
EIGE
European Institute
for Gender Equality
Gender
in health

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Contents

1. Relevance of gender in the policy area

Gender plays a specific role both in the incidence and the prevalence of specific pathologies, as well as in their treatment and impact in terms of well-being and recovery. This is due to the interrelations between sex-related biological differences and socioeconomic and cultural factors that affect the behaviour of women and men and their access to health services ([1]).

Regarding the health policy field, it is of utmost importance to bear in mind the distinction between the concepts of 'sex' and 'gender'. Health research and health policy need to adequately explore and address the combination of social and biological sources of differences in women's and men's health ([2]). An understanding of the interaction between sex and gender in the development and management of health and disease can benefit both sexes in terms of prevention, intervention and outcome. For example, gender medicine has made strong advances in explaining how the incorporation of gender issues into research can affect medical understanding. This affects the treatment of heart disease, osteoporosis, arthritis and pain, among other conditions ([3]).

In the European population, there are more women than men. Women generally live longer than men in all parts of Europe and there are more male deaths than female deaths in the working-age population (15-64 years). However, while living longer, women experience more years of disability than men. Across Europe, women are expected to live a smaller proportion of their years in good health than men, as measured in healthy life years (HLYs). This is an indicator of disability-free life expectancy, or the remaining years a person of a specific age is expected to live without any moderate or severe health problems, or acquired disabilities ([4]). With an ageing population, the risk of chronic disease such as diabetes and mental health problems — dementia, Alzheimer's disease, and depression — is increased, notably among women. Moreover, some diseases such as breast cancer, osteoporosis and eating disorders are more common in women, while others, such as endometriosis and cervical cancer, affect women exclusively. Men are more likely to contract, and die from, lung and colorectal cancers, ischaemic heart diseases and traffic accidents. Some diseases, such as prostate cancer, affect men exclusively ([5]).

Besides biological factors, social norms also affect the health status of women and men differently. Women are less likely to engage in risky health behaviour and consequently face fewer of the related illnesses and disabilities than men. However, they are more likely than men to present 'invisible' illnesses and disabilities which are often not adequately recognised by the healthcare system. Examples include depression, eating disorders, disabilities related to home accidents and sexual violence, as well as diseases and disabi lities related to old age.

> *Sexual abuse and domestic violence particularly affect women and girls in all countries and in all social classes. Domestic violence against women remains one of the most pervasive human rights violations of our time. In the EU, 9 out of 10 victims of intimate partner violence are women. The number of women victims of physical intimate partner violence in the EU Member States ranges between 12 % and 35 % ([6]). The World Health Organisation (WHO) provides global data on violence against women. Recent global prevalence figures indicate that 35 % of women worldwide have experienced either intimate partner violence or non-partner sexual violence in their lifetime. Moreover, on average, 30 % of women who have been in a relationship report that they have experienced some form of physical or sexual violence by their partner. Globally, 38 % of murders of women are committed by an intimate partner ([7]).*

An EU-28 survey on violence against women was launched in 2010 by the Fundamental Rights Agency (FRA), and carried out between April and September 2012 ([8]).

([1]) EGGSI Network, *Access to healthcare and long-term care: equal for women and men?*, 2009.

([2]) Bird, C.E., and Rieker, P., 'Gender matters: An integrated model for understanding men's and women's health', *Social Science and Medicine*, Vol. 48, No 6, 1999, pp. 745-755, http://www.ncbi.nlm.nih.gov/pubmed/10190637.

([3]) Baggio, G., Corsini, A., Floreani, A., Giannini, S., Zagonel, V., 'Gender medicine: A task for the third millennium', *Clinical Chemistry and Laboratory Medicine*, Vol. 51, No 4, 2013, pp. 713-727, doi: 10.1515/cclm-2012-0849, http://www.ncbi.nlm.nih.gov/pubmed/23515103.

([4]) European Institute for Gender Equality (EIGE), *Beijing + 20: The fourth review of the Implementation of the Beijing Platform for Action in the EU Member States*, 2015, http://eige.europa.eu/rdc/eige-publications/beijing-20-4th-review-implementation-beijing-platform-action-eu-member-states-report.

([5]) European Commission — Directorate-General Health and Consumers, *Data and information on women's health in the European Union*, 2009, http://ec.europa.eu/health/population_groups/docs/women_report_en.pdf; European Commission — Directorate-General for Health and Consumers, *The state of men's health in Europe*, 2011, http://ec.europa.eu/health/population_groups/docs/men_health_ extended_ en.pdf.

([6]) EIGE, *Review of the implementation of the Beijing Platform for Action in the EU Member States: violence against women — victim support*, 2012, http://eige.europa.eu/rdc/eige-publications/violence-against-women-victim-support-report.

([7]) WHO, *Violence against women: intimate partner and sexual violence against women: factsheet*, 2014, http://www.who.int/mediacentre/factsheets/fs239/en/.

([8]) The FRA survey is the first survey realised at Member State level and on an EU-28-wide basis on violence against women. It is based on interviews with 42 000 women across the EU, who were asked about their experiences of physical, sexual and psychological violence, including incidents of intimate partner violence ('domestic violence'). The survey also included questions on stalking, sexual harassment, and the role played by new technologies in women's experiences of abuse. See http://fra.europa.eu/sites/default/files/fra-2014-vaw-survey-main-results-apr14_en.pdf.

According to the FRA survey, an estimated 13 million women in the EU had experienced physical violence over the course of the 12 months preceding the survey interviews. This corresponds to 7 % of women aged 18-74 years in the EU. Around 22 % of women are, or have been, involved in a relationship with a partner where they experience(d) physical and/or sexual intimate partner violence. Equally, around 1 in 5 women (22 %) has experienced this type of violence by somebody other than an intimate partner. Overall, 1 in 3 women in the EU has been a victim of physical and sexual violence by a partner, a non-partner, or both ([9]).

Overall, it can be noted that women are more aware of their health status and are greater users of healthcare services than men. There are several reasons for this:

- their reproductive role;
- their role as caregivers for dependants (children and the elderly or disabled);
- their position in representing a larger proportion of the older population;
- gender stereotypes.

There is a strong gender dimension to lifestyle choices and risky behaviours that place men at higher risk of ill health. Men face greater levels of occupational exposure to physical and chemical hazards, behaviours associated with 'masculine norms' of risk-taking and adventure. There are health-behaviour paradigms related to masculinity and the fact that men are less likely to visit a doctor when they are ill. When they do see a doctor, men are less likely to report on the symptoms of disease or illness. At the same time, men usually tend to pay less attention than women to health-related issues ([10]).

Men generally have poorer knowledge and awareness of health. Across the EU, women and men make different use of health systems and services, and this affects their health status. There is evidence that some men use primary health services less frequently and are more likely to need hospitalisation for the principal causes of disease compared to women. This may be due to the services only being available during the working day, and thus less accessible to many working men. In addition, women and men may receive a different diagnosis and treatment when they seek medical assistance for similar health problems. For example, women are more frequently diagnosed with 'depression' and men with 'stress', based on the same complaints ([11]).

Health is also important while considering the sexual and reproductive behaviours of people. Reproductive health is defined as a state of physical, mental and social well-being in all matters relating to the reproductive system, at all stages of life. Good reproductive health implies that people are able to have a satisfying and safe sex life, the ability to reproduce and the freedom to decide if, when and how often to do so. This implies that women and men should be informed about and have access to safe, effective, affordable and acceptable methods of family planning of their choice. They should also have the right to appropriate healthcare services that ensure women a safe pregnancy and childbirth ([12]).

The healthcare workforce is predominantly composed of women ([13]). However, women healthcare workers tend to occupy lower-status positions (e.g. nurses and midwives) and, at the same time, to be a minority among more highly trained health professionals (e.g. doctors and dentists). Women are also under-represented in managerial and decision-making positions in the sector ([14]). Moreover, due to the high presence of women in the healthcare sector, specific attention should be paid to gender-sensitive training and education in the sector ([15]).

The major gender differences and inequalities within the health policy sectors are the following:

- gender differences in health status and behaviours;
- gender inequalities and barriers in terms of access to health services;
- sexual and reproductive health;
- gender segregation in the healthcare workforce;
- gender-sensitive training and education for health professionals.

([9]) FRA, *Violence against women: an EU-wide survey: main results*, 2014, http://fra.europa.eu/sites/default/files/fra-2014-vaw-survey-main-results-apr14_en.pdf.

([10]) WHO, *The men's health gap: Men must be included in the global health equity agenda*, 2014, http://www.who.int/bulletin/volumes/92/8/13-132795/en/; European Commission — Directorate-General for Health and Consumers, *The state of men's health in Europe*, 2011, http://ec.europa.eu/health/population_ groups/docs/men_health_extended_en.pdf.

([11]) European Commission — Directorate-General for Health and Consumers, *The state of men's health in Europe*, 2011, http://ec.europa.eu/health/population_groups/docs/men_health_report_en.pdf.

([12]) European Commission — Directorate-General for Health and Safety, *Reproductive Health*, n.d., http://ec.europa.eu/health/population_groups/gender/reproductive/index_en.htm.

([13]) European Foundation for the Improvement of Living and Working Conditions, *Employment and industrial relations in the healthcare sector*, 2011, http://www.eurofound.europa.eu/observatories/eurwork/comparative-information/employment-and-industrial-relations-in-the-healthcare-sector.

([14]) WHO, 'Gender and health workforce statistics', *Spotlight on Statistics — a fact file on health workforce statistics*, No 2,, 2008, http://www.who.int/hrh/statistics/spotlight2/en/.

([15]) EIGE, *Mapping of gender training policies and practices in the European Union: summary of findings*, 2012, http://eige.europa.eu/sites/default/files/documents/Gender%20Training%20-%20Summary%20of%20findings.pdf.

2. Issues of gender inequalities in the policy area

Gender differences in health status

Women's life expectancy has been increasing in the EU-28 and exceeds that of men ([16]). In 2013, the average life expectancy at birth in the EU-28 was 83.1 years of age for women and 77.5 years for men ([17]). However, despite longer life expectancy, women spend more of their lives in disability and ill health. In 2013, the number of HLYs at birth was estimated at 61.4 years for men and 61.5 years for women in the EU-28. This represented approximately 79 % and 74 % of total life expectancy for women and men. The gender gap was considerably smaller in terms of HLYs than it was for overall life expectancy ([18]). This means that women suffer from health problems at a later age but for a longer time than men ([19]).

While life expectancy rates are higher for women than for men in the EU, these differences decrease as educational attainment rises. Life expectancy rises with higher educational attainment (i.e. more educated people live longer than less educated people). In general, this trend is observed both in women and in men. However, the life expectancy of men with higher education is still lower than the life expectancy of women with the lowest educational attainment.

Though more women are diagnosed with mental health problems, this masks the extent of the problem among men. Men's depression and other mental health problems are under-detected and undertreated in all European countries. This is due to men's difficulty in seeking help and the limited capacity of health services to reach out to men. Men present symptoms differently compared to women, with higher levels of substance abuse and challenging behaviours ([20]).

Differences in health-risk behaviour exist between women and men from childhood onwards. The literature shows that in childhood and adolescence, boys present a higher mortality rate due to behaviour-generated causes (suicide, drug abuse, traffic accidents) and more physical and mental health problems than girls ([21]). Overall, the main health problems among young men are injuries caused by traffic accidents ([22]). Young women suffer especially from invisible health risks such as excessive use of medication and dieting, and sexual violence. Their economic situation is generally less favourable than that of men leading to socioeconomic deprivation, with serious effects on their health status ([23]).

Cardiovascular disease (CVD) is still the main natural cause of death for both women and men in the EU. The most frequent types of cancer and causes of cancer-related mortality are breast cancer, colon and lung cancer for women, and prostate cancer for men. The increase in the incidence of lung cancer and lung cancer mortality in women, compared to the decrease in men, is due to the growing number of women smokers ([24]).

Gender-based violence has serious health consequences for women, from injuries to unwanted pregnancies, sexually transmitted infections (STIs), depression and chronic diseases ([25]). Between 15 % and 71 % of women around the world have suffered physical or sexual violence committed by an intimate male partner at some point in their lives. The abuse cuts across all social and economic backgrounds.

([16]) EIGE, *Beijing + 20: The fourth review of the implementation of the Beijing Platform for Action in the EU Member States*, 2015, http://eige.europa.eu/rdc/eige-publications/beijing-20-4th-review-implementation-beijing-platform-action-eu-member-states-report.
([17]) EIGE, *Gender equality index*, 2015, http://eige.europa.eu/gender-statistics/gender-equality-index/2012/domain/health.
([18]) See: http://ec.europa.eu/eurostat/statistics-explained/index.php/Healthy_life_years_statistics.
([19]) See: http://ec.europa.eu/health/population_groups/gender/index_en.htm.
([20]) See: http://ec.europa.eu/health/population_groups/docs/men_health_leaflet_en.pdf.
([21]) WHO, *Gender and health in adolescence: Health policy for children and adolescents (HEPCA)*, Series No 1, prepared by P. Kolip and B. Schmidt, Copenhagen, 1999, http://www.euro.who.int/__data/assets/pdf_file/0004/119371/E66082.pdf.
([22]) WHO, *Gender and health in adolescence: Health policy for children and adolescents (HEPCA)*, Series No 1, prepared by P. Kolip and B. Schmidt, Copenhagen, 1999, http://www.euro.who.int/__data/assets/pdf_file/0004/119371/E66082.pdf.
([23]) European Parliament — Directorate-General for Internal Policies, *Discrimination against women and young girls in the health sector*, prepared by the European Institute of Women's Health, Brussels, 2007, http://eurohealth.ie/discrimination-against-women-and-girls-in-health-sector/.
([24]) Curado, M.P. et al., 'Cancer incidence in five continents', *IARC Scientific Publications*, Vol. 9., No 160, Lyon, 2008, http://www.iarc.fr/en/publications/pdfs-online/epi/sp160/CI5vol9.pdf.
([25]) See: http://www.who.int/features/factfiles/women_health/en/index2.html.

Gender inequalities and barriers in access to healthcare

There are no significant reported differences between women and men in terms of unmet medical needs ([26]). EU statistics on income and living conditions (EU-SILC) data on unmet medical needs show that women in general are more likely than men to perceive unmet medical needs, even if gender differences are small. In the EU-28 in 2013, 7.4 % of women declared that they had unmet needs terms of medical examinations, compared to 6.4 % of men. Gender differences are more relevant when considering the reasons for unmet medical needs. Women are usually more likely than men to be constrained by barriers to accessing medical services. This can be the cost of medical care which can be prohibitively expensive, time and geographical barriers caused by waiting lists and the distance to travel for care. Men are more likely than women to declare other reasons, such as lack of time ([27]).

Gender plays a specific role in the incidence and prevalence of certain types of pathologies (as described above), but also in their treatment and their impact in terms of well-being and recovery. This is due to the interrelation of biological aspects, psychological and cultural behaviour (related to ethnic, social and religious backgrounds), socioeconomic conditions and the features of healthcare systems. Some factors can exacerbate gender inequalities in health and well-being, such as differences in economic resources and the burden of family and care responsibilities, as well as poverty and isolation. As such, women are particularly vulnerable, especially in financial terms, when it comes to accessing health services. Their longer lifespan compared to men increases their chance of living a longer proportion of their life in illness and disability, as stated above. European countries use a wide variety of institutional arrangements to provide health insurance coverage and to finance and deliver healthcare services. National differences are relevant in explaining gender gaps in relation to insurance coverage and financial barriers in accessing healthcare services. For example, the presence of a tax-based, comprehensive national public system providing universal coverage has a strong effect on access to healthcare systems. A public healthcare system mainly financed through compulsory social insurance contributions, or even a mix of the two (such as out-of-pocket payments and private insurance schemes), can also be effective ([28]).

Sexual and reproductive health

Sexual and reproductive health is very personal, so people may have trouble finding or asking for accurate information about it. This may also help explain why these issues are still not addressed openly, and services are inadequate, fragmented and unfriendly in some countries in the EU. There has been good progress but there are still major differences between and within the Member States. Many people lack information on, for example, sexuality, family planning, pregnancy and childbirth, STIs, infertility, cervical cancer prevention and menopause ([29]). Young people are particularly vulnerable, often facing barriers to sexual and reproductive health information and care. Young people are disproportionately affected by HIV, for example. Every year millions of girls face unintended pregnancies, exposing them to risks during childbirth or unsafe abortions, and interfering with their ability to go to school ([30]).

EU-28 figures show that some aspects of the sexual and reproductive health situation is improving. Maternal mortality and infant mortality have decreased in many countries as a result of prevention strategies, and as a consequence of many programmes and plans on maternal health. A decrease in legal abortions has been reported in many countries, which may be explained by an increase in consultations on family planning and improved access to contraceptive methods, especially among young women. Finally, regarding STIs, a decrease in new HIV/AIDS infections and sexually transmitted disease, both among women and men, has been reported in several Member States ([31]).

([26]) EIGE, *Beijing + 20: The fourth review of the implementation of the Beijing Platform for Action in the EU Member States*, 2015, http://eige.europa.eu/sites/default/files/documents/MH0414886ENN.PDF.

([27]) See: Eurostat database, http://ec.europa.eu/eurostat/data/database?node_code=hlth_silc_08.

([28]) European Commission — Directorate-General for Employment, Social Affairs and Equal Opportunities, *Access to healthcare and long-term care — equal for women and men?*, 2009.

([29]) WHO Europe, *Sexual and reproductive health*, http://www.euro.who.int/en/health-topics/Life-stages/sexual-and-reproductive-health.

([30]) United Nations Population Fund (UNFPA), http://www.unfpa.org/sexual-reproductive-health.

([31]) EIGE, *Beijing + 20: The fourth review of the implementation of the Beijing Platform for Action in the EU Member States*, 2015, http://eige.europa.eu/sites/default/files/documents/MH0414886ENN.PDF.

Gender segregation in the healthcare workforce

The workforce in the healthcare sector is dominated by women, with 78 % of workers being female in the EU-28 ([32]). Both vertical and horizontal occupational segregation can be observed when comparing women's and men's healthcare positions. On the one hand, women are under-represented in managerial and decision-making positions. On the other hand, the female healthcare workforce is usually concentrated in occupations such as nursing, midwifery and other 'care' professions such as community health workers. These occupations tend to be perceived as low-status jobs, while medicine, dentistry and pharmacy (positions mostly occupied by men) are understood as high-status occupations ([33]).

Gender-sensitive training and education of health professionals

Due to the high presence of women in the healthcare sector, specific attention should be paid to gender-sensitive training and education. Gender equality training activities remain scarce and tend not to be tailored specifically to the needs of the participants. There is a recognised need for tailored or issue-specific gender training and some good practices have been identified in some of the EU Member States ([34]).

([32]) European Foundation for the Improvement of Living and Working Conditions, *Employment and industrial relations in the healthcare sector*, 2011, http://www.eurofound.europa.eu/observatories/eurwork/comparative-information/employment-and-industrial-relations-in-the-healthcare-sector.

([33]) WHO, 'Gender and health workforce statistics', *Spotlight on Statistics — a fact file on health workforce statistics*, No 2, 2008, http://www.who.int/hrh/statistics/spotlight_2.pdf.

([34]) EIGE, *Mapping of gender training policies and practices in the European Union: Summary of findings*, 2012, http://eige.europa.eu/sites/default/files/documents/Gender%20Training%20-%20Summary%20of%20findings.pdf.

3. Gender equality policy objectives at the eu and international levels

Both at the EU and the international level, the eradication of gender-based inequalities in health is a policy priority. Existing gender-based inequalities in health regard health status as well as the provision of healthcare services.

EU level

European Council

In June 2006, the Council of the European Union adopted a statement on common values and principles in EU healthcare systems ([35]), listing the overarching values of universality, access to good-quality care, equity and solidarity. 'Equity' in healthcare is defined as follows: '[E]quity relates to equal access according to need, regardless of ethnicity, gender, age, social status or ability to pay.'

In 2006, in its Council Conclusions on women's health ([36]), the Council invited the European Commission to:

- integrate gender aspects in health research;
- support the exchange of information and experience on good practice in gender-sensitive health promotion and prevention;
- assist Member States in developing effective strategies to reduce health inequalities with a gender dimension;
- promote and strengthen the comparability and compatibility of gender-specific information on health across Member States and at EU level through the development of appropriate data;
- present a second report on the state of women's health in the EU (which was published in 2009) ([37]).

The Council Conclusions on *Equity and health in all policies: solidarity in health* ([38]) was published in 2010. In it, the Council expressed concerns about differences in health status between the EU Member States and the vulnerability of certain groups of people to poor health. The Council recognised that health services alone are not enough to maximise health potential and address inequalities. It invited Member States to develop policies and actions to reduce inequalities, optimise the collection of data and knowledge, and enhance public health capacities.

European Commission

The European Commission, in its health strategy *Together for health* ([39]) dating from 2007, defines health inequities as 'inequalities in health that are avoidable and unfair'. It is committed to working towards reducing such inequities.

The second programme of community action in the field of health 2008-2013 came into force on 1 January 2008, aiming to complement, support and add value to the policies of the Member States. This should contribute to increasing solidarity and prosperity in the EU by protecting and promoting human health and safety, and improving public health. In this programme, the European Commission is committed to promoting health and reducing health inequalities, increasing HLYs and promoting healthy ageing. Moreover, the third multi-annual health programme covering the period between 2014 and 2020 strengthened the European Commission's commitment 'to contribute to addressing health inequalities through action under the different objectives and by encouraging and facilitating the exchange of good practices to tackle them'.

The action plan for the EU health workforce ([40]) recognises some gender inequalities in this area:

- the gender pay gap;
- overall wage levels being lower in the healthcare sector (when compared to other sectors of the economy);
- work-life balance;
- the provision of supportive and safe working environments.

([35]) European Council, Council Conclusions on common values and principles in European Union health systems, http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2006:146:0001:0003:EN:PDF.
([36]) European Council, Council Conclusions on women's health, http://ec.europa.eu/health/ph_information/dissemination/documents/women_council_en.pdf.
([37]) European Commission, *Data and information on women's health in the European Union*, 2009, http://ec.europa.eu/health/population_groups/docs/women_report_en.pdf.
([38]) Council Conclusions on equity and health in all policies: solidarity in health (2010), http://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/lsa/114994.pdf.
([39]) European Commission, *White Paper: Together for health: a strategic approach for the EU 2008-2013*, 2007, http://ec.europa.eu/health/ph_overview/Documents/strategy_wp_en.pdf.
([40]) See: http://ec.europa.eu/health/workforce/docs/staff_working_doc_healthcare_workforce_en.pdf.

The Commission staff working document ([41]) on the action plan explains:

> *The issue of work-life balance is all the more relevant in the healthcare sector as the participation of women in the workforce has historically been significant and is increasing. Overall, there were more than 13.1 million women working in the healthcare sector in 2010, making up more than three quarters of the health workforce in the EU. In many Member States the intake of women to medical schools is now over 50 %. However, so far, this growing feminisation of the healthcare workforce has not always been properly reflected in measures to improve the reconciliation of professional and private life. It is a factor which might increase the difficulties to retain the healthcare workforce in the future.*

Moreover, although skill levels are relatively high and working conditions are often demanding (e.g., night and shift work), overall wage levels in health and social services tend to be lower than in other sectors. This tendency, which is related to the high rate of women's employment and the gender pay gap, is becoming more pronounced and may be another disincentive to work in this sector.

The Commission's plans to address health inequalities are set out in the Commission communication *Solidarity in health: reducing health inequalities in the EU* ([42]), published on 20 October 2009. This includes, but is not limited to, those inequalities based on sex and gender. In this communication, the European Commission commits to helping address health inequalities including through the following actions:

- collaboration with national authorities, regions and other bodies;
- assessment of the impact of EU policies on health inequalities to ensure they help reduce them where possible;
- regular statistics and reporting on the size of inequalities in the EU and on successful strategies to reduce them;
- better information on EU funding to help national authorities and other bodies address the inequalities.

European Parliament

In March 2011, the European Parliament adopted a resolution on reducing health inequalities in the EU, highlighting common values and principles such as access to highquality care, equality and solidarity. The resolution reiterates that health is influenced by gender. Women are more affected by malnutrition and unhealthy behaviours such as smoking. They are under-represented in clinical trials, and suffer health consequences related to experiencing violence. It recognises that violence against women is a public health issue and also that the number of women involved in the development of health policies and programmes should increase. Inequality in accessing healthcare for economic reasons is also underlined. Various groups, such as people with disabilities, also face exclusion from the healthcare system. In conclusion, the European Parliament called on the Commission and the Member States to improve access to disease prevention, health promotion and healthcare services and to reduce inequalities between social and age groups. It also called for a focus on access to healthcare for disadvantaged groups as well as a focus on women's access to methods of contraception. Disadvantaged groups include children and adolescents, migrant groups, undocumented migrants especially women, ethnic minorities, people with disabilities and the elderly ([43]).

International level

Council of Europe

The Council of Europe adopted a Recommendation in 2008 on the inclusion of gender differences in health policy ([44]). The Council issued a series of recommendations and specific measures to governments of Member States as to ensure the mainstreaming of gender in the health sector.

United Nations

At the Fourth World Conference on Women held in Beijing in 1995, the following strategic objectives on women and health were outlined (critical area of concern 'C'). The Beijing Platform for Action (BPfA) ([45]), adopted in 1995 by 189 UN Member States, defined health as complete well-being, not just the absence of illness or infirmity.

([41]) See: http://ec.europa.eu/health/workforce/docs/staff_working_doc_healthcare_workforce_en.pdf.

([42]) European Commission, Commission Communication — Solidarity in Health: Reducing Health Inequalities in the EU, 2009, http://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:52009DC0567&from=EN.

([43]) European Parliament resolution of 8 March 2011 on reducing health inequalities in the EU, http://www.europarl.europa.eu/sides/getDoc.do?pubRef=-//EP//NONSGML+TA+P7-TA-2011-0081+0+DOC+PDF+V0//EN.

([44]) See: https://search.coe.int/cm/Pages/result_details.aspx?ObjectID=09000016805d4212.

([45]) See http://www.un.org/womenwatch/daw/beijing/pdf/BDPfA%20E.pdf.

It stipulated that women must enjoy the highest standards of health throughout their lives and that there should be increased resources for research and follow up on women's health concerns. It reaffirmed women's right to sexual and reproductive health and choices about their sexuality. Among other actions, governments committed to:

- delivering affordable quality care and boosting investments in services essential to women;
- increasing women's access throughout the life-cycle to timely, appropriate, affordable and quality healthcare, information and related services;
- strengthening preventive programmes that promote women's health;
- undertaking gender-sensitive approaches that ensure sexual and reproductive health and rights, including in the area of HIV/AIDs;
- promoting research and disseminating information on women's health;
- increasing resources and monitoring mechanisms with engendered indicators to ensure gender mainstreaming of health policies and programmes.

Under each of these objectives, there are details of actions to be taken by governments and other stakeholders, both individually and collectively. The declaration also emphasises the rights-based approach to women's health in all its dimensions — on the demand side in particular — and the gender-sensitive provision of health services on the supply side, respecting women's rights. It emphasises women's participation and leadership in the health sector as critical to gender equality and women's empowerment. It also portrays the overall objective of the attainment of the highest standards of health for women as a right, and stresses it is the responsibility of the state and the community to ensure the enjoyment of this right.

The *Convention on the elimination of all forms of discrimination against women* ([46]), adopted in 1979 by the UN General Assembly, can be described as an international bill of rights for women. It defines what constitutes discrimination against women and sets up an agenda for national action to end such discrimination. Article 21 of the convention empowers the Committee on the Elimination of Discrimination against Women (CEDAW) to make suggestions and general recommendations based on the examination of reports and information received from state parties. CEDAW's General Recommendation 24 ([47]) (1999) sets out a series of recommended actions for state parties. The recommendations are summarised below.

- Place a gender perspective at the centre of all policies and programmes affecting women's health and involve women in the planning, implementation and monitoring of such policies and programmes and in the provision of health services to women.
- Ensure the removal of all barriers to women's access to health services, education and information, including in the area of sexual and reproductive health, and in particular, allocate resources to programmes directed at adolescents for the prevention and treatment of STDs, including HIV/AIDS.
- Prioritise the prevention of unwanted pregnancy through family planning and sex education and reduce maternal mortality rates through safe motherhood services and prenatal assistance. Where possible, legislation criminalising abortion could be amended to remove punitive provisions imposed on women who undergo abortion.
- Monitor the provision of health services to women by public, non-governmental and private organisations, to ensure equal access and quality of care.
- Require all health services to be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice.
- Ensure that training curricula for health workers include comprehensive, mandatory, gender-sensitive courses on women's health and human rights, in particular gender-based violence.

In the framework of the sustainable development goals, *Transforming our world: the 2030 agenda for sustainable development*, a set of aspiration goals with 169 targets were established. Goals and targets specifically devoted to health and gender equality were defined ([48]).

Goal 3. Ensure healthy lives and promote well-being for all at all ages

1. By 2030, reduce the global maternal mortality ratio to less than 70 per 100 000 live births.

([46]) *Convention on the elimination of all forms of discrimination against women*, http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm.

([47]) See: http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm#recom24.

([48]) https://sustainabledevelopment.un.org/post2015/transformingourworld; United Nations, resolution adopted by the General Assembly on 27 July 2012, A/RES/70/1 of 25 September 2015, http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/66/288&Lang=E.

2. By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1 000 live births and under-5 mortality to at least as low as 25 per 1 000 live births.

3. By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.

4. By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being.

5. Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.

6. By 2020, halve the number of global deaths and injuries from road traffic accidents.

7. By 2030, ensure universal access to sexual and reproductive healthcare services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.

8. Achieve universal health coverage, including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

9. By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination.

10. Strengthen the implementation of the World Health Organisation Framework Convention on Tobacco Control in all countries, as appropriate.

11. Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all.

12. Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States.

13. Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks.

Goal 5. Achieve gender equality and empower all women and girls

1. End all forms of discrimination against all women and girls everywhere.

2. Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation.

3. Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation.

4. Recognise and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies and the promotion of shared responsibility within the household and the family as nationally appropriate.

5. Ensure women's full and effective participation and equal opportunities for leadership at all levels of decision making in political, economic and public life.

6. Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.

7. Undertake reforms to give women equal rights to economic resources, as well as access to ownership and control over land and other forms of property, financial services, inheritance and natural resources, in accordance with national laws.

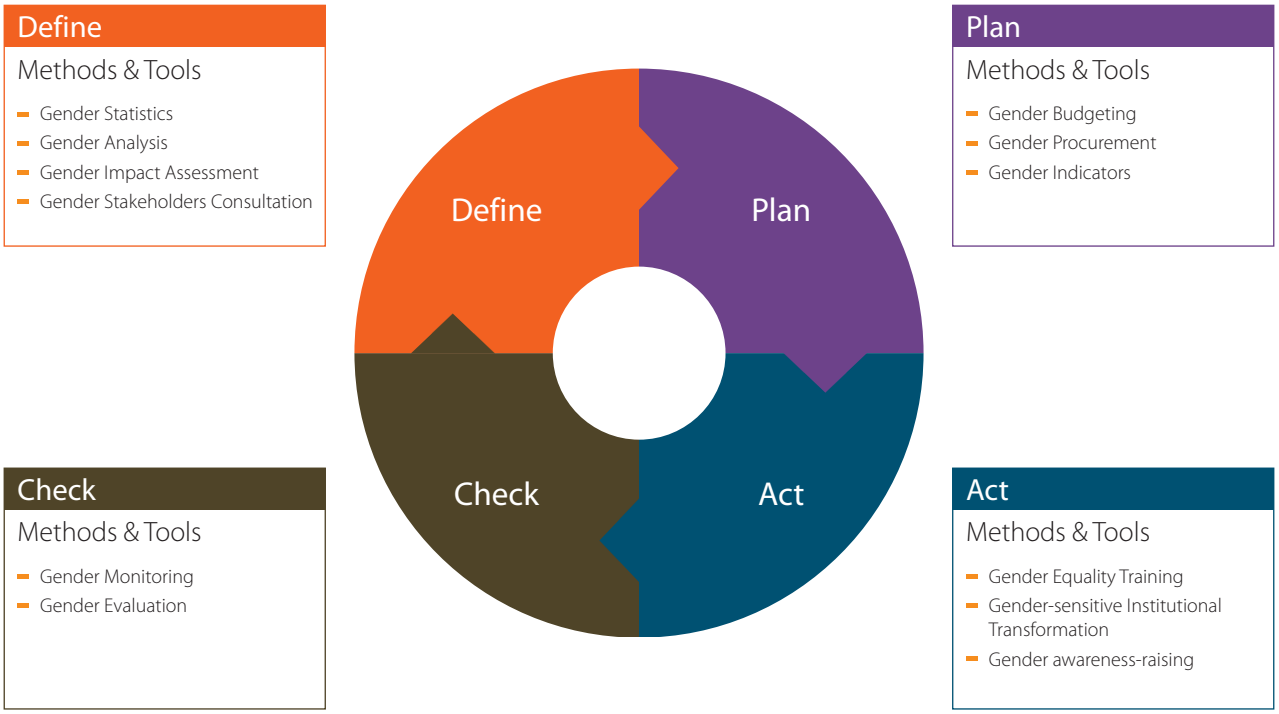
8. Enhance the use of enabling technology, in particular information and communications technology, to promote the empowerment of women.

9. Adopt and strengthen sound policies and enforceable legislation for the promotion of gender equality and the empowerment of all women and girls at all levels.

4. How and when? health and the integration of the gender dimension into the policy cycle

The gender dimension can be integrated in all phases of the policy cycle.

Below, you can find useful resources and practical examples for mainstreaming gender into health policy. They are organised according to the most relevant phase of the policy cycle they may serve.



Define

DEFINE PLAN ACT CHECK

In this phase, it's recommended that information is gathered on the situation of women and men in a particular area. This means looking for sex-disaggregated data and gender statistics, as well as checking for the existence of studies, programme or project reports, and/or evaluations from previous periods.

Examples of gender and health statistics

Eurostat

Health statistics measure both objective and subjective aspects of a population's health. They cover different kinds of health-related issues in different parts of everybody's life, including key indicators on the functioning of the healthcare systems. Equality indicators made available by Eurostat that relate to gender issues include indicators for *life expectancy*, *life expectancy by highest level of education attained*, *HLYs*, *causes of death*, and *hospital discharges by diagnosis*. Disaggregation by sex is available. The health dimension refers to both drivers and outcomes as well as the aspect of access to healthcare. Health outcomes include data on life expectancy as well as data on self-perceived physical and mental health. 'Drivers' refer to (un)healthy behaviours and include data on smoking, alcohol consumption, physical activity, and body mass index. *Access to healthcare* is operationalised by self-reported unmet medical needs.

These aspects include the following.

Health status and health determinants

The section presents data on various aspects of the health status of a population and its non-medical determinants, lifestyles and health behaviour. The data enable an analysis of public health issues as well as demographic and socio-economic patterns and disparities in health status and its

determinants, and provide a tool for monitoring the effects of health policies. Statistics on self-reported health and morbidity, functional and activity limitations, injuries, overweight and obesity, physical activity, dietary habits, risky behaviours such as tobacco and alcohol consumption data are included.
http://ec.europa.eu/eurostat/web/health/health-status-determinants/data/database

Healthcare

The section presents data on various aspects of healthcare systems:

- healthcare expenditure;
- human and technical healthcare resources;
- healthcare activities in hospitals and outside hospitals (covering treatment and prevention);
- use of medicines;
- unmet needs for healthcare.

The indicators can be used for evaluating the functioning and performance of healthcare systems including quality and access to healthcare services, healthcare expenditure, healthcare resources (staff and facilities) and activities (hospital and ambulatory services).
http://ec.europa.eu/eurostat/web/health/healthcare/data/database

Disability

Disability statistics provides data on the number of disabled persons as well as on their involvement in society, through data related to living conditions, social inclusion, labour market, health, or education. Prevalence of disability, employment of disabled persons, barriers to the social integration of disabled persons data are included.
http://ec.europa.eu/eurostat/web/health/disability/data/database

Causes of death

Statistics on causes of death provide information on mortality patterns and form a major element of public health information.
http://ec.europa.eu/eurostat/web/health/causes-death/data/database

Health and safety at work

This section provides data on accidents at work, work-related health problems and exposure to risk factors.
http://ec.europa.eu/eurostat/web/health/health-safety-work/data/database

The European health interview survey (EHIS)

The European health interview survey (EHIS) collects a large variety of data on health status, health determinants and healthcare activities on a non-annual basis. It consists of four modules on health status, healthcare use, health determinants and socioeconomic background variables. EHIS targets the population aged at least 15 and living in private households. Disaggregation by sex is available.

It represents one of the major sources of data and statistics on health status, health determinants and healthcare activities at the EU-28 level, used for populating the Eurostat statistics on health.

The four modules cover the following topics:

- background variables on demography and socioeconomic status such as sex, age, household type;
- health status such as self-perceived health, chronic conditions, limitation in daily activities, disease specific morbidity, physical and sensory functional limitations;
- healthcare use such as hospitalisation, consultations, unmet needs, use of medicines, preventive actions;
- health determinants such as height and weight, consumption of fruit, smoking, alcohol consumption.

http://ec.europa.eu/eurostat/web/microdata/european-health-interview-survey
http://ec.europa.eu/eurostat/web/income-and-living-conditions/data/database

The Eurostat statistics on income, social inclusion and living conditions

The main source for the compilation of statistics on income, social inclusion and living conditions at the EU-28 level is the EU living conditions survey from EU-SILC. EU-SILC provides cross-sectional and longitudinal information on income, poverty, social exclusion and living conditions, disaggregated by sex, age, nationality, education level, activity status and type of household. The EU-SILC contains seven annual variables on health status and healthcare use:

- self-perceived health;
- chronic morbidity;
- activity limitation;

- self-reported unmet needs;
- medical care;
- dental care;
- main reasons for unmet needs.

Breakdowns are given by: sex, age, labour status, educational attainment level, and income quintile group. It represents one of the major sources of data and statistics on health status, used for populating the Eurostat Statistics on Health.
http://ec.europa.eu/eurostat/web/health/health-status-determinants/data/database

The European Union labour force survey (EU-LFS)

The European Union labour force survey (EU-LFS) provides the main aggregated statistics on labour market outcomes in the EU. The EU-LFS is the main data source for employment and unemployment. Tables on population, employment, working hours, permanency of job, professional status, etc. are included. It provides disaggregated statistics by sex, age groups, economic activity, education attainment and field of education, from which the characteristics of the labour force of women, by age, can be measured. Numbers of women and men in the labour force by economic activities related to human health and social work activities are available. Periodically EU-LFS ad hoc modules cover employment of disabled people and accidents at work and work-related health problems.
http://ec.europa.eu/eurostat/web/lfs/data/database

Eurostat — education and training database

This database produces and publishes data, indicators and analysis on the operation, evolution and impact of education from early childhood through formal education to learning and training throughout life. Data and indicators disseminated include:

- participation rates at different levels of education;
- enrolments in public and private institutions;
- third-level education graduates;
- pupil-teacher ratios;
- foreign language learning;
- expenditure on education per student;
- relative GDP.

Data are disaggregated by sex, age, educational level and field of education. The data collection on education statistics is based on the International Standard Classification of Education (ISCED). For data on educational attainment based on the EU-LFS the *International Standard Classification of Education 2011* (ISCED 2011) is applied as from 2014. Numbers of women and men by education attainment and field related to health (e.g. health, health and welfare, medicine nursing and caring, dental studies, medical diagnostic and treatment technology, therapy and rehabilitation) are available.
http://ec.europa.eu/eurostat/web/education-and-training/data/database

EIGE — gender statistics

EIGE assists EU institutions and the Member States in the collection, analysis and dissemination of objective, reliable and comparable information and data on equality between women and men. The gender statistics database provides statistics on the indicators established and implemented for monitoring the BPfA critical areas of concern. Indicators related to health are included in Area C — women and health.
http://eige.europa.eu/gender-statistics/women-and-men-in-the-eu-facts-and-figures

European Institute for Gender Equality (2015) — gender equality index report

Measuring gender equality in the European Union 2005-2012

EIGE's gender equality index compiled two main indicators for monitoring gender in health, referring to health status, health behaviours and access to health structures. You can find the results for the EU and the 28 Member States here:
http://eige.europa.eu/gender-statistics/gender-equality-index/2012/domain/health.

World Health Organisation (WHO)

Health workforce data sources

This database contains the latest and trending data on core health indicators from WHO sources, including the annual World Health Statistics Report and the statistical annexes of the World Health Report.

It comprises more than 100 indicators, including those on human resources for health.
http://apps.who.int/gho/data/?theme=home

OECD Statistics on Health

This database provides data and statistics on health status and health risks, disaggregated by sex.
http://www.oecd.org/statistics/datalab/health.htm

Examples of studies, research, reports

Faculty of Medicine Carl Gustav Carus Research Association Public Health, 2009

Saxony and Saxony-Anhalt. Technische Universität Dresden, Dresden, Germany.

Data and Information on Women's Health in the European Union

This report presents an overview of the state of women's health in the EU. The report focuses on women aged 15 years and older in the 27 EU Member States, as well as the EEA countries Iceland, Liechtenstein, Norway, and occasionally Switzerland. The report shows there is persistent evidence that sex and gender differences are not only relevant for reproductive health issues, but also for the prevalence of diseases, risk factors and healthcare among women. It is essential to acknowledge that differences in health between women and men are due to interactions between environmental, behavioural, and biological factors.
http://ec.europa.eu/health/population_groups/docs/women_report_en.pdf

UN Women, World survey 2014 on the role of women in development

Gender equality and sustainable development

Coming on the heels of the UN Secretary-General's climate summit in September 2014, the report focuses on the theme of gender equality and sustainable development by examining a select range of issues that are fundamental to women's lives and are strategic for achieving gender equality and sustainability, including:

- patterns of growth, employment generation and the role of public goods;
- food production, distribution and consumption;
- population dynamics and women's bodily integrity;
- water, sanitation and energy.

The report makes concrete recommendations also related to the health sector. In particular, it calls on Member States to ensure that sustainable population policies are grounded in sexual and reproductive health and rights. This includes the provision of universally accessible quality sexual and reproductive health services, information and education.
http://www.unwomen.org/en/digital-library/publications/2014/10/world-survey-2014

World Health Organisation, 2010

A conceptual framework for action on the social determinants of health

This report pursues a comprehensive discussion of conceptual frameworks for science and policy for health equity. The report summarises the evidence on how the structure of societies, through social interactions, norms and institutions, are affecting population and health, and what governments and public health can do about it. A review and summary of different frameworks for understanding the social determinants of health were carried out. This review was summarised and synthesised into a single conceptual framework for action on the social determinants of health.
http://apps.who.int/iris/bitstream/10665/44489/1/9789241500852_eng.pdf?ua=1&ua=1

World Health Organisation, 2015

Beyond the mortality advantage. Investigating women's health in Europe

The report presents some of the preliminary findings of the investigation, focusing on broad causes of mortality and morbidity during four age stages. This covers the girl child, adolescents, adult women and older women, and emphasises how factors that influence health cut across the stages. It shows how gender and socioeconomic determinants affect opportunities for girls and women in the European Region to realise their right to health and well-being across the life-course. It also provides a basis for prioritising actions for all sectors of governments and societies.
http://www.euro.who.int/__data/assets/pdf_file/0008/287765/Beyond-the-mortality-advantage.pdf

World Health Organisation, Women and health, 2009

Today's evidence — tomorrow's agenda

This report uses available data to take stock of the health of girls and women around the world. It draws attention to the consequences and costs of failing to address health issues at appropriate points in their lives. In particular, the study notes the importance of women's multiple contributions to society in their productive and reproductive roles, and both as consumers and — just as importantly — as providers of healthcare. In recognition of this, the report calls for primary healthcare reforms to be implemented in ways that ensure health systems better meet the needs of girls and women.
http://www.who.int/gender/women_health_report/full_report_20091104_en.pdf

European Women's Lobby, Position paper, 2010

Women's health in the European Union

This paper presents the analysis of the European Women's Lobby regarding the issues of health and well-being (both physical and mental), considered as crucial conditions for the full development of every human being. It calls for national and European decision makers for public policies in the health sector to fully address women's health needs.
http://www.womenlobby.org/spip.php?article90&lang=en

European Institute of Women's Health, Women's health in Europe, 2006

Facts and figures across the European Union

The report captures the state of women's health across the enlarged EU of 25 Member States. The study acknowledges that gender is a key determinant of health and equally important as the social, economic or ethnic background of any individual in relation to that individual's health. The report is divided into three sections: demographic and socioeconomic trends; women's health issues; policy recommendations and suggestions for future research in the field of women's health at the EU level.
http://eurohealth.ie/reports/

Lasch, V., Freitag, W., and Sonntag, U. (eds.), 2006

Gender, health, and cultures: networking for a better future for women

This book gives an overview of gender and health in the EU with a strong focus on Eastern European countries. The specific country cultures are not only different with regard to their health systems, but also in integrating gender aspects in research, policy and practice. The very definitions of health, illness and health-related social problems are different. If networks focus on gender-specific aspects of health and illness, the necessity for transnational communication is evident. Instruments for bringing gender aspects into health-related research, prevention and healthcare are introduced. The increasing importance of the internet is shown. Central elements in the process of intercultural networking are described.
http://www.uni-kassel.de/upress/online/frei/978-3-89958-164-5.volltext.frei.pdf

One of the first steps to take when defining your policy/project/programme is to gather information and analyse the situation of women and men in the respective policy area. The information and data you collect will allow an understanding of the reality and assist you in designing your policy, programme or project. Specific methods that can be used in this phase are gender analysis and gender impact assessment.

Examples of gender analysis

RinGs (2015). How to do gender analysis in health systems research

RinGs is a new initiative funded by the UK Department for International Development. It brings together three health systems into Research Programme Consortia (RPC): future health systems, ReBUILD and RESYST in a partnership to galvanise gender and ethics analysis in health systems. On 8 September 2015 RinGs held a cross-RPC webinar on *How to do gender analysis within health systems research*. Gender analysis is important for all health systems research and there are multiple ways in which gender analysis can be incorporated, all of which will help to strengthen research evidence and recommendations. The webinar drew upon research evidence and examples to explore ways in which health systems researchers can incorporate gender analysis into their research.
http://resyst.lshtm.ac.uk/resources/how-do-gender-analysis-health-systems-research

World Health Organisation Department of Gender, Women and Health, 2003

Gender analysis in health: a review of selected tools

This critical review examines the content of 17 widely-used gender tools and their usefulness for gender analysis in health. The review is a useful resource for those working on gender and health.
http://apps.who.int/iris/bitstream/10665/42600/1/9241590408.pdf

World Health Organisation Commission on social determinants on health, 2008

Closing the gap in a generation — health equity through action on the social determinants of health

The study deals with systematic differences in health that can be avoidable by reasonable action in order to contribute to remedy differences in health between and within countries. Reducing health inequities is, for the Commission on Social Determinants of Health (CSDH), an ethical imperative. Social injustice is killing people on a grand scale. The study dedicates Chapter 13 to the improvement of gender equity for health.
http://www.who.int/social_determinants/final_report/csdh_finalreport_2008.pdf

Interagency Gender Working Group, 2009

A manual for integrating gender into reproductive health and HIV programmes

The manual is a companion to the guide for incorporating gender considerations in USAID's family planning and reproductive health requests for applications and requests for proposals. It complements the guide by orienting programme designers, managers, and technical staff on how to integrate gender issues into programme design, implementation and evaluation. The manual promotes greater understanding of how gender relations and identities affect the capacity of individuals and groups to make informed choices about their sexual and reproductive health.
http://www.igwg.org/igwg_media/manualintegrgendr09_eng.pdf

Clow, B., Pederson, A., Haworth-Brockman, M., and Bernier, J., 2009

Rising to the challenge: sex and genderbased analysis for health planning, policy and research in Canada

Sex and genderbased analysis rests on the understanding that both biology (sex) and the social experience of being a man or a woman (gender) affect people's lives and their health. Taking into consideration these biological and social differences between women and men, and analysing how they relate to a particular health problem, is the crux of sex and genderbased analysis.
http://bccewh.bc.ca/wp-content/uploads/2012/05/2009_Rising_to_the_challenge.pdf

The Women's Health Council, 2007

Integrating the gender perspective in Irish health policy: a case study

This entails integrating attention to sex and gender differences in all stages of health policy development: problem definition and agenda setting; policy design; decision making; policy implementation and monitoring. This case study aimed to describe the extent to which gender was included in the national cardiovascular health policy and its follow-up reports, and to assess the extent to which gender was taken into account in the development of the strategy.
http://health.gov.ie/wp-content/uploads/2014/03/Integrating-the-Gender-Perspective-in-Irish-Health-Policy-A-Case-Study.pdf

Arber, S., and Thomas, H., 2001, *From women's health to a gender analysis of health*

The Blackwell Companion to Medical Sociology

The health experiences of women differ from those of men. These differences primarily reflect gender roles relating to the social, cultural and economic circumstances of women's and men's lives. The study explores how gender roles and relationships affect health, and points to some of the ways in which changes in gender roles over time and between societies influence gender differences in health.

Sundari Ravindran, T.K., and Kelkar-Khambete, A., 2007

Women's health policies and programmes and gender mainstreaming in health policies, programmes and within health sector institutions

The paper reviews published literature in English on experiences in mainstreaming gender within the health sector since the 1990s. It has a focus on policies, programmes, research and health provider training, and institutional changes within health sector organisations.
http://www.who.int/social_determinants/resources/womens_health_policies_wgkn_2007.pdf

World Health Organisation, 2011, Human rights and gender equality in health sector strategies

How to assess policy coherence

This tool is designed to support countries as they design and implement national health sector strategies in compliance with obligations and commitments. The tool focuses on practical options and poses critical questions for policymakers to identify gaps and opportunities in the review or reform of health sector strategies, as well as other sectoral initiatives. It is expected that using this tool will generate a national multi-stakeholder process and a cross-disciplinary dialogue to address human rights and gender equality in health sector activities. The tool aims to operationalise a human rights-based approach and gender mainstreaming through their practical application in policy assessments.
http://www.ohchr.org/Documents/Publications/HRandGenderEqualityinHealthSectorStrategies.pdf

Examples of gender impact assessments

European Commission, Gender in Research

Gender impact assessment of the specific programmes of the fifth framework programme: an overview

This report presents a synthesis of the key findings and recommendations of seven studies carried out as part of the gender impact assessment exercise, launched by the European Commission in June 2000. These studies were undertaken with a view to assessing the way in which gender issues are being addressed within the fifth framework programme (FP5).

Each study focused on one specific programme or sub-programme of the FP5, assessing whether and how gender issues have been taken into account. It also provided recommendations for a better integration of the gender dimension in future Community research in that area. A review of research in the field of gender and health is also included.
ftp://ftp.cordis.europa.eu/pub/science-society/docs/women_gender_impact_fp5_en.pdf

Women's Health Victoria

Guide to developing a gender impact assessment

The Australian not-for-profit organisation focused on improving the lives of Victorian women has produced topic-based gender impact assessments. These analyse the extent to which existing or proposed policy and practice is based on gendered evidence, and responds appropriately to gender. They highlight policies and practices that are gender blind, and make recommendations that promote gender equity and improved outcomes for women. The content emphasises the social model of health, and has an Australian focus.
http://whv.org.au/publications-resources/gender-impact-assessments

Ontario Ministry of Health and Long-Term Care

Health Equity Impact Assessment (HEIA)

The Health Equity Impact Assessment is a decision support tool that walks users through the steps of identifying how a programme, policy or similar initiative will impact population groups in different ways. The end goal is to maximise positive impacts and reduce negative impacts that could potentially widen health disparities between population groups for more equitable delivery of the programme, service, policy, etc.
http://www.health.gov.on.ca/en/pro/programs/heia/tool.aspx

Consider consulting stakeholders (e.g. gender experts, civil society organisations) on the topic at hand, to share and validate your findings and to improve your policy or programme proposal. This will enhance the learning process on the subject for all those involved and will improve the quality of the work done at EU level. The stakeholders consultation process will start in this phase, but could also be considered as an important method to be applied along all the policy cycle's phases.

Examples of stakeholder involvement

World Health Organisation

In 2005 the WHO set up the Commission on Social Determinants of Health. This was formed to marshal the evidence on what can be done to promote health equity, and to foster a global movement to achieve it. CSDH has identified principles and recommendations to tackle health inequities: the factors responsible for avoidable health inequalities, which persist globally and in the EU.
http://www.who.int/gender/en/

European Institute of Women's Health

This is a non-governmental organisation set up to promote gender equity in public health, research and social policies across Europe.
http://eurohealth.ie/

European Women's Lobby

The European Women's Lobby, among its several working areas, increasingly requests a stronger position and expertise in the area of health. Thus the network developed actions to push for gender equality principles to be fully embedded into European health policies in order to ensure and reach an improvement of women's health status.
http://womenlobby.org/

European Gender Medicine Network

This network was developed by a project funded by the European Commission. The project identified focal areas of work where sex and gender play a major role and set timelines for the generation of materials. All materials together constitute the road map for specific target audiences by the consortium and experts. All partners will contribute to the dissemination of the road map.

During the project, six meetings with key stakeholders were organised in order to produce recommendations, guidelines and teaching materials. The drafted materials will be disseminated through a European gender health portal. The aim is to create a truly multi-sectoral sourcing of knowledge, a key factor for building consensus and helping close the participatory governance gaps.
http://www.eugenmed.eu/

European Public Health Alliance

The European Public Health Alliance (EPHA) is the European platform bringing together public health organisations representing health professionals, patient groups, health promotion, disease specific non-governmental organisations, academic groupings and other health associations. EPHA's mission is to protect and promote public health in Europe.

EPHA brings together organisations across the public health community, to share learning and information and to bring a public health perspective to European decision making. Its aim is to ensure health is at the heart of European policy and legislation. On October 2011 it launched the European Charter for Health Equity, inviting all relevant stakeholders, organisations and institutions to sign it. The charter calls for action from the civil society to all relevant stakeholders and in particular decision makers, relevant governmental and civil society partner organisations, and other regulatory bodies. The aim is to protect and promote people's health by acting on health inequalities between and within countries in Europe.

Institute of Gender and Health

The Institute of Gender and Health's mission is to foster research excellence regarding the influence of gender and sex on the health of women and men throughout life, and to apply these research findings to identify and address pressing health challenges.
http://www.cihr-irsc.gc.ca/e/8677.html

Plan

DEFINE PLAN ACT CHECK

In this phase, it is appropriate to analyse budgets from a gender perspective. Gender budgeting is used to identify how budget allocations contribute to promoting gender equality. Gender budgeting brings visibility to how much public money is spent for women and men respectively. Thus, gender budgeting ensures that public funds are fairly distributed between women and men. It also contributes to accountability and transparency about how public funds are being spent.

Example of gender budgeting in health

United Nations Population Fund/United Nations Development Fund for Women, 2006

Gender responsive budgeting and women's reproductive rights: a resource pack

The *Budgeting for reproductive rights resource pack* was produced under a UNFPA/United Nations Development Fund for Women (UNIFEM) strategic partnership aimed at developing a coordinated approach for effective technical assistance to gender responsive budgeting (GRB). GRB encompasses a broad range of possible activities. The types of activities for which country partners request support are also very diverse. Thus, it is not possible to provide simple recipes for either the country partners or for UNFPA country support teams. The purpose of this resource pack is to provide relevant knowledge that may facilitate mainstreaming gender responsive approaches into reproductive health. It is also aimed at assisting with the inclusion of specific aspects of gender inequality and disadvantage into national policy frameworks. The resource pack focuses primarily on health, particularly reproductive health, on HIV/AIDS and on violence against women as it relates to health services.
http://www.unfpa.org/sites/default/files/pub-pdf/gender_responsive_eng.pdf

When planning, do not forget to establish monitoring and evaluation systems, and indicators that will allow measurement and compare the impact of the policy or programme on women and men over the timeframe of its implementation. Remember to define the appropriate times to monitor and evaluate your policy.

Examples of indicators for monitoring gender and health

Life expectancy at birth, by sex

The indicator measures the mean additional number of years that a person can expect to live, assuming current mortality conditions. It is disaggregated by women and men and is also considered in the calculation of the EIGE gender equality index under the health domain. In 2013, the average expectancy at birth in EU-28 for women was 83.3 years of age and 77.8 years for men ([49]). The indicator is available from the Eurostat's statistics on health (online data code: *hlth_hlye*).
http://ec.europa.eu/eurostat/data/database?node_code=%20hlth_hlye

Healthy life years, by sex (BPfA Area C — women and health)

This indicator, also called disability-free life expectancy, measures the number of remaining years that a person of a certain age is still expected to live without disability. HLY introduces the concept of quality of life into life expectancy. It is used to distinguish between years of life free of any activity limitation and years experienced with at least one activity limitation. The emphasis is not exclusively on the length of life, as is the case for life expectancy, but also on the quality of life. HLY is a functional health status measurement increasingly used to complement the conventional life expectancy measures. Chronic disease, frailty, and disability tend to become more prevalent at older ages, so a population with a higher life expectancy may not be healthier.

([49]) EIGE, *Gender equality index*, 2015, http://eige.europa.eu/gender-statistics/gender-equality-index/2012/domain/health/1.

This indicator measures the number of HLYs that a person is expected to live without any severe or moderate health problems. The calculation is based on two data sources: Eurostat demographic data on mortality and the EU-SILC. The self-perceived disability is based on the EU-SILC survey. An 'unhealthy' condition is defined by the limitation in people's usual activities because of health problems for at least the previous 6 months. It is disaggregated by women and men and is also considered in the calculation of the EIGE gender equality index under the health domain ([50]). The indicator is included in the set of indictors for monitoring Area C — women and health, in the BPfA ([51]).

In 2013, the number of HLYs at birth was estimated at 61.4 years for men and 61.5 years for women in the EU-28; this represented approximately 79 % and 74 % of total life expectancy for men and women. The gender gap was considerably smaller in terms of HLYs than it was for overall life expectancy ([52]). The indicator is available from the Eurostat's statistics on health (online data code: *hlth_hlye*).
http://ec.europa.eu/eurostat/data/database?node_code=%20hlth_hlye

Access to healthcare — self-reported unmet needs for medical examination, by sex

BPfA Area C — women and health

This indicator is defined as the share of women and men aged 16 and over perceiving an unmet need for medical examination or treatment. Reasons include problems of access and other issues:

- could not afford to;
- waiting list;
- too far to travel;
- could not take time off;
- fear;
- wanted to wait and see;
- didn't know any good doctor or specialist;
- other reason.

It is disaggregated by women and men and is also considered in the calculation of the EIGE gender equality index under the health domain ([53]). The indicator is included in the set of indictors for monitoring Area C — women and health, in the BPfA ([54]). In 2013, 7.4 % of women declared they had unmet needs for medical examination, compared to 6.4 % of men.

The indicator is available from the Eurostat's statistics on health, calculated on the basis of the European Union living conditions survey (EU-SILC) (online data code: *hlth_silc_08*).
http://ec.europa.eu/eurostat/data/database?node_code=hlth_silc_08

Self-perceived health by sex

The indicator focuses on self-perceived health, based on an auto-evaluation that excludes any temporary health problem, and it is a subjective measure. Although influenced by impressions or opinions from others, it provides an account of a woman or man's assessment of their health relative to their own beliefs and attitudes. The categories considered are 'good' and 'very good'. The indicator is disaggregated by women and men and is also considered in the calculation of the EIGE gender equality index under the health domain. In 2012, the EU-28 is close to gender equality in self-perceived health, with an average gender gap of 5.5 percentage points ([55]). The calculation is based on the EU-SILC and included in the Eurostat's statistics on health (online data code: *hlth_silc_01*).
http://ec.europa.eu/eurostat/data/database?node_code=hlth_silc_01

When preparing calls for proposals in the framework of funding programmes, or terms of reference in the context of public procurement procedures (notably for contractors to be hired for policy support services), don't forget to formalise gender-related requirements. This will ensure the projects and services which the European Commission will fund are not gender blind or gender biased.

([50]) EIGE, *Gender equality index*, 2015, http://eige.europa.eu/gender-statistics/gender-equality-index/2012/domain/health/1.
([51]) http://eige.europa.eu/gender-statistics/women-and-men-in-the-eu-facts-and-figures/area/41/indicator/224
([52]) http://ec.europa.eu/eurostat/statistics-explained/index.php/Healthy_life_years_statistics
([53]) EIGE, *Gender equality index*, 2015, http://eige.europa.eu/gender-statistics/gender-equality-index/2012/domain/health/2.
([54]) http://eige.europa.eu/gender-statistics/women-and-men-in-the-eu-facts-and-figures/area/41/indicator/66
([55]) EIGE, *Gender equality index*, 2015, http://eige.europa.eu/gender-statistics/gender-equality-index/2012/domain/health/1.

Example of procurement

Swedish Association of Local Authorities and Regions

Stockholm Country Council: equality requirement for procurement of healthcare

The Swedish Association of Local Authorities and Regions has published a guide to inform on the legal possibilities of imposing gender equality requirements on public procurements. The guide has primarily been elaborated for politicians who wish to increase their knowledge on gender equality issues and to improve quality of services. It provides concrete examples of how requirements in public procurement can be carried out, and aims to encourage local authorities to start using this as an instrument to advance gender equality. The guide reports on the best practice of the Stockholm Country Council (SCC) that states they should guarantee provision of good healthcare on equal terms regardless of gender. Therefore, they have set general requirements for companies or partners that enter into an agreement with them. A precondition for entering into an agreement with SCC is that the caregiver has to follow SCC's equality policy. Among other things, this includes taking part in ongoing quality work and focusing on providing equal treatment for women and men in health care. Furthermore, in the evaluation of activities all relevant key figures and statistics should be reported divided by gender and age.
http://www.charter-equality.eu/exemple-de-bonnes-pratiques/gender-equality-requirements-in-public-procurement.html

Act

DEFINE PLAN **ACT** CHECK

In the implementation phase of a policy or programme, ensure that all who are involved are sufficiently aware about the relevant gender objectives and plans. If not, set up briefings and capacity-building initiatives according to staff needs. Think about researchers, proposal evaluators, monitoring and evaluation experts, scientific officers, programme committee members, etc.

Examples of capacity-building initiatives about gender and health

National Women's Council of Ireland

Gender matters, training handbook on gender mainstreaming in health

The objectives of this handbook are:

- to improve understanding and awareness about how gender inequalities impact on the health of women, men and transgender people, including their access to healthcare;
- to raise awareness about how services can be provided so that they take account of the needs and experiences of women and men;
- to give a specific focus on addressing attitudes and stereotypes, and how people think and act as a result of learned gender roles;
- to show how gender mainstreaming tools can be used to provide gender-sensitive health services, so that services are provided in equal and non-discriminatory ways;
- to enhance capacity for the planning and delivery of healthcare services by focusing on the gender-specific health needs of women and men.

http://www.nwci.ie/images/uploads/NWCI_GM_Training_Manual_A4_WEB.pdf

Pan American Health Organisation

Gender and health, awareness, analysis and action: a virtual course

The purpose of this course is to provide basic skills on gender mainstreaming in health. The objectives are as follows:

- increase knowledge and awareness of how outcomes in health are related to sex, gender norms, roles, relations and other determinants of health;
- initiate the building of core analytical skills for gender analysis and its application in a public health context;
- understand how the health sector can use gender analysis tools to effectively reduce health inequities.

http://www.who.int/gender-equity-rights/knowledge/virtual-course-gender-health/en/

Medical Women's International Association, 2013

Training manual for gender mainstreaming in health

The Medical Women's International Association developed a training manual for gender mainstreaming in health. This was in response to the need for physicians to understand how adding a gender perspective to health and healthcare could positively influence the health of women and men.

Although this manual was published in 2001, it has been updated in 2013 and is, therefore, a useful example for a capacity-building initiative about gender and health.
http://fmwc.ca/docs/TrainingManualonGenderMainstreaminginHealth%5B1%5D.pdf

World Health Organisation, 2011

Gender mainstreaming for health managers: a practical approach. Facilitator's guide

This manual focuses on gender as a determinant of health for women and men and the particular ways that gender equality contributes to better health outcomes for women and girls. In particular, this manual addresses how gender norms, roles and relations affect health-related behaviours and outcomes as well as health sector responses. At the same time, it recognises that gender inequality is a cross-cutting determinant of health that operates in conjunction with other forms of discrimination. This may be based on such factors as age, socioeconomic status, ethnicity or place of origin and sexual orientation. The manual provides a basis for addressing other forms of health-related discrimination.
http://apps.who.int/iris/bitstream/10665/44516/1/9789241501071_eng.pdf

European Commission, Gender in research as a mark of excellence, 2011

Gender in EU-funded research: toolkit and training (module on health)

The toolkit and training packages give the research community practical tools to integrate gender aspects into seventh framework programme research. They include equal opportunities for women and men and the gender dimension of research, thereby contributing to excellence in research. The first module is specifically dedicated to health research.
http://www.yellowwindow.be/genderinresearch/downloads/YW2009_GenderToolKit_field1_Health_001.pdf

Ontario Women's and Health Council

Gender and health collaborative curriculum

The site presents a series of training modules covering the topics of gender and health. These include an introductory module, gender and CVD, gender and depression, and gender and dementia.
http://genderandhealth.ca/

Example of gender language in health

Campbell White, A., Catsambas, T. and Monnet, M., 2002

Language, culture and health: the gender divide using proverbs to tackle gender inequities in health

This paper examines the use of proverbs as an innovative way of helping health policymakers and service providers to understand how inherent socio-culture influences public perceptions of gender roles. The use of proverbs facilitates self-awareness of gender biases and engages people in deeper and more sincere dialogue about possible solutions. Planners and providers of health services have to think beyond requirements based on statistical trends and economic considerations such as costing and prioritisation; they also have to consider societal attitudes that determine demand. The task of identifying and understanding gender roles might seem overwhelming enough without the additional task of analysing the culture and values that created the gender roles. Yet, without a way to increase self-awareness about culture and values around gender roles, it is difficult for people to hear and understand messages that depart from their cultural norms about gender. Planners and providers of health services need a strategy to overcome the natural resistance and defences people have against gender discussions.

Check

A policy cycle or programme should be checked both during — monitoring, and at the end — evaluation, of its implementation.

Monitoring the ongoing work allows for the follow up of progress and for remedying unforeseen difficulties. This exercise should take into account the indicators delineated in the planning phase and realign data collection based on those indicators.

At the end of a policy cycle or programme, a gender-sensitive evaluation should take place. Make your evaluation publicly accessible and strategically disseminate its results to promote its learning potential.

Examples of gender monitoring and evaluation on health

USAID from the American people

Monitoring and evaluation of gender and health

This USAID-funded measure evaluation project aims at strengthening health systems in low-resource settings. Strong health systems are able to gather, interpret and use data to maximise health programme impact. Strong health information systems are a crucial element in overall health systems and, therefore, a critical factor in achieving better health for people.

The document intends to contribute to the identification of the importance of gender to health outcomes and programming, and the identification of donor gender monitoring and evaluation requirements. The overall goal is to contribute to the understanding of how to apply gender indicators to health programmes, to integrate gender into monitoring and evaluation in the health sector.
http://www.cpc.unc.edu/measure/resources/training/materials/m-e-of-gender-and-health/view

Pan American Health Organisation

Guide for analysis and monitoring of gender equity in health policies

This guide provides a comprehensive framework and a method for monitoring and evaluating the effects of health policies on gender equity. It includes guidelines for the analysis of the social, economic, legal and political context of gender equity. It also has detailed lists of indicators and variables to be used in data collection tools. It includes guidelines and tables of benchmarks, indicators, and questions for monitoring and analysing the impact of health policies on gender equity. These cover nine fields of the health system including access to care, quality of care, health system financing, the management of human resources and intersectorial action.
https://www.k4health.org/sites/default/files/Guide%20for%20Analysis%20%26%20Monitoring%20of%20GndEquity%20in%20Health%20pgms.pdf

International Planned Parenthood Federation/Western Hemisphere Region, 2000 Manual for evaluating quality of care from a gender perspective.

This manual provides tools, strategies and methods to evaluate (from a gender-based perspective) the quality of care at reproductive health institutions. The manual will also help the institutions analyse the evaluations and identify areas that need improvement.
https://www.k4health.org/sites/default/files/Manual%20to%20Evaluate%20Quality%20of%20Care%20from%20Gender%20Perspective.pdf

5. Practical examples of gender mainstreaming in health

Ireland

Women's Health Council, 2007 — a guide to creating gender-sensitive health services

Drawing on the models already in place internationally, this document aims to act as a guide to creating and implementing gender-sensitive health services in Ireland. Looking to the excellent examples set by Australia, Canada and Sweden, extensive reference to the models of best practice in these countries has been included in this guide. Case studies on mental health and CVD have also been included to demonstrate the gendered nature of health in an Irish context.

Health Service Executive and the National Women's Council of Ireland, 2012

Equal but different: a framework for integrating gender equality in health service executive policy, planning and service delivery

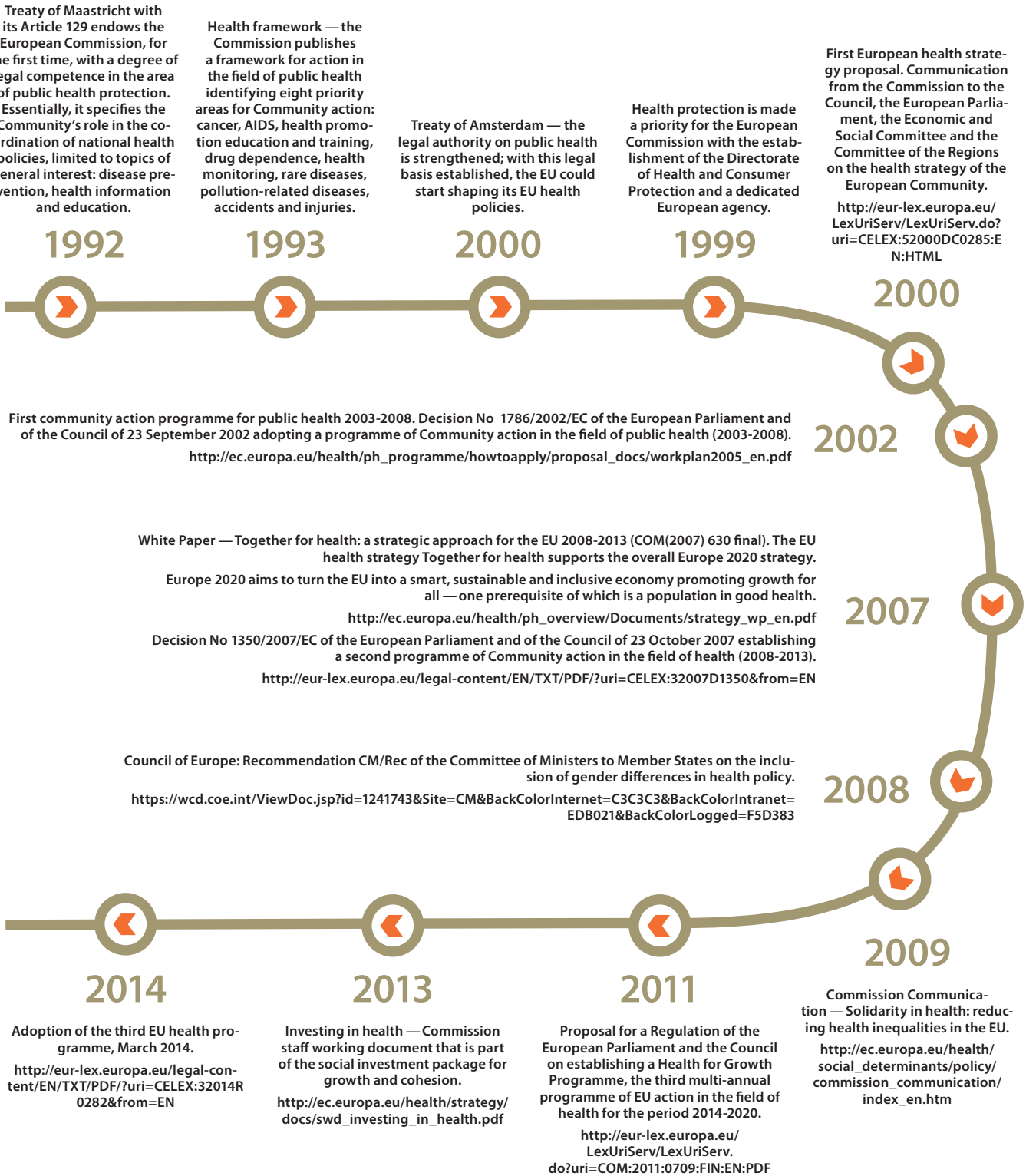
The purpose of this framework is to support the Health Service Executive (HSE) in developing a gender mainstreaming policy.

It is foreseen that the implementation of gender mainstreaming should be built into the HSE's performance monitoring system in order to monitor progress against the gender mainstreaming goals. Monitoring should be tied into the systems developed under the Health Inequalities Framework 2010-2012 and reporting on key performance indicators. These indicators would be very important to measuring the impact of gender mainstreaming and whether a gender perspective has been taken into account. Moreover, an annual report on gender mainstreaming should be presented to the HSE management team and the HSE board.
https://www.nwci.ie/download/pdf/equal_but_different_final_report.pdf

6. Want to know more?

Timeline

The key milestones of the EU health policy are presented below.



7. Current policy priorities at the EU level

EU health policy complements national policies to ensure that everyone living in the EU has access to quality healthcare. EU actions are directed towards improving public health, preventing physical and mental illness and diseases, and avoiding sources of danger to physical and mental health. Such actions cover the fight against the major health scourges by promoting research into their causes, their transmission and their prevention. They also include health information and education, and monitoring, early warning and combating serious cross-border threats to health. The EU complements the Member States' actions in reducing drugs-related health damage, including information and prevention ([56]).

The European health policy thus aims to give all people living in the EU access to high-quality healthcare, specifically by:

- preventing illnesses and diseases;
- promoting healthier lifestyles;
- protecting people from health threats such as pandemics.

The EU health policy, implemented through the Health Strategy ([57]), focuses on:

- prevention — especially by promoting healthier lifestyles;
- equal chances of good health and quality healthcare for all (regardless of income, gender, ethnicity, etc.);
- tackling serious health threats involving more than one EU country;
- keeping people healthy into old age;
- supporting dynamic health systems and new technologies.

In this context, the current priorities of EU policy for health are clearly identified in the third EU health programme ([58]), which is the main instrument the European Commission uses to implement the EU health strategy. It is implemented by means of annual work plans which set out priority areas and the criteria for funding actions under the programme.

In particular, the current third health programme (2014-2020) has four overarching objectives. It seeks to:

1. promote health, prevent diseases and foster supportive environments for healthy lifestyles taking into account the 'health in all policies' principle;
2. protect Union citizens from serious cross-border health threats;
3. contribute to innovative, efficient and sustainable health systems;
4. facilitate access to better and safer health care for Union citizens.

Through the funding of health projects, the health programme aims to:

- improve the health of EU citizens and reduce health inequalities;
- encourage innovation in health and increase sustainability of health systems;
- focus on themes that address current health issues across Member States;
- support and encourage cooperation between Member States.

([56]) http://www.lisbon-treaty.org/wcm/the-lisbon-treaty/treaty-on-the-functioning-of-the-european-union-and-comments/part-3-union-policies-and-internal-actions/title-xiv-public-health/456-article-168.html
([57]) http://ec.europa.eu/health/ph_overview/Documents/strategy_wp_en.pdf
([58]) http://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32014R0282&from=EN

Resources

Selected policy documents relevant to health

Regulation of the European Parliament and of the Council on establishing a Health for Growth Programme, the third multi-annual programme of EU action in the field of health for the period 2014-2020.
http://ec.europa.eu/health/programme/docs/prop_prog2014_en.pdf

European Community, White paper, *Together for health: a strategic approach for the EU 2008-2013*.
http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2010:0639:FIN:EN:PDF

Council Conclusions on common values and principles in European Union health systems.
http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2006:146:0001:0003:EN:PDF

Council Conclusions on women's health.
http://ec.europa.eu/health/ph_information/dissemination/documents/women_council_en.pdf

Gender equality relevant policy documents

Commission Communication, *Solidarity in health: reducing health inequalities in the EU*.
http://ec.europa.eu/health/social_determinants/policy/commission_communication/index_en.htm

Council of Europe, Recommendation CM/Rec (2008)1 of the Committee of Ministers to Member States on the inclusion of gender differences in health policy.
https://wcd.coe.int/ViewDoc.jsp?id=1241743&Site=CM&BackColorInternet=C3C3C3&BackColorIntranet=EDB021&BackColorLogged=F5D383

Selected references of studies on gender issues in health

European Commission, *Data and information on women's health in the European Union*, Directorate-General Health and Consumers, 2009.
http://ec.europa.eu/health/population_groups/docs/women_report_en.pdf

European Commission, *The state of men's health in Europe*, Directorate-General for Health and Consumers, 2011.
http://ec.europa.eu/health/population_groups/docs/men_health_extended_en.pdf

European Commission, *Quality in and equality of access to healthcare services*, European Communities, Directorate-General for Employment, Social Affairs and Equal Opportunities, 2008.

http://www.euro.centre.org/data/1237457784_41597.pdf

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EIGE, *Beijing + 20: The fourth review of the implementation of the Beijing Platform for Action in the EU Member States*, 2015.
http://eige.europa.eu/sites/default/files/documents/MH0414886ENN.PDF

EIGE, *Beijing + 20: The Platform for Action (BPfA) and the European Union Area C: women and health*, 2015.
http://eige.europa.eu/sites/default/files/documents/C_MH0415022ENC.pdf

European Monitoring Centre for Drugs and Drug Addiction, *Annual report: a gender perspective on drug use and responding to drug problems*.
http://www.emcdda.europa.eu/themes/women

FRA, *Violence against women: an EU-wide survey, main results*, 2014.
http://fra.europa.eu/sites/default/files/fra-2014-vaw-survey-main-results-apr14_en.pdf

Klinge, I., and Wiesemann, C. (eds.), *Sex and gender in biomedicine — theories, methodologies, results*, Göttingen University, 2010.

UN Women, *World Survey on the Role of Women in Development 2014: Gender equality and sustainable development*, 2014.
http://www.unwomen.org/en/digital-library/publications/2014/10/world-survey-2014

WHO, 'Gender and health workforce statistics', *Spotlight on Statistics — a fact file on health workforce statistics*, No 2, 2008.
http://www.who.int/hrh/statistics/spotlight_2.pdf

WHO, *A conceptual framework for action on the social determinants of health*, 2010.
http://apps.who.int/iris/bitstream/10665/44489/1/9789241500852_eng.pdf?ua=1&ua=1

WHO, *Beyond the mortality advantage: investigating women's health in Europe*, 2015.
http://www.euro.who.int/en/health-topics/health-determinants/gender/publications/2015/beyond-the-mortality-advantage.-investigating-womens-health-in-europe

Other resources

European Commission, *Report on equality between women and men*, Directorate-General for Employment, Social Affairs and Equal Opportunities, Office for Official Publications of the European Communities, Luxembourg, 2008.

European Foundation for the Improvement of Living and Working Conditions, Employment and industrial relations in the healthcare sector, 2011.
http://www.eurofound.europa.eu/sites/default/files/ef_files/docs/eiro/tn1008022s/tn1008022s.pdf

WHO, *Gender, climate change and health*, 2011.
http://www.who.int/globalchange/GenderClimateChange-Healthfinal.pdf

Yellow Window, *Gender in EU-funded research*, European Commission, 2009.
http://www.yellowwindow.be/genderinresearch/

Different treatment in healthcare settings: *We've broken our water* — a project for gender-equal obstetric care, Include-gender.org
http://vimeo.com/79096531

Canadian Institute of Health and Institute for Gender and Health video about the importance of sex and gender analysis in health research.
http://www.youtube.com/watch?v=LCiSytha55U

Organisations and institutions

World Health Organisation
http://www.who.int/gender/en/

8. Glossary

Determinants of health

'Determinants of health are health indicators that represent factors which either directly cause illness and disease, or are risk factors that affect the health status of populations and individuals. Determinants of health include the social environment (such as political, policy, socioeconomic factors), the physical environment (living and working conditions), person-related dimensions (such as genetic endowment and health behaviour), and access to healthcare services.' ([59])

Gender-based violence and violence against women

The terms gender-based violence and violence against women are often used interchangeably as most violence inflicted against women and girls is based on their gender. The terms employed by different institutions at different times show the progress in making visible the phenomenon of gender-based violence against women as a social issue that violates fundamental human rights. The only definition at the EU level that uses the terminology 'gender-based violence' can be found in the preamble of Directive 2012/29/EU: *'(…) violence that is directed against a person because of that person's gender, gender identity or gender expression or that affects persons of a particular gender disproportionately. It may result in physical, sexual, emotional or psychological harm, or economic loss, to the victim. It is a form of discrimination and a violation of the fundamental freedoms of the victim […]'.* It uses a broader definition of gender-based violence which includes gender identity and gender expression, going beyond the (hetero)normative male-female dichotomy. Besides, it offers a gender-neutral perspective when it comes to gender. It neither mentions women as victims nor men as perpetrators, but does it indirectly when mentioning that it disproportionately affects a particular gender. The main issue with gender neutrality in legislation is that disregards the power relations between women and men that reinforce gender-based violence. Indeed, the use of concepts such as 'men's violence against women' in some national and international contexts engender both the perpetrators and the victims to avoid gender neutrality. The expression 'against women' added to 'gender-based violence', used in other international texts, aims to engender the victims (EIGE, 2014) ([60]).

Gender equality training

This is a broad concept which encompasses any educational tool or process with the purpose of making policymakers and other actors in the EU and Member States more aware of gender equality issues. It should build their gender competence and enable them to promote gender equality goals in their work at all levels. Gender equality training has been understood as covering a wide range of different educational tools and processes. Examples are face-to-face training events and courses of study, staff induction, online modules, guidance materials and compendia of resources, consultancy arrangements and networks for sharing expertise ([61]). Due to the high presence of women in the healthcare sector, specific attention should be given to gender-sensitive training and education in the sector. In all sectors, gender training activities are not diffuse and tend not to be tailored to the specific policy areas of work of the participants ([62]).

Gender medicine

Gender medicine recognises differences in women and men's health patterns, and adapts the diagnosis and treatment to suit these differing needs (EIGE, 2013) ([63]). Women and men may have different experiences of the same disease: they may present with different symptoms, respond differently to therapy and tolerate/cope with the disease differently (The International Society for Gender Medicine) ([64]).

([59]) European Commission, *Data and information on women's health in the European Union*, Directorate-General Health and Consumers, 2009, http://ec.europa.eu/health/population_groups/docs/women_report_ en.pdf.

([60]) EIGE, *Administrative data sources on gender-based violence against women in the EU: current status and potential for the collection of comparable data*, 2014, http://eige.europa.eu/rdc/eige-publications/administrative-data-sources-gender-based-violence-against-women-eu-report.

([61]) EIGE, *Gender mainstreaming, concepts and definitions*, http://eige.europa.eu/gender-mainstreaming/concepts-and-definitions.

([62]) EIGE, *Mapping of gender training policies and practices in the European Union summary of findings*, 2012, http://eige.europa.eu/sites/default/files/documents/Gender%20Training%20-%20Summary%20of%20findings.pdf.

([63]) EIGE, *Women and men inspiring Europe resource pool, Margarethe Hochleitner, gender medicine expert*, 2013, http://eige.europa.eu/more-areas/women-and-men-inspiring-europe-resource-pool/margarethe-hochleitner.

([64]) The International Society for Gender Medicine, http://www.isogem.com/?CategoryID=164&ArticleID=83.

Health inequalities

Health inequalities are preventable and unjust differences in health status experienced by certain population groups. People in lower socioeconomic groups are more likely to experience chronic ill health and die earlier than those who are more advantaged. Health inequalities are not only apparent between people of different socioeconomic groups — they exist between different genders and different ethnic groups ([65]). The combination of poverty and other forms of vulnerability, such as childhood or old age, disability or minority background, further increases the risks of health inequalities. Ill health can exacerbate or lead to poverty and/or social exclusion ([66]).

Intimate partner violence

This covers all acts of physical, sexual, psychological or economic violence that occur within the family or domestic unit or between former or current spouses or partners. It applies whether or not the perpetrator shares or has shared the same residence with the victim. These include, but are not restricted to, domestic violence (EIGE, 2014) ([67]).

Occupational segregation in healthcare workforce

Gender segregation in employment refers to the tendency of women and men to work in different occupations and sectors. The literature usually distinguishes between different types of segregation. Horizontal segregation is understood as the under- (or over-) representation of a certain group of workers in occupations or sectors not ordered by any criterion. Vertical segregation refers to the under- (or over-) representation of a group of workers in occupations or sectors at the top of a ranking based on 'desirable' attributes — income, prestige, job stability, etc. (European Commission, 2012). Both vertical and horizontal occupational segregation can be observed when comparing women's and men's health care job positions. On the one hand, women are under-represented in managerial and decision-making positions. On the other hand, the female health care workforce is usually concentrated in occupations such as nursing and midwifery personnel and other 'caring' professions such as community health workers. These occupations tend to be perceived as low-status jobs, while medicine, dentistry and pharmacy (positions mostly occupied by men) are understood as high-status occupations (EIGE, 2014) ([68]).

Reproductive health

Reproductive health is defined by the WHO as a state of physical, mental, and social well-being in all matters relating to the reproductive system at all stages of life. Reproductive health implies that people are able to have a satisfying and safe sex life with the capability to reproduce and the freedom to decide if, when, and how often to do so. Implicit in this are the rights of men and women to be informed and to have access to safe, effective, affordable, and acceptable methods of family planning of their choice. They also have the right to appropriate healthcare services that enable women to safely go through pregnancy and childbirth ([69]).

Reproductive healthcare

Reproductive healthcare is defined as the collection of methods, techniques, and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, not just counselling and care related to reproduction and STIs ([70]).

([65]) CSDH, *Closing the gap in a generation: health equity through action on the social determinants of health*, final report of the Commission on Social Determinants of Health, Geneva, World Health Organisation, 2008, http://www.who.int/social_determinants/final_report/csdh_finalreport_2008.pdf.

([66]) European Parliament resolution of 8 March 2011 on reducing health inequalities in the EU (2010/2089(INI), http://www.europarl.europa.eu/sides/getDoc.do?pubRef=-//EP//TEXT+TA+P7-TA-2011-0081+0+DOC+XML+V0//EN.

([67]) EIGE, *Administrative data sources on gender based violence against women in the EU: current status and potential for the collection of comparable data*, 2014, http://eige.europa.eu/rdc/eige-publications/administrative-data-sources-gender-based-violence-against-women-eu-report.

([68]) WHO, 'Gender and health workforce statistics', *Spotlight on Statistics — a fact file on health workforce statistics*, No 2, 2008, http://www.who.int/hrh/statistics/spotlight_2.pdf.

([69]) WHO and European Commission, http://ec.europa.eu/health/population_groups/gender/reproductive/index_en.htm.

([70]) WHO and European Commission, http://ec.europa.eu/health/population_groups/gender/reproductive/index_en.htm.

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