54), Turkmenistan (43), Uzbekistan (34), Kyrgyzstan (33), Azerbaijan (32), Kazakhstan (27) and Georgia (26) (United Nations Statistics Division, 2010). In contrast, the countries with the lowest estimated rates in 2008 were San Marino (1) and Sweden, Luxembourg, Liechtenstein and Iceland (all 2) (United Nations Statistics Division, 2010).

Measles vaccination coverage has improved substantially since 1990, with an estimated rate of 94% in 2008 compared to 83% in 1990 (WHO Regional Office for Europe, 2010a:10). There has been a concomitant drop in measles cases, from 200 000 in 1994 to 8883 in 2008 (WHO Regional Office for Europe, 2010a:10). The unvaccinated are generally from the most excluded communities, with measles outbreaks reflecting this trend. Several have been among the European Region's excluded Roma population, and there have also been outbreaks among Travellers and within religious communities that decline vaccination (Orlikova et al., 2010:4). This highlights the need for health systems to actively reach out to the most marginalized sections of society to ensure their access to appropriate services and to protect population health.

Improving maternal health – MDG 5

Estimates compiled by WHO/United Nations Children's Fund (UNICEF)/United Nations Population Fund (UNFPA)/World Bank show that the maternal mortality ratio fell from 44 deaths per 100 000 live births in 1990 to 21 in 2008 (WHO, 2010a), although underreporting is still a problem. In the European Region, five countries (Estonia,

Latvia, Poland, Romania and Turkey) have achieved the annual decline of 5.5% needed to reach the MDG 5 Target A, which is to reduce the maternal mortality ratio by three quarters between 1990 and 2015 (WHO, 2010a).

Disparities in maternal mortality also exist among countries, with a rate of 51 in the newly independent states (NIS) (United Nations, 2009:26). In some of the lower mortality countries of western Europe, such as France, the Netherlands, Norway, Switzerland and the United Kingdom, the maternal mortality ratio has increased since 1990 (WHO Regional Office for Europe, 2010a:10), although this may be due to improved reporting. Data may not represent the true extent of disparities because maternal deaths in particular may be underreported (WHO Regional Office for Europe 2010; Elebro et al., 2007). Moreover, because of the relative rarity of maternal death, it is also essential to look at absolute numbers, not just the ratio. Compared to other countries, there are few maternal deaths in, for example, the United Kingdom, but it is instructive to look at the individual cases and note what percentage occur among African-born women, what percentage occur in London, and so on. This analysis aids policy and programme response as well as efforts to ensure accountability. In this regard, the confidential enquiry into maternal deaths from 2003 to 2005 in the United Kingdom (Lewis, 2007) provides a thorough analysis of the causes behind maternal deaths.

Almost all births in the European Region are attended by a skilled health professional, with the rate in the NIS and the transition countries of south-eastern Europe at 98% in 2005 (WHO Regional Office for Europe, 2010a:15). Despite this fairly high rate, concerns persist about the quality of care provided and how to overcome in-country inequities in access to quality care for all, particularly poor and marginalized women.

The preponderance of maternal deaths in the European Region arises from complications that can be addressed with a comprehensive integrated package of essential interventions and services that includes emergency obstetric care (EmOC) (Box 5), health system strengthening and health workforce capacity building (WHO Regional Office for Europe, 2005a:2). Many of these complications could be prevented by addressing upstream determinants and providing safe family planning services, including providing safe abortion (United Nations Millennium Project, 2005:74). A continuum of care around pregnancy, childbirth and the postnatal period, in which complications can be identified and referrals made, should be available. EmOC and post-abortion care (PAC) should be part of this continuum of care, but EmOC care may not be adequately available in the European Region due to factors such as shortages of essential medicines, equipment and supplies, outdated clinical guidelines and absence of professional case reviews to improve the quality of care (Bacci et al., 2007; WHO Regional Office for Europe, 2008b:15). Safe abortion and/or management of abortion complications may not be available due to political constraints, policy choices, financial constraints and stigma, as well as lack of qualified personnel.

Box 5. EmOC

Even in cases where pregnant women are in good health and antenatal care is good, about 15% of pregnant women will experience maternal complications. In this case, women should have access to a strong referral network that ensures timely access to comprehensive EmOC. Comprehensive EmOC services include the ability to:

- administer parenteral antibiotics
- administer parenteral oxytocic drugs
- administer parenteral anticonvulsants for pre-eclampsia and eclampsia
- perform manual removal of retained products (for example, manual vacuum aspiration)
- manage abortion complications
- perform assisted vaginal delivery
- perform surgery (caesarean section)
- perform blood transfusion (United Nations Millennium Project, 2005:84).

Regardless of whether or not abortion is legal, all countries should provide quality post-abortion care. This means that in settings where abortion is not legal, women should not fear being reported to authorities if they seek PAC.

Rates of unsafe abortion in the European Region are unknown. Due to laws and policies limiting access to safe abortion, as well as stigma, fear of contact with the state (because of immigration, drug use or other status) and bureaucratic or other delays in the provision of care, women may seek unsafe abortions outside of licensed facilities. These abortions may play a major role in maternal mortality: unsafe abortion causes more than 20% of all cases of maternal mortality in some countries of the European Region (WHO Regional Office for Europe, 2010a:17).

Adolescent birth rates, or the number of births per 1000 women between the ages of 15 and 19, have decreased throughout the European Region, from 52.1 in 1990 to 28.4 in 2005 in the NIS and from 48.2 to 29 in the transition countries of south-eastern Europe (WHO Regional Office for Europe, 2010a:15). The rate is 24 in the

European Region overall (WHO, 2009a:19). In the context of the European Region, it is also important to consider the total birth rate, which is generally decreasing. Examining the percentage of overall births among adolescents, as opposed to just the adolescent birth rate, will give a more complete picture of age and other disparities.

Not all Member States collect data on contraceptive prevalence and unmet need for family planning. Existing data suggest that access to these technologies is far from universal. For example, unmet need for family planning in Romania was found to be 28% for women and 23% for men (WHO Regional Office for Europe, 2010a:16). In general, married respondents in eastern Europe and central Asia appeared to have higher levels of unmet need, with rural women and women with secondary or less education being particularly affected (WHO Regional Office for Europe, 2010a:16). Data show a similar trend in western Europe, with contraceptive use in Ireland, for example, tracking education levels (Layte et al., 2006:235). This highlights the importance of fulfilling and protecting full sexual and reproductive rights for women and girls.

3. Intersectionality between gender and other social determinants of health

The links between maternal mortality and education are just one area highlighting those between gender and other social determinant of health. While gender inequity is “among the most influential of the social determinants of health” (Sen, Östlin & George, 2007:1), gender inequity may operate differently – or even more strongly – when it intersects with other axes of inequity. This phenomenon is referred to as “intersectionality” (Sen, Östlin & George, 2007:8).

Intersectionality is not widely explored in the current health equity literature, which focuses on the SEP gradient. However, concentrating primarily on socioeconomic differences is insufficient to understand health inequities. Examining inequality only in terms of socioeconomic differences fails to explain how socioeconomic position (SEP) shapes health differently for men and women, for urban and rural populations, for young and old, for individuals of different ethnic or racial groups, or for people with disabilities. Intersectionality is essential to understanding the role that gender inequity plays in shaping MCH in the European Region.

The gender dimension of poverty and social exclusion and implications for health

In the context of this briefing, one of the most salient intersections is between gender and socioeconomic position. As noted above, women are more likely to have insecure employment. Related to this, income remains strongly correlated to gender in the European Region. It is important to note that sex-disaggregated measures of income probably do not accurately capture the dynamic intersection of gender and socioeconomic status. The global evidence base suggests that income measures are inadequate to describe how poverty is growing; as a result, poverty, human development and other specialists are creating new ways to measure deprivation. For example, a recent paper by the Oxford Poverty and Human Development Initiative (OPHDI) lays out a new multidimensional poverty index (MPI) that “reflects the overlapping deprivations that members of a household experience ... which shows the intensity and the composition of several aspects of poverty at the same time” (Alkire & Santos, 2010).

The MPI is composed of health, education and asset indicators. OPHDI explains that these data should be disaggregated by sex to document intrahousehold inequities, but that unfortunately, these data are rarely available (Alkire & Santos, 2010:13). The CSDH Social Exclusion Knowledge Network (SEKN) also states that sex-disaggregated income measures do not accurately capture the gendered dynamics of poverty and suggests that understanding the control of resources, rather than just resource distribution, is essential to understanding gender and poverty (SEKN, 2008:46).

A review of data related to migration status and MCH outcomes shows how measures of income may be inadequate to capture poverty and exclusion. A literature review of 65 epidemiological studies comparing pregnancy outcomes in migrant versus native women in Europe from 1966 to 2004 found that migrant women faced a 43% higher risk of bearing a low-birth-weight child, a 24% higher risk of preterm delivery, 50% higher risk of perinatal mortality and a 61% greater risk of congenital malformations (Bollini et al., 2009:452). Many of the studies included in the review controlled for biological factors and/or income, suggesting that other factors particular to the migration experience were salient (Bollini et al., 2009). Other studies reviewing more recent data have similar findings (Schutte et al., 2009). Contributing factors could include low health service demand among certain migrant communities and lack of cultural appropriateness of health services. Suffice it to note that exclusion and deprivation, and consequently exposure to ill health and limited health service access, go far beyond income-related disparities.

Given the lack of sex-disaggregated measures of multidimensional poverty, the following paragraphs provide an

overview of existing data related to sex and income inequalities. In 2007, the gender pay gap was on average 17.5% (Eurostat, 2010). Women also bear a much greater burden of unpaid labour: in the EU, women average 278 minutes per day of unpaid domestic work, while men commit less than half that time (Carus, 2009:12). Unpaid responsibilities, particularly those relating to care for the family, may intensify poverty and insecurity among women (UNDP, 2008:19). These discrepancies may be even deeper in eastern Europe, due in part to transition. Since the end of communism in the region, gender inequalities have increased both within the labour market and within the household, with women bearing a greater share of increased unemployment (Herasymenko, 2009:53). For example, in Albania, females earn an estimated US\$ 4954 per year, while males earn US\$ 9143 (UNDP, 2009c). This gender pay gap may also be more significant among those of a lower SEP (Iyer, Sen & Östlin, 2010).

Single-headed households are at greater risk of poverty, and most of these households are headed by women. The 2008 Ministry of Labour and Social Affairs report on poverty and wealth in Germany, for example, found that 35% of social welfare recipients are single parents, with female-headed households comprising a significant majority (Babitsch, 2010:86).

Gendered income inequalities may be worsening in the context of the economic crisis. The crisis has had a disastrous effect on the poor in the European Region. The World Bank states that Europe and central Asia's reduction in poverty over the last 10 years is eroding (World Bank, 2010). In some countries, women are especially affected. For example, the Republic of Moldova's crisis poverty and social impact analysis (PSIA)³ recommends that women should be especially targeted to receive unemployment and social protection benefits (Otter, 2009).

Links between gender, child health, water and sanitation

Housing and sanitation further demonstrate the complex links between gender, MCH and other determinants of health. Women are central to the management and control of water. In addition, access to clean water and sanitation acts as an important determinant of child health. The WHO/UNICEF joint monitoring programme estimated that as many as 140 million people in the European Region (16% of the population) had no household connection to a drinking-water supply, while 85 million did not have improved sanitation. The Fifth Conference on Environment and Health in Parma in 2010 underlined the need to address inequities in access to water and sanitation and its importance to child health. Table 2 underlines the extent to which under-five mortality is driven by the social environment in which children find themselves, and The Tallinn Charter: "Health Systems for Health and Wealth" (WHO Regional Office for Europe, 2008a) affirmed water and sanitation as essential components of health services, further demonstrating the need for health system leadership in this area.

In short, a health system that addresses the biological needs of men and women and that takes into account the social determinants of health must consider the intersection of gender inequity and other social determinants, particularly SEP. A "gender-only" lens is insufficient to identify vulnerable populations and their needs.

4. Policy options for health systems

The Tallinn Charter: "Health Systems for Health and Wealth" (WHO Regional Office for Europe, 2008a), endorsed by Member States of the European Region, outlines policy consensus on the four health system functions:

1. delivering health services
2. financing
3. resource generation
4. stewardship.

Delivering health services entails the direct provision of services that are evidence-based, rights-promoting and comprehensive. **Financing** encompasses the funding of health services, including protecting against the financial risk of using health care, and sound decision-making regarding resource allocation to prevention and curative activities. **Resource generation** refers to health system responsibilities to generate knowledge, infrastructure and a strong health workforce. And **stewardship** includes providing policy guidance, intelligence and oversight, regulating activities that impact on health and building coalitions with stakeholders within and outside the health sector (WHO Regional Office for Europe, 2008a).

³ PSIA's have been undertaken in many countries by UNDP and partners to ascertain the social impact of the economic crisis and to suggest policy responses.

Policy guidance should relate to more than health policy. Stewardship involves influencing policies and programmes in all sectors that may influence health. It also involves channelling health-donor funding and using it effectively to address health priorities.

Health systems will finance and provide services, create resources, steward knowledge and undertake other activities in the context of larger frameworks, policy assessments and commitments to address MCH that have been developed at global and European levels. Relevant frameworks include those detailed in the Annex 1. Many of these frameworks, particularly the Cairo programme of action, provide greater guidance than the MDGs on how to promote gender equity and address the gendered social determinants of health. Fulfilling commitments enshrined in the Cairo programme of action, along with those in the Convention to Eliminate All Forms of Discrimination Against Women (CEDAW), the Beijing platform for action and the Convention on the Rights of the Child (CRC) are essential complements to activities implemented to achieve MDGs 3, 4 and 5. The August 2010 global strategy for women's and children's health integrates these strategies and commitments to provide guidance to countries – both as implementers of national programmes and as donors (United Nations, 2010b).

The need for gendered health systems

Women experience gendered exposure to several risk factors that relate to MDGs 4 and 5. An exhaustive description of these is beyond the scope of this briefing, partly because data are not adequately disaggregated by sex and other factors and a robust evidence base on the causal pathways from gender inequity, exposure to risk factors, health sector response and health status is lacking. Lack of data reinforces lack of action.

Outcomes may be inequitable because women do not receive the care they require for these gendered exposures. Differences in care reflect upstream issues such as: allocation of resources to health concerns that affect females and children versus those that primarily affect males; knowledge of the way particular illnesses and treatments manifest in female bodies versus male bodies; differential patterns of treatment for illness; and understanding of the health needs of women who have sex with women, transgender and intersex populations (Payne, 2009; Sen, Östlin & George, 2007; Govender & Penn-Kekana, 2009).

Services for other issues that primarily affect women may not be adequately available. In addition to sexual and reproductive health services for women (including youth-friendly services), this may include services for violence against women.⁴ Besides indicating women's low status in the household and in society more generally, violence against women has been linked to poor reproductive outcomes (Türmen, 2009:8; Bott, 2010:141). Health and social services for women who have experienced violence may not be available at all, or may be delivered in a way that increases stigma (WHO Regional Office for Europe, 2008b:17). Health care workers may not be trained to identify domestic violence and they may not be aware of agencies and services to which women can be referred (Lasch, Maschewsky-Schneider & Sonntag, 2010:7).

Gender-based violence is one of the most sensitive indicators of gender inequity. While no woman is immune, the intersection with other inequities such as poverty, disability, ethnicity, age and lower levels of education heighten vulnerability to such abuse and compound its effects. The profound and enduring physical, psychological and sexual health consequences of gender-based violence have considerable implications for child and maternal health.

At the same time, sexual and reproductive health services for men may be very limited, leaving them without adequate health information and making women responsible for both pregnancy and sexually transmitted infection (STI) prevention (WHO Regional Office for Europe, 2001b:10). Lack of sexual health information for men is a form of gender inequity. National strategies and services may perceive reproduction as something that relates solely to women, to the detriment of both men and women (Östlin, 2010:15). To increase male use of services and shared responsibility of pregnancy, the WHO Regional Office for Europe has made increasing male participation in sexual and reproductive health decision-making and promoting the use of male contraceptive methods one of five regional objectives relating to reproductive choice (WHO Regional Office for Europe, 2001b:10). Male involvement remains insufficient, but good programme models exist, such as a facility-based programme in Turkey providing postpartum counselling to men and women which resulted in increased use of contraceptives and increased conversations between partners about postpartum issues (WHO, 2007b:51).

Governments must make conscious policy decisions to remedy gender inequity and other social determinants

⁴ While women are disproportionately impacted by intimate partner violence, it is important to point out that violence against men may be even more stigmatized, and the availability of services may be quite low.

of MCH. As a point of interface between the state and almost the entire population, including many of the most vulnerable, health systems have a key role to play in identifying needs and designing and implementing policies.

Addressing gender inequities in the provision of services

The CSDH Health Systems Knowledge Network (HSKN) explains that health systems: “promote health equity when their design and management specifically consider the circumstances and needs of socially disadvantaged and marginalized populations, including women, the poor and groups who experience stigma and discrimination” (Gilson et al., 2007). To ensure access to services, health systems therefore need to consider intersectionality, ensuring that high-quality services are accessible to men and women in different socioeconomic circumstances. In addition to this, they should leverage knowledge of the gendered social determinants of health to strengthen health policies and policies in other sectors.

Strengthening the primary health care approach

Good MCH requires PHC at decentralized levels, coupled with a well-functioning referral system. Access may be curtailed for those who live in underserved rural areas. For example, health facilities have closed in Tajikistan in recent years, and data show a linear relationship between distance from a health facility and the likelihood of giving birth at home (Fan & Habibov, 2009:957). Difficulties in reaching health facilities have also been identified as an important barrier to receiving care in other countries of the region (Kulzhanov & Rechel, 2007:133–135; Atun et al., 2008). In other cases, facilities are physically proximate, but the services required are not available. Many countries of the European Region are characterized by an imbalance in the distribution of physicians, with physicians concentrated in urban centres (WHO Regional Office for Europe, 2008b:15). As a result, important MCH services may not be provided in rural facilities.

The PHC approach will strengthen health systems in a way that reduces health inequities. Such an approach aims for universal access, puts people at the centre of care, integrates health into broader public policy and provides inclusive leadership for sustainable improvements in health (World Health Assembly, 2010). In the context of MCH, ensuring optimal human resource coverage and training is key to facilitating universal access to health services in under-served areas.

The Tallinn Charter: “Health Systems for Health and Wealth” (WHO Regional Office for Europe, 2008a) stipulates that as an integral component of delivering health services, effective PHC should promote community involvement and intersectoral collaboration (WHO Regional Office for Europe, 2008a:3). Intersectoral collaboration implies cooperation between the health system and other actors and occurs at health service level through, for instance, referrals to social welfare or other programmes or collaboration between the ministry of health and the ministry of education in the development of comprehensive sexuality education. It also occurs in the context of wider strategy development, such as social inclusion strategies designed with input from the ministry dealing with social welfare, ministry of health, ministry of education and others.

In the context of gender equity and MCH, health systems could strive to deliver services that integrate STI prevention, family planning, violence against women services and antenatal care as much as possible (Mitchell et al., 2004; Östlin, 2010:23). The United Kingdom’s Royal College of Obstetricians and Gynaecologists, for example, has developed service standards for sexual health services that outline the need for strong referral systems to services within and outside the public health sector and the minimum number of services that should be offered within sexual health services in PHC settings (FFPRHC, 2006). As part of national strategies to reduce HIV and as part of WHO/ Joint United Nations Programme on HIV/AIDS (UNAIDS) collaboration in the European Region, some Member States have fostered collaboration among STI prevention programmes, MCH programmes and nongovernmental organizations that work with vulnerable groups to increase prevention of mother-to-child transmission coverage (Ostergen & Malyuta, 2006:55).

Removing gender barriers to physical accessibility

Health services can be **inaccessible** in several different ways. ECOSOC explains that realizing women’s right to health requires removing “all barriers interfering with access to health services, education and information” (ECOSOC, 2000:para. 21).

Physical accessibility refers to the ability of individuals to actually reach required preventive and curative services. Barriers can be physical, geographic, social, or some combination of these: geographic barriers, for instance, may be due to social factors such as inequitable investment in the construction and operation of health facilities in certain parts of the country.

Gender inequity and its intersection with other inequities, such as SEP, may have a direct link to physical accessibility. For example, 77% of women in the wealthiest quintile in Kazakhstan reported that they had the final say in whether or not to obtain health services, as opposed to 53% of the poorest quintile (Sen, Östlin & George, 2007:63).

Finally, services may not be “physically” accessible insofar as undocumented migrants lack the legal right or the ability to access them. No country that denies undocumented women access to health care during labour and delivery was identified. In general, European countries provide health services to undocumented people in the event of an emergency or to protect the public health (Ruiz-Casares et al., 2010:334). However, as has been explained, health services related to MCH include more than just labour and delivery and other emergency services. Evidence from several countries suggests that even when undocumented people do have the legal right to access certain services, they may not do so due to fear of, or difficulties in, fulfilling bureaucratic requirements (Ruiz-Casares et al., 2010; UNIFEM, 2009). Given that undocumented migrants probably have greater than average health care needs, one could say that in this case, challenges to accessing health care services exacerbate inequities.

Making services culturally accessible

Just as the health system should proactively identify and engage social and gender inequities, so too should it proactively ensure that services are culturally accessible. Cultural accessibility may be particularly relevant to sexual and reproductive health, as norms around discussing sex and sexual practices may be culturally specific. For example, women from certain groups may not seek services in the event of rape or intimate partner violence because of a high degree of stigma.

Cultural accessibility needs to be promoted in tandem with economic accessibility. Certain groups experience dynamic exclusion from the health system and face multiple challenges to cultural and other kinds of accessibility. For example, ethnic minorities may be poorer due to discrimination and other factors and are consequently more likely to find health services economically inaccessible. Economic inaccessibility can be compounded by cultural inaccessibility.

Making services culturally accessible may require outreach from the health system, rather than just the creation of culturally sensitive services. Contraceptive use in Germany is lower among migrants, which has been attributed in part to inadequate outreach by the German health services (Smith & Qian, 2010:98). The need to actively promote cultural accessibility for Europe’s Roma minority has been repeatedly highlighted, with one frequent health policy response being the creation of “Roma health mediators” (Schaaf, 2010:248–249). Mediators facilitate cultural accessibility at the point of service, but they also conduct community outreach to increase demand for health services. This model of cultural mediation has also been used in the European Region to increase cultural accessibility for other ethnic and minority groups (Open Society Institute, 2005; Barzon et al., 2010). The provision of linguistic translation in health care settings and information that engages pertinent cultural issues (such as female genital mutilation) are other examples of how health services can be culturally accessible.

The rise in immigration to western Europe has led some countries to start to systematically promote cultural accessibility. The Health Service Executive in Ireland, for example, has created a national intercultural health strategy for 2007 to 2012. Developed via a participatory consultative process, the strategy is a good example of health policy-makers executing multiple health system functions to enhance accessibility. The strategy includes recommendations related to mechanisms of health service access, service delivery, data and research, and human resources and organizational development. The needs of various cultural groups and particular health needs, including maternal and reproductive and child health, are discussed (Health Service Executive, 2007).

Responding to victims of gender-based violence

Reproductive health services and primary care services are entry points in the system for women victims of abuse. Health providers need to be trained on how to address violence and its consequences and need to be part of an intersectoral system that coordinates responses to the needs of these women. In the last demographic health survey in Albania, 33% of women found one reason for which wife beating is justified (Institute of Statistics, Institute of Public Health [Albania] & ICF Macro, 2010).

Violence during pregnancy is associated with higher levels of placental abruption, spontaneous abortion and stillbirth, antepartum haemorrhage, fetal bruising and haematomas, preterm delivery and low birth weight. The pregnancy may itself be the result of sexual violence or may be unplanned because of reproductive coercion from the woman’s partner. Children living in homes where there is violence are more vulnerable to physical and emotional abuse and are at elevated risk of developing health problems across their entire life-course.

Several countries in the Region, such as Spain and the United Kingdom, have initiated gender-based violence programmes in the health sector. In 2008, the Scottish Government (United Kingdom) launched a three-year programme to address the health consequences of gender-based violence which outlines the responsibility of all health boards in:

- introducing a routine enquiry of abuse in mental health, maternity, addictions, sexual and reproductive health and primary care settings;
- disseminating guidance on gender-based violence to staff;
- producing an employee policy for staff with experience of abuse and staff who are perpetrators of abuse; and
- developing a multi-agency response to abuse, with a particular focus on homelessness and child protection.

Making financing systems gender equitable

Providing universal access to health and social protection

Universalism entails providing services to all who require them, including the creation of specific measures for groups experiencing social exclusion who may otherwise fall through the cracks of universal services. Universal coverage reforms need to:

- reduce the proportion of total health cost due to out-of-pocket expenditure at point of service delivery;
- increase the range of services available as part of a basic essential package available to all, irrespective of ability to pay; and
- identify and provide health service coverage for population groups who are considerably disadvantaged in terms of access to health services (WHO, 2008).

Following a global evidence review, the HSKN concluded that universal systems lead to greater equity (Gilson et al., 2007). Means testing and other forms of targeting are less effective and may have high, inefficient transaction costs. That being said, to be truly universal, health and social protection systems must strive to reach those who may otherwise not be reached by “universal services” (Gilson et al., 2007). People experiencing social exclusion across the four dimensions (economic, political, social and cultural) and those who live in rural areas can benefit from specific measures to ensure that they do not fall through the cracks (CSDH, 2008:99). Health systems might also consider targeting within households, as women may be disenfranchised within the household (Sen, Östlin & George, 2007:9).

Public health systems and other actors in the European Region have initiated programmes to increase access to MCH services. With support from the EC, the Ministry of Health in Kazakhstan and WHO are collaborating to improve access to good-quality services for mothers and children with the aim of decreasing informal payments for health care, regional differences in per capita allocations for health services, uneven distribution of health facilities and health care workers and insufficient access to pharmaceuticals (WHO Regional Office for Europe, 2009a).

Increasing economic accessibility

In the context of MCH, services may not be adequately economically accessible because:

- too few services are provided free of charge;
- resources and risks are not pooled for maximum equity, meaning that certain regions or populations have less access;
- payments are not provided to health care providers in a way that promotes responsiveness and accessibility; or
- financing is inefficient overall (WHO Regional Office for Europe, 2007c:8–9).

Lack of economic accessibility leads to lower demand for health care and implies very negative economic consequences when health care is sought.

While there is widespread agreement that PHC, including MCH services, should be provided at very low or no cost (United Nations Millennium Project, 2005:57,108; CSDH, 2008:94–106; WHO Regional Office for Europe, 2005b:13), official user fees persist in some contexts, as do informal payments for care (WHO Regional Office for Europe, 2008b:18; Kulzhanov & Rechel, 2007:133–135; Östlin, 2010:19). Informal payments have a greater impact on poor populations, which may self-medicate or delay treatment, seeking to avoid payments (WHO Regional Office for Europe, 2008b:18). Moreover, as they are more likely to be poor and exert less control over household resources, women, who are often responsible for their own care as well as their children’s, may be disproportionately affected by these costs (Payne, 2009:35; Iyer et al., 2009:82–83; UNRISD, 2005). Insurance may also not cover services germane to MCH, such as family planning services and safe abortion (USAID, 2008; IPPF

EN, 2006).

Economic consequences of illness may be disastrous for the poor, who may allocate a larger percentage of their income to health care costs than the non-poor (WHO Commission on Macroeconomics and Health, 2001:23; Whitehead & Dahlgren, 2006:10). This so-called “medical poverty trap” may disproportionately impact on women, who are more likely to be poor and may lack control over household resources, while also requiring more preventive reproductive health care (Sen, Östlin & George, 2007:63). Gender differences in the poverty trap may be reflected in gender differences in the rate of people at risk of poverty. For example, on average, 15% of men and 17% of women in the EU are at risk of poverty (European Women’s Lobby, 2010).

Gender budgeting

Gender budgeting is about ensuring that resources are equitably distributed throughout the health system by using specific financing and budgeting tools. Gender-responsive budgeting is a tool that assists in identifying gender gaps in sector and local government policies, plans and policies. It also aims to analyse the gender-differentiated impact of revenue-raising policies and the allocation of domestic resources and official development assistance (UNIFEM, 2010). There are several experiences in the Region that could be applied to the MCH sector.

Promoting gender equity within health system resources

Ensuring the availability of skilled health professionals to assist at birth and providing a quality medical infrastructure in rural/remote and disadvantaged areas are important in addressing the specific health needs of mothers, neonates and children.

The optimal use of human and other resources is key to ensuring universality, but resource utilization may be suboptimal because of regulatory obstacles. For example, restrictions in some countries limit the licensing and functioning of midwives (WHO Regional Office for Europe, 2008b:14). Other challenges include the concentration of physicians and other staff in urban areas and insufficient attention being paid to continuing education and career advancement opportunities, performance management and appropriate reimbursement (WHO Regional Office for Europe, 2008b:14–15). To tackle some of these challenges, Armenia’s national strategy for child and adolescent health and development prioritizes increased coverage in rural areas, in part by motivating and supporting health care workers (WHO Regional Office for Europe, 2007d:33–34).

Making information accessible

Information accessibility means having access to reproductive health information, comprehensive sexuality education and, where legal, information related to abortion care. All may be constrained by political concerns and policy choices in certain countries (WHO Regional Office for Europe, 2008b:18), related in part to beliefs about women’s role in society. In the case of poor or otherwise marginalized women, health services may not provide comprehensive reproductive health information due to beliefs that such women do not adequately control their fertility (Lasch, Maschewsky-Schneider & Sonntag, 2010:6) or due to provider bias against certain methods of family planning, discomfort with discussing sex or unwillingness to spend time on counselling individual patients (Tavrow, 2010:34).

Some countries do not provide certain information as a matter of policy, while in other countries, particularly in contexts where public health implementation is decentralized, information might be lacking primarily in rural areas (Wellings & Parker, 2006:14). In addition, health information and information about available health services and rights may not be appropriate for the populations that may be in greatest need – adolescents, ethnic minorities (WHO Regional Office for Europe, 2008b:21; Channon, Falkingham & Matthews, 2010:84) and migrants.

Information accessibility also relates to the context in which information is provided. If it is provided in a non-confidential, punitive or demeaning setting, neither men nor women may feel comfortable asking questions, or they may make choices based on a perception of what the health care provider wants. In some cases, the provision of information in a hierarchical or disrespectful manner may be due to health care providers’ inaccurate or patriarchal feelings about women or the poor (Östlin, 2010:19; Travrow, 2010:21).

Investing in the capacity of health workers

WHO has developed a strategy to integrate gender analysis into its own work (WHO, 2007a). Among other priorities, this strategy includes building health system capacity to measure the impact of gender inequities on health. WHO has created a teaching manual that can be used to educate professionals within the health system about gender and rights in reproductive health (WHO, 2001). A comprehensive evaluation indicated that health professionals and others trained throughout the world felt that the course enhanced their ability to address gender

in the provision of services (WHO, 2010b). In addition, a WHO training module on gender mainstreaming for health managers has been used to build capacity among ministries of health staff working on MCH policy and programmes in Albania, Tajikistan and Kyrgyzstan.

Ensuring no gender discrimination in the health sector workforce

Health services employ a large workforce in many European countries. This provides a great opportunity for health services to lead by example in promoting gender equity and gender-sensitive workplace practices.

Several studies show that gender imbalance exists in the health sector workforce. Women form the majority of the nursing and midwifery workforce, while men are still predominant among medical doctors. A study in the National Health Service in the United Kingdom (Allen, 2005) showed that in spite of the increase in numbers of women doctors, the proportion of female principals fell sharply between 1993 and 2003, from 73% to 53%, while the proportion of male principals working full time remained at over 90%. Part-time consultant posts or reduced clinical commitments appeal not only to those with young children, but also to those with caring responsibilities for older relatives.

Another study showed that female general practitioners (GPs) worked 11 fewer hours than male GPs, mainly because the hours of female GPs with children were reduced more than those of male GPs with children. Once their children were over 18 years of age, female GPs worked as many hours as males (Gravelle & Risa Hole, 2007).

Addressing gender equity within the stewardship function

At stewardship level, collaboration between the health system and other sectors can entail joint strategy development, such as joint inclusion memoranda developed to promote social inclusion in EU states and multisectoral national action plans developed as part of the “decade of Roma inclusion” (2002–2012).

Fostering gender and health equity through the provision of universal services via a PHC approach will ensure that health systems fulfil the right to MCH. Addressing the gendered social determinants of maternal and child morbidity and mortality will require strong political commitment. The collection, analysis and use of rigorous disaggregated data will contribute to the transformative change urgently required to reach MDGs 4 and 5 across the European Region (United Nations Millennium Project, 2005:2):

The Millennium Development Goals are not a charity ball. The women and children who make up the statistics that drive the goals are citizens They have rights – entitlements to the conditions, including access to health care, that will enable them to protect and promote their health; to participate meaningfully in the decisions that affect their lives; and to demand accountability from the people and institutions whose duty it is to take steps to fulfill those rights.

Promoting gender equity in policies and programmes that impact on MDGs 4 and 5.

In terms of promoting gender equity in their operations and service content, both the United Kingdom and Norway have tried to operationalize this principle through legislation. The 2006 Equality Act passed in the United Kingdom and the Norwegian Gender Equality Act of 2002 mandate that all public authorities, including the national health system, promote gender equality. This duty has led to the implementation of several policies, including gender budgeting and gender impact assessments (Payne 2009:9). The WHO Regional Office for Europe also recently published a policy brief on how health systems can address gender equity (Payne, 2009). Some of the approaches highlighted in the brief, particularly gender mainstreaming, are also discussed in this briefing.

Gender mainstreaming

Gender mainstreaming can be used as a strategy to ensure that services are gender responsive (operational mainstreaming) and that health systems address the ways in which institutions may perpetuate gender inequalities (institutional mainstreaming).

WHO (WHO, 2007a), the CE (CE Committee of Ministers, 2007) and the EC (Commission of the European Communities, 1996) have called for gender mainstreaming in their own work and in every stage of Member State policy processes. ECOSOC defines gender mainstreaming as (United Nations, 2002):

The process of assessing the implications for women and men of any planned action, including legislation, policies or programs, 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 in all political, economic and societal spheres... The ultimate aim is to achieve gender equality.

There are two kinds of mainstreaming:

1. “operational mainstreaming”, or the integration of gender equality concerns in the content of policies and activities; and
2. “institutional mainstreaming”, or addressing the ways in which institutions function that perpetuate gender inequality (Ravindran & Kelkar-Khambete, 2010:276).

In its final report, the CSDH called on governments and international institutions to create a gender equity unit tasked with both types of mainstreaming (CSDH, 2008:148).

Substantial literature exists on how gender mainstreaming can be realized. Most of this literature, however, relates to particular programmes rather than to public policy as a whole (Ravindran & Kelkar-Khambete, 2009:124). Sweden is a rare example of a country that has integrated gender into the overall public health programme (Östlin & Diderichsen, 2001). Similarly, the Observatory of Women’s Health, an integral part of the Spanish Ministry of Health and Social Policy, aims to develop and disseminate knowledge on gender analysis and to ensure that knowledge is used to promote gender equity in areas such as sexual and reproductive health, mental health and cardiovascular diseases (Ministry of Health and Social Policy, 2004).

A background paper prepared for the WGEKN identified common challenges in gender mainstreaming in health, including:

- challenges specific to the health sector:
 - a tendency to attribute all differences between males and females to biology, rather than to social determinants;
 - lack of data relating to gendered differences in health;
- challenges faced in all sectors:
 - confusion about the concept of gender equality and mainstreaming;
 - misinterpretation that gender mainstreaming and women-focused approaches are mutually exclusive, as opposed to complementary;
 - considering gender and health inequity as a technical problem rather than as a fundamental matter of social justice.

With an eye towards overcoming these challenges within WHO and within Member States, WHO has developed a strategy to mainstream gender into its own work (WHO 2007b).

Human rights approach

MDGs 3, 4 and 5 are viewed as protecting universally recognized human rights. Adopting a human rights approach means that health service delivery, financing, resource generation and stewardship will be anchored in a system of entitlements and obligations established by international law.

Rights’ norms have been increasingly invoked in discussions of reproductive and sexual health as dominant strategies have undergone a paradigm shift in the past 20 years. At the International Conference on Population and Development (ICPD) held in Cairo in 1994, discussion focused on reproductive autonomy, in stark contrast to the earlier focus on population control (United Nations, 1995; Gruskin, 2008; Greer et al., 2009; Türmen, 2009). This focus on autonomy is key; having access to family planning and other services allows women, men and families to make choices regarding family size and promotes gender and social equity and poverty reduction (Türmen, 2009; Malarcher, 2010:3).

For some women, exclusionary treatment by the health system marks the experience of being poor (United Nations Millennium Project, 2005:12). There are opportunities to strengthen how rights’ norms are integrated and respected both within and outside health systems. Structures of accountability are an important way of operationalizing rights, and greater gender equity will obviously entail greater rights for women. Mainstreaming rights protection and rights awareness-raising activities into health systems’ activities will promote better health outcomes and action on the upstream social determinants of health. The Ministry of Health of Uzbekistan, for example, has cooperated with the WHO country office to provide human rights training to health care workers and policy-makers (WHO Regional Office for Europe, 2009a).

The WHO European Region strategy for making pregnancy safer indicates human rights as a core value, with associated tools providing practical guidance. One tool, for example, assists ministries of health in conducting

rights-based adolescent sexual and reproductive law and policy assessments, helping health policy-makers to identify the regulatory and policy barriers to access to, and use of, sexual and reproductive care (WHO, in press). This has been successfully piloted in two countries of the WHO European Region: in the Republic of Moldova, legal and regulatory barriers to reproductive health were evaluated and recommendations for improvement agreed; in Tajikistan, the tool was used with a particular focus on the legal framework for services for adolescents.

Sex-disaggregated data and gender analysis

Collecting and using data disaggregated by sex, age, socioeconomic status, rural/urban living and other variables can enable gender inequities and the intersectionality of determinants to be better understood and addressed. Both quantitative and qualitative data are required.

Stewarding action on the upstream determinants can consist of participation in governmental efforts outside of the health system, such as providing disaggregated health data to inform strategy development related to early childhood education or social protection, or general gender equality and legislation. Summarizing the evidence base in terms of laws and policies relating to political representation and antidiscrimination legislation is beyond the scope of this briefing. These laws constitute the supportive foundation for actions on gender inequity and must form an integral component of overall government responses to gendered health inequities (CSDH, 2008:147).

Implementing all four health system functions in a way that reduces health inequities requires reliable data. Accountability and effective gender mainstreaming also depend on reliable data. For example, the first step in Sweden's development of their equity-oriented public health policy was to update their knowledge base regarding health inequalities (Östlin & Diderichsen, 2001:20). WHO, the CE and the EC have also developed tools to aid in data collection that can be leveraged for gender mainstreaming and accountability, such as the CE's conceptual framework for gender mainstreaming (CE Group of Specialists on Mainstreaming, 1999) and handbook on gender budgeting (Quinn, 2009).

As noted, data should be disaggregated by sex as well as by a host of other factors. Simply collecting quantitative data is insufficient, however. As the SEKN found, data should aim to "capture the dynamics of exclusionary processes," "incorporate both quantitative and qualitative data" and "seek to obtain 'evidence' on the impact of exclusionary processes on health status and health inequalities" (SEKN, 2008:192). Simply collecting quantitative data on vaccination coverage, for example, might show us that ethnic minorities are disproportionately unvaccinated: qualitative data that seeks to describe processes of exclusion will tell why this is the case.

Accountability mechanisms

Establishing accountability mechanisms for addressing gender and other inequities is an underlying principle for action on MDGs 4 and 5 and is essential for delivering health services and effective financing. Internal accountability systems can include gender audits, gender impact assessments, evaluation tools and other guidance to review gender and social equity within the health system.

As the beneficiaries of health services, communities and all individuals should be involved in accountability efforts (Murthy, 2009:243).

In fostering accountability, health systems have a key role to play in two areas:

1. functioning as part of larger systems of accountability between governments and residents, particularly the most excluded; and
2. creating internal mechanisms of accountability.

Health systems' role in the first area might include some of the gender equity activities noted above, as well as collaboration with citizens who seek to use law and policy to advocate for particular improvements in the health system. In brief, the health system should be accountable to residents for fulfilling many components of the right to health.

Internal accountability entails creating and using systems for monitoring gender equality and equity within health systems (Sen, Östlin & George, 2007:16) and creating systems to monitor particularly undermonitored domains, such as the private sector (Sen, Östlin & George, 2007:67). Internal monitoring might consist of gender audits of facilities and the system and monitoring of health issues that reflect gender inequities. For example, the United Kingdom conducts confidential enquiries into maternal deaths (Drife, 2006), while the Republic of Moldova undertakes near-miss (of maternal death) case reviews (Bacci et al., 2007). Merely creating mechanisms is not a cure-all, however. Process is key to ensuring authentic accountability is realized. The WGEKN found several

common problems that plague audits, including poor dissemination of results, resistance to openness among those holding authority, vertical command structures and negative views of accountability and responsibility (Sen, Östlin & George, 2007:17). In the worst cases (Sen, Östlin & George, 2007:17):

Errors are covered up or blamed on individuals, rather than used as an opportunity to improve the system and reduce harm; quality management is seen as a type of inspection, controlling rather than encouraging improvement of the system.

Guidelines and tools exist to assist policy-makers in creating internal accountability systems. The CE Committee of Ministers encouraged Member States to create accountability mechanisms to continuously improve health services in a recommendation on the development and implementation of quality improvement systems (QIS) in health care (CE Committee of Ministers, 1997). WHO has created several tools that can be used for internal accountability efforts, including an assessment tool for the quality of hospital care for mothers and newborn babies (WHO Regional Office for Europe, 2009b), a book on reviewing maternal deaths and complications to make pregnancy safer (WHO, 2004) and a handbook on monitoring obstetric care (WHO, 2009b).

Equal participation in decision-making

Ensuring equal participation of women and men in decision-making, design and financing of health systems is important. Addressing health inequities between the sexes is insufficient; the structures that enable the gendered division of labour and inequities in educational attainment and political power must be dismantled.

Additional research needed

It is important to note that research is particularly important in the context of gender mainstreaming. The WGEKN identified biased research as one of four factors on the causal pathway from gendered structured determinants to differential outcomes (Sen, Östlin & George, 2007:11). Health systems have an especially important role to play in gendering research. The European Commission has sought to address this; applicants for funding for research, technology and development must submit a gender action plan.

The next chapter includes a list of priorities for future research.

5. Priorities for future research

- Ways to address the serious challenges with monitoring and underreporting (or incomplete reporting) in relation to MDG 4 and 5 indicators should be identified. In many countries, better data collection and more timely analysis of patterns are needed to strengthen policy responses. The role that pressure to achieve targets plays in facilitating misreporting or underreporting should be researched, with an eye towards adapting European-level efforts to minimize these problems.
- Gender-related inequities should be further identified by improving the collection of data disaggregated by sex, socioeconomic and other variables for MDG 4 and 5 indicators in the European Region through demographic and health surveys and other surveys.
- A gender lens is insufficient to enable an understanding of the distribution of opportunities for good health. While the importance of intersectionality is acknowledged, data illustrating overlap are lacking. Qualitative data can help in understanding the dynamics of how gender inequity and other social determinants interact to shape health.
- New efforts are being made to design ways of collecting and analysing data describing the multiple dimensions of poverty. The inclusion of sex-disaggregated data and a gender lens in new national survey efforts should be promoted.
- Additional quantitative and qualitative data relating to individuals who fail to be reached through mainstream services, including migrants and vulnerable populations, should be collected. Again, efforts to increase access must be based on an understanding of what the most important barriers are and how they influence behaviour.
- Best practices in transforming gender norms should be documented. Gender equity lacks the same evidence base as biomedical health issues, probably due to lack of historical commitment to gender equity and to the fact that collecting data for biomedical causes of ill health is more straightforward than collecting data relating to gender equity and health. However, given that gender hierarchies in and

of themselves constitute one of the most important social determinants of health, identifying ways of dismantling these hierarchies is an urgent priority. Much of the literature relates to legislation and policy requirements, but these are often inadequately translated into practice. More models for fostering deep change in gender norms are needed.

- Additional programme research on how to effectively involve men in MCH service delivery should be conducted.
- Additional research on challenges and successes in integrating services at operational and strategy levels should be conducted.

Annex

Framework	Key commitments/recommendations
WHO Gender mainstreaming strategy	Build WHO capacity for gender analysis and planning
	Bring gender into the mainstream of WHO's management
	Promote the use of sex-disaggregated data and gender analysis
	Establish accountability
WHO Women and health: today's evidence, tomorrow's agenda	Leadership, including gender mainstreaming and accountability
	Responsive health services that address the needs of marginalized women and give women a voice, including women who work in the health system
	Universal service coverage at low or no cost
	Women's health in all policies, including creating economic opportunities for women
	Tracking progress, including tracking maternal deaths, keeping disaggregated data and investing in women's health research
United Nations: Cairo programme of action	Empower women and eliminate inequalities between men and women
	Special efforts to emphasize men's shared responsibility in reproductive health
	Provision of reproductive health care to all individuals of appropriate ages through primary health care (PHC) systems
	Eliminate disparities in child mortality rates among and within countries
	Significant reductions in measles, mumps and rubella, in part through expanded provision of maternal health services in PHC
	Implement programmes to address nutritional needs of women of childbearing age
	Control the AIDS pandemic through a multisectoral approach
Protect, promote, and support breastfeeding	
WHO European strategy for child and adolescent health and development	Improve maternal and newborn health in the poorest countries and among most vulnerable groups in wealthier countries
	Improve nutrition for infants and young children in poorest countries and decrease obesity in all countries
	Lessen injuries and violence, with road injuries and domestic violence as priorities
	Implement Children's Environment and Health Action Plan for Europe, including clean water, hygiene and sanitation, indoor and outdoor air pollution and agents
	Provide youth-friendly services to adolescents
	Improved care to enhance psychological and mental health
WHO European Action Plan for Food and Nutrition Policy 2007–2012	Promote optimal fetal nutrition, including by ensuring maternal nutrition
	Protect, promote and support breastfeeding and appropriate and safe complementary feeding
	Promote the development of preschool and school nutrition policies
	Improve the availability and affordability of fruit and vegetables
	Promote appropriate micronutrient fortification of staple food items
	Establish targeted programmes for the protection of vulnerable and low socioeconomic groups
	Reduce the consumption of alcohol
	Ensure the provision of safe drinking water
	Engage PHC in nutrition assessment
	Improve services for prevention, diagnosis and treatment of nutrition-related diseases
	Establish targeted programmes for the protection of vulnerable and low socioeconomic groups
	Create surveillance systems on nutritional status with disaggregated data
	Increase knowledge to make free and informed choices on number and timing of children

WHO European regional strategy on sexual and reproductive health	Reduce induced abortion
	Improve the accessibility and range of contraceptive services
	Increase the responsibility and involvement of men in sexual and reproductive health
	Reduce maternal morbidity and mortality
	Reduce perinatal and neonatal morbidity and mortality
	Increase general knowledge on pregnancy and childbirth
	Reduce incidence and prevalence of HIV, other sexually transmitted infections and cervical cancer
	Increase knowledge in general population re: HIV and other sexually transmitted infections
	Reduce sexual abuse and violence
	Inform and educate adolescents on all aspects of sexuality and reproduction
	Ensure easy access to youth-friendly sexual and reproductive health services
	Decrease inequities in sexual and reproductive health between migrants and the resident population
	Eliminate endemic measles and rubella by 2010
	WHO European regional strategy on making pregnancy safer	Optimize political commitment
Build stronger partnerships	
Develop supportive legislative and regulatory framework	
Build a stronger skilled workforce	
Strengthen infrastructure and supply system	
Strengthen monitoring for better decision-making	
Establish an evidence-based package and quality standards of care	
Strengthen referral systems	
Implement maternal and perinatal quality improvement mechanism	
Collaborate with other public health programmes	
Improve cross-sector collaboration for health	
Empower women, families and communities	
WHO European Region strategic plan for measles and rubella	Prevent congenital rubella infection (to < 1 case per 100 000 live births)
	Improve children's access to safe drinking water and sanitation
WHO Children's Environment and Health Action Plan for Europe	Prevent and reduce pregnant women's and children's exposure to air pollution
	Protect children and adults in the reproductive period from exposure to hazardous chemicals
	Improve quantity and quality of children's dietary intake

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Notes



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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