

Gender equality and health in the EU

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1. Introduction

Gender and health

Women and men are confronted with gender-specific health risks and diseases. Although life expectancy is lower for men, (7)women's advantage does not translate into healthier years as women in Europe report worse health status than men and suffer from a higher burden of non-fatal and debilitating conditions (Roxo et al., 2020). Gender norms affect health status, as well as access to and uptake of health services. The former is partially due to biological differences, but several social factors also underpin differences in health and certainly access and uptake. For example, men and women are differently influenced by the social determinants of health, with women particularly hit by unfavourable socioeconomic and psychosocial factors. Women's morbidity disadvantage – and men's mortality disadvantage – may be as a consequence of societal structures, traditions, discrimination, gender norms and policies that restrain women's access to social and employment-related privileges and economic resources. Work-family strain is also more likely to impact women's physical and mental health. Women are more likely to experience single parenthood, and to be unemployed or underemployed due to family responsibilities and, especially historically, lower access to education. Gender inequalities in the field of health need to be analysed and addressed to advance gender equality and support all Europeans to thrive and attain their full potential.

International research

In recent years, the World Health Organization (WHO) has conducted extensive research on women and men's health through a gender-based approach in research papers, such as *'Women's health and well-being in Europe: beyond the mortality advantage'* (2015), *'The health and well-being of men in the WHO European Region: better health through a gender approach'* (2018) and *'SDG policy brief: Health and Gender Equality'* (2019). The Eurostat report, *'Sustainable development in the European Union: Monitoring report on progress towards the SDGs in an EU context'* (2020) provides a detailed description of the situation in the European Union (EU) and its Member States, in relation to the 17 Sustainable Development Goals (SDGs) in an EU context with sex-disaggregated data. The European Commission Directorate General for Health and Food Safety (DG SANTE) has previously published reports on men's and women's health in the EU (2011 and 2006 respectively), and the European Institute for Gender Equality (EIGE) reviewed the Beijing Platform for Action (BPfA) Area C, Women and Health in 2020.

Policy framework

Equality between men and women is a fundamental principle of the European Union guaranteed in the Treaty on the Functioning of the European Union (TFEU) and is one of the objectives and tasks of the EU. Article 8 TFEU states that *‘in all its activities, the Union shall aim to eliminate inequalities, and to promote equality between men and women.’* Article 168 TFEU gives the Union complementary competence in the field of public health. The Union is required to ensure a high level of human health protection in the definition and implementation of all its policies. In addition, the Fundamental Right Charter of the European Union protects the rights to non-discrimination on the grounds of sex, equality between women and men, and access to healthcare. The European Pillar of Social Rights states that gender equality is a concern and establishes access to timely, affordable, and good-quality healthcare as a social right. Efforts to empower both women and men, in all their diversity, to attain their full health potential must be supported in medical research, health policy and health services. The European Union Gender Equality Strategy 2020–2025 recognises the gender-specific health risks and among others foresees the facilitation of regular exchanges of good practices between Member States and stakeholders on the gender aspects of health, including on sexual and reproductive health and rights.

Aim of the current report

This report provides a cross-cutting view of key health topics in the EU from a gender perspective,¹ analysing the main issues with a specific focus on differences between women and men. Gender is discussed at the level of individual mental and physical health and within healthcare systems. The report presents current data and literature and outlines main areas for policy development and actions. Illustrative practices are provided on access to services and on gender-sensitive health services. A view on gender issues in COVID-19 is provided. Recognising the importance of social, environmental and economic determinants on health (WHO, 2019c), the conclusions and recommendations locate the data within the broader framework of social policies and gender health equity (Beckfield et al., 2017).²

1 Gender is a social construct that intersects with, but differs from, biological sex. It refers to the socially constructed norms, roles, behaviours, attributes and relations that a given society considers appropriate for women and men, see http://www.euro.who.int/_data/assets/pdf_file/0008/404495/SDG-5-policy-brief_2.pdf?ua=1. Both sex and gender define the individual and affect all aspects of disease prevention, development, diagnosis, progression, and treatment, see <https://pubmed.ncbi.nlm.nih.gov/23414074/>.

2 Health **inequities** are differences in health status or in the distribution of health resources between different population groups, arising from the social conditions in which people are born, grow, live, work and age. Health inequities are unfair and could be reduced by the right mix of government policies https://www.who.int/features/factfiles/health_inequities/en/#:~:text=Health%20inequities%20are%20differences%20in,right%20mix%20of%20government%20policies.

Gender dimensions and structure of the report

Based on the findings of research in this area, several dimensions can be distinguished when examining the relationship between gender and health. Health status shows clear differences in both physical and mental health between women and men. Other personal characteristics, such as age, influence health and gender differences in health, and where this is known reference is made in the text. Statistical data often lack disaggregation by ethnicity so the available information across the subjects has been brought together in a separate chapter, in order to reflect the importance of this factor. People's health is influenced by at least four types of factors: biological, social, economic and public policy. Work is an important factor explaining differences between men and women, so health and safety at work are discussed in more detail. Two further dimensions addressed in the report are the health and social care sector, with its predominantly female worker population, and the organisation of healthcare services. An analysis is provided on policies and measures to facilitate access to and gender sensitivity of these services.³

³ The authors wish to thank the Country Experts of SAAGE (Scientific Analysis and Advice on Gender Equality in the EU), for their generous contributions.

2. Gender and health: research and data

This chapter focuses on comparing the health and healthcare of women and men, providing an overview of gender-related health inequalities, and highlighting the main concerns for specific groups of women (older women, lower education, and migrant and ethnic minority women). The information covers a) physical health; b) mental health; c) migrant and ethnic minority women; d) medication; e) occupational health and safety; and f) health workers.

For this chapter, web searches were conducted to find the most up-to-date and publicly available comparable data for as many EU Member States as possible, prioritising EU and WHO data sources where available. Data for women and men were tabulated and the gender gap calculated where needed. Data were then presented in a variety of bar charts to aid interpretation, with a commentary highlighting the key findings. In addition, literature searches were conducted in PubMed and Cochrane Collection, and a review was done on grey literature on health and gender by European and international organisations. Research and reports on ‘violence in childbirth’ and ‘sex and gender in the curriculum of healthcare professionals’ across the EU-28 was collated from the European network of experts on gender equality, that provides external expertise to the European Commission in the field of gender equality policy. The indicators of gender inequalities in physical and mental health across the European Union are presented in the figures in this section with the underpinning data tables presented in Appendix III.

2.1 Overview of the gender and health inequalities research field

The gender and health research field has highlighted an important paradox (Doyal, 1995). Decades of research shows that, in Europe, **men have shorter life expectancies and higher mortality** rates than women, and yet, **women report higher morbidity** or, to put it more simply, **‘women get sicker, men die quicker’** (Macintyre, Hunt and Sweeting, 1996).

Men’s mortality disadvantage is evident across all-cause mortality, life expectancy, respiratory disease and cancer mortality, as well as deaths from external causes including violence and suicide (OECD and EU, 2018, p. 89). **Men are also more likely to engage in risky health behaviours such as excessive alcohol consumption, drug use and smoking in most European countries.** For example, men smoke more than women in all European countries, except in Sweden and Iceland (where the rate is virtually equal). 25 % of men and 15 % of women smoke daily across the EU, the European Economic Area (EEA) and the United Kingdom (UK). The gender gap is particularly large in Cyprus, Latvia, Lithuania and Romania (OECD and EU, 2018, p. 114). These gender differences are fairly stable throughout the life course. However, there is emerging evidence which suggests that among

younger age groups, risky health behaviours are more equal between the sexes because over time, the gender gap in smoking (WHO, 2019b) and alcohol consumption is closing in Europe but remains high (Bratberg et al., 2016). **Men's mortality disadvantage is particularly evident in the countries in the Eastern part of the European Union** – potentially related to excess alcohol consumption (Grigoriev et al., 2020) and smoking rates (OECD and EU, 2020, p. 119).

Women's morbidity disadvantage is evident across various indicators including **self-rated health, pain, obesity and especially mental health**. Women are also more likely to report long-standing illnesses or health problems more often than men and they **live longer with limiting long-term conditions** (OECD and EU, 2020, p. 98). For example, while men have higher cardiovascular disease mortality rates, due to women's higher life expectancy, the average patient receiving treatment for cardiovascular disease is a woman and while cardiovascular disease rates are declining on average, the decline has slowed or even stalled among women (Wilkins et al., 2017).⁴ On average, across EU countries, women can expect to live about 77 % of their lives free of disability while men can expect to live 81 % – because women report more activity limitations and because women live longer (OECD and EU, 2020, p. 86). Morris et al. (2018) explored **effects of family and employment policies on cardiovascular disease (CVD) in Europe**, finding that government spending on early childhood education and childcare was associated with lower CVD mortality rates for both men and women equally, and government spending on paid parental leave was more strongly associated with lower CVD mortality rates for women. Additionally, government spending on public employment services was associated with lower CVD mortality rates for men but was not significant for women, while government spending on employment training was associated with lower CVD mortality rates for women but was not significant for men.

Explanations for the gender health paradox are multiple but it is thought that both sex (biological factors) and gender (social factors) play important – and interacting – roles (Rieker and Bird, 2005). The reasons for the observed gender differences in health are numerous. Gender stereotypes, norms and inequalities influence women's and men's behaviour and life opportunities, and gender intersects with social determinants of health such as ethnicity and educational attainment to generate additional inequalities in health outcomes. Examples of factors that influence women's health across the life course, include levels of gender equality, education, employment, working conditions and access to economic resources. Men's health and risk behaviours are also related to many of the same factors, and to the 'dominant form of masculinity' that influences attitudes to risk-taking, and engagement with health services (WHO, 2016b, 2018).

Broadly, the scientific research literature has four types of explanations to gendered differences in health: biological, social, economic and public policy.

- **Biological explanations**⁵ explore how some of the gender health paradox may be a result of differences between men and women in terms of their **biological and genetic make-up**, leading to more or less susceptibility to certain health outcomes:
 - » There are **immune system differences** between men and women, diffe-

4 The European Parliament funded pilot project 'GenCAD: Gender-specific mechanisms in coronary artery disease in Europe pilot' examines this in more detail, see https://ec.europa.eu/health/social_determinants/projects/ep_funded_projects_de#fragment3.

5 The biological explanation focuses on sex differences, not gender differences.

- rential responses to oxidative stress, and differences in mitochondrial fitness. These may contribute to the gender health paradox; however, the **biomedical evidence examining this is underdeveloped** (Austad and Fischer, 2016).
- » A clear example of biological pathways is how increased morbidity for women from diseases of the connective tissue such as **osteoporosis is related to reduced levels of oestrogen** associated with the menopause. Indeed, hormone levels have a strong impact on healthy ageing in both men and women.⁶
 - » Similarly, studies have suggested that the higher levels of depression among women may be partly genetic (in combination with social factors) (Rusby et al., 2016).
- **Social explanations** focus on variations in the behaviour of men and women, including those linked to constructions of **masculinity and work-family roles** (Hill, 2015):
 - » Most directly, traditional conceptions of masculinity have meant that men are more likely to engage in **health damaging risk-taking behaviours** such as excessive alcohol consumption (Stanistreet et al., 2005). **Men are also less likely to use healthcare services** and more likely to present late with symptoms (Wang et al., 2013). These **behavioural differences may contribute to men's higher mortality rates**.
 - » Further, stress theories of health suggest **men have traditionally been more exposed to negative health effects from workplace hierarchies, unemployment**, and the need to be the **main breadwinner** – all factors associated with an increased risk of mortality from key diseases such as cardiovascular disease (Bambra, 2010).
 - » **Women in comparison are more likely to be underemployed but experience physical and mental health problems as a result of work-family strain** from the dual burden of employment and caring. While family relationships can have beneficial effects to physical and mental health over the life-course (Thomas et al., 2017), **dual roles have been posited as health damaging** with studies finding associations between work-family conflict and physical ill health, depression, hypertension and alcohol misuse (van de Velde et al., 2013).
 - **Economic explanations** focus on how **women are particularly hit by unfavourable socioeconomic factors** such as higher rates of poverty, historically lower rates of education, discrimination in the labour market, and lower employment rates (Artazcoz et al., 2004).
 - » For example, **women are more likely to be single parents, to work part-time or be underemployed** (partly due to family responsibilities). They are also more likely to be precariously employed, or to be employed in low wage parts of the economy. Subsequently, **women are more likely to experience poverty** (European Commission, 2018a).
 - » There is a **gender pay gap in Europe** and **labour markets are still highly segregated**, with women taking jobs connected to their traditional roles as caregivers or jobs with limited opportunities for advancement (European Commission, 2018b).
 - » It has been shown that **women tended to be more affected than men**

⁶ For further information compare with the dedicated page on the website of the National Healthcare System, available at: <https://www.nhs.uk/conditions/osteoporosis/causes/>.

- in those countries that experienced a severe economic recession** (Bambra, 2019).
- » Research shows that these **economic disadvantages are associated with higher rates of morbidity among women** including chronic diseases and self-reported poor health (Boerma et al., 2016) while increased participation in the workforce can have beneficial health effects for women (Backhans et al., 2007).
 - » Studies have documented the negative health (especially mental health) effects of precarious work (Benach et al., 2014).
 - » There are also **larger gender differences** in morbidity and mortality among men and women **in the lowest socioeconomic groups** (Bambra et al., 2009).
- **Public policy** explanations focus on how public policies act as **macro-level determinants of gender inequalities** which shape other social and economic factors, in turn influencing gender inequalities in health and wellbeing (Bird and Rieker, 2008).
 - » **European countries have been leaders in family policy** enacting various social investments focused on: childcare, parental leave, active labour market programmes, and long-term care policies. These are in part implemented to **reduce the gendered burden of family care work and strengthen gender equity** (OECD, 2007).
 - » The impacts of these social investment policies on gender inequalities in health are mixed. In terms of mortality, **public childcare provision is associated with lower cardiovascular disease mortality rates for both men and women** equally, while government spending on **paid parental leave** and employment training **decreases cardiovascular disease mortality for women** (Morris et al., 2019).
 - » In terms of morbidity, **women's health benefits more than men from social investment policies** with government investments in childcare; active labour market programmes; and long-term care reducing disability levels. **Publicly funded childcare also benefits men's morbidity** (Beckfield et al., 2017).

This section has provided an overview of the key issues in the research literature around gender and health. It has outlined the '**gender health paradox**' whereby **men have a mortality disadvantage** and **women have a morbidity disadvantage**. It has outlined the competing explanations for this paradox focusing on the interacting **biological, social, economic and public policy pathways**. The next sections of this chapter provide an overview of the latest available data and statistics⁷ for the European Union – highlighting empirically the gender and health issues described above, as well as a discussion of some key issues regarding gender differences in the healthcare sector and the organisation of healthcare services.

⁷ Data for the figures and tables presented in the report were accessed on 20 April 2020.

2.2 Physical health

Life expectancy and healthy life expectancy at birth

Figure 1 details the gap in life expectancy⁸ and healthy life expectancy⁹ at birth between men and women across all of the 28 EU Member States in 2018.¹⁰ The average life expectancy gender gap at the EU level stands at 5.3 years, with life expectancy at birth an average of 83.6 years for women and 78.3 years for men. **In all 28 EU countries, women have a higher life expectancy than men.** Life expectancy is highest for women in Spain and lowest in Bulgaria. Italy has the highest life expectancy for men and Latvia has the lowest life expectancy for men. Lithuania has the largest gender gap in life expectancy at 9.8 years, and the smallest gender gap in life expectancy is 3.1 years in the Netherlands. Indeed, as Figure 1 shows the life expectancy gap is much larger in eastern European Union countries.

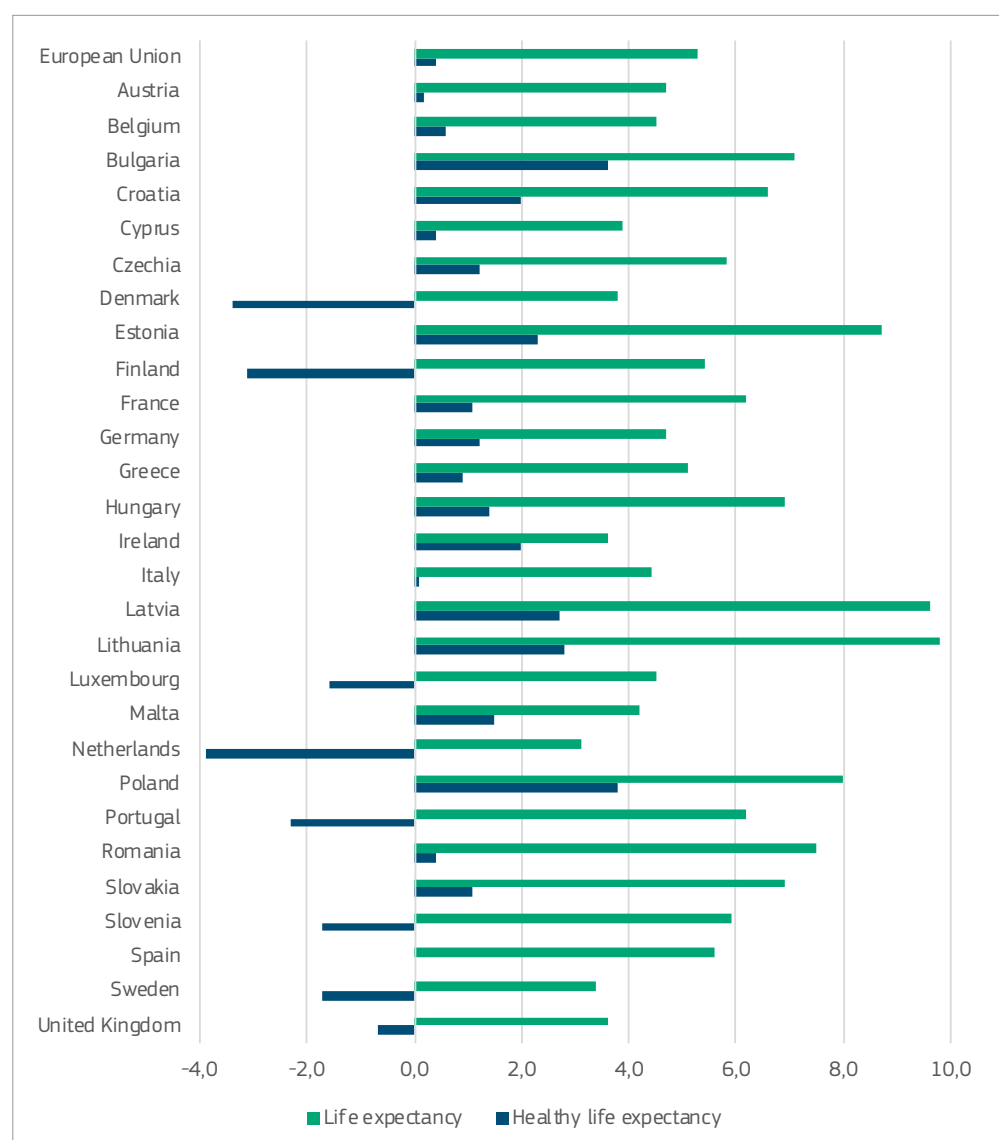
Figure 1 also shows cross-national patterns for healthy life expectancy at birth (HLE). The average gender gap in HLE at the EU level stands at 0.4 years, with HLE at birth an average of 63.8 years for women and 63.4 years for men. Figure 1 shows that **the gender patterning of HLE is more complicated than that of life expectancy.** For example, in some countries there is a very small gender gap in favour of women (e.g. Spain has no gender gap in HLE; countries such as Italy and Austria have very small gaps of 0.1 and 0.2 years). In contrast, other countries such as Denmark and the Netherlands have HLE gaps that favour men – HLE is higher for men than for women. HLE is highest for women in Malta and lowest in Latvia. Sweden has the highest HLE for men and Latvia has the lowest HLE for men. Poland has the largest gender gap in HLE at 3.8 years higher for women, while Spain has no gender gap in HLE (0 years). Again, **the gender gap in favour of women is much larger in eastern European Union countries (with the exception of Slovakia and Slovenia). In the western and northern parts of the European Union, the gender gap is either much smaller in favour of women or actually favours men** (e.g. Denmark, Finland, Luxembourg, the Netherlands, Portugal, Sweden and the UK).

8 Life expectancy at a given age represents the average number of years of life remaining if a group of persons at that age were to experience the mortality rates for a particular year over the course of their remaining life.

9 Healthy life expectancy measures the number of a person's years of life without any severe or moderate health problems. Estimates presented here are based on self-reported limitations in daily activities (Global Activity Limitation Instrument foreseen in the annual EU-SILC survey) in the last six months because of a health problem.

10 As of 1 February 2020, the United Kingdom is no longer part of the European Union. The EU now includes 27 Member States, see: <https://ec.europa.eu/eurostat/help/faq/brexit>.

Figure 1. Gap in life expectancy and healthy life expectancy at birth between women and men (years) in 28 EU Member States, 2018



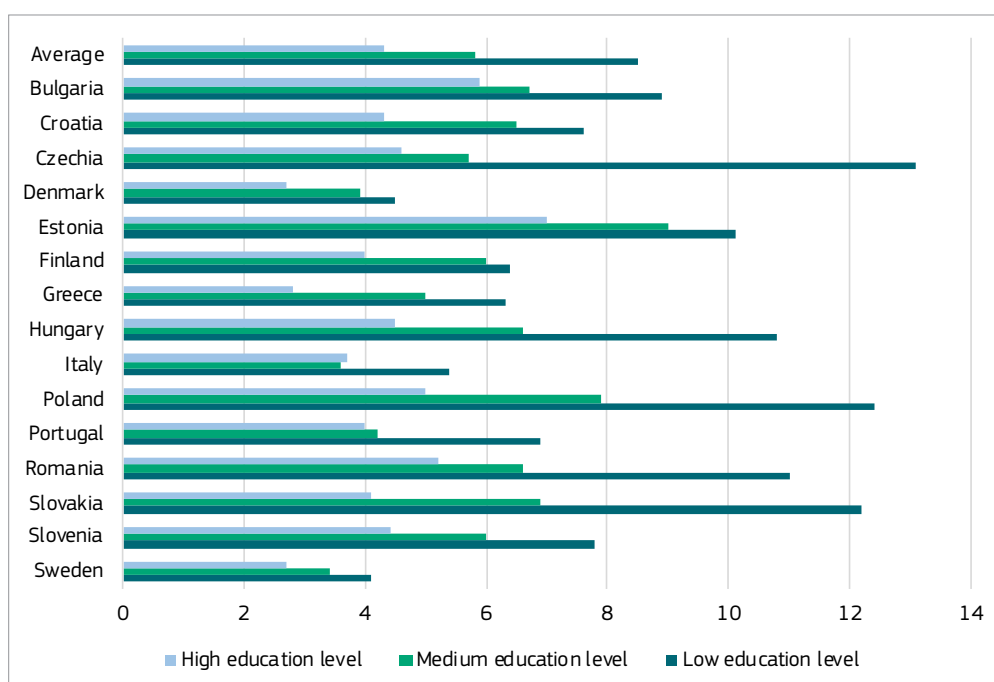
Sources: EU Sustainable Development Goals (SDG) indicator set, European Statistical System (ESS). Eurostat (2018), Life expectancy by age and sex [demo_mlexpec]. Retrieved from https://ec.europa.eu/eurostat/data/database?node_code=demo_mlexpec; Eurostat (2018), Healthy life years by sex (from 2004 onwards) [hlth_hlye]. Retrieved from https://ec.europa.eu/eurostat/data/database?node_code=hlth_hlye.

Notes: Bars show the difference in excess life expectancy of women over men in years. Life expectancy at birth represents the mean number of years that a newborn child can expect to live if subjected throughout their life to the current mortality conditions (age-specific probabilities of dying). Healthy life expectancy is defined as expected years of life without severe or moderate health problems. Data are shown in Appendix Table III.1.

Life expectancy at birth by level of education

Figure 2 details the intersection between gender and educational attainment¹¹ in terms of the life expectancy gap at birth. Data are presented for the 15 EU Member States that were analysed as part of the European Core Health Indicators (ECHI) in 2016. Figure 2 demonstrates that the variation in the gender gap in life expectancy between educational groups is consistent in the 15 countries analysed. The gender gap is much greater between men and women with a lower level of education than among men and women with a medium or higher level of education. In other words, **there is a social gradient in the gender gap in life expectancy across the European Union.** The average gender gap in life expectancy for the 15 EU countries for those with a lower level of education stands at 8.5 years in favour of women, for medium level at 5.8 years in favour of women, and for those with a higher level of education, it stands at 4.3 years in favour of women. **In all 15 EU countries analysed, the gender life expectancy gap is highest for those with the lowest education.** The lowest educated group in Czechia has the largest gender gap in life expectancy at 13.1 years, and the smallest gender gap in life expectancy is among the highest educated in Denmark and Sweden at 2.7 years. Generally, **the gender life expectancy gap decreases with education in most European Union countries, and is particularly large in the lowest educated groups in all countries.**

Figure 2. Gap in life expectancy at birth (years) between women and men by level of education in 15 EU Member States, 2016



Source: European Core Health Indicators. European Commission. (2016). Life expectancy by educational attainment. Retrieved from https://ec.europa.eu/health/indicators_data/indicators_en.

Notes: Bars indicate the difference between excess of women's life expectancy at birth compared to men in years. Data are shown in Appendix Table III.2

11 Education level based on the International Standard Classification of Education (ISCED): 'low educational level' is less than primary, primary and lower secondary education (levels 0–2), 'medium educational level' is upper secondary and post-secondary non-tertiary education (levels 3–4) and 'high educational level' is tertiary education (levels 5–8).

Life expectancy and healthy life expectancy at age 65

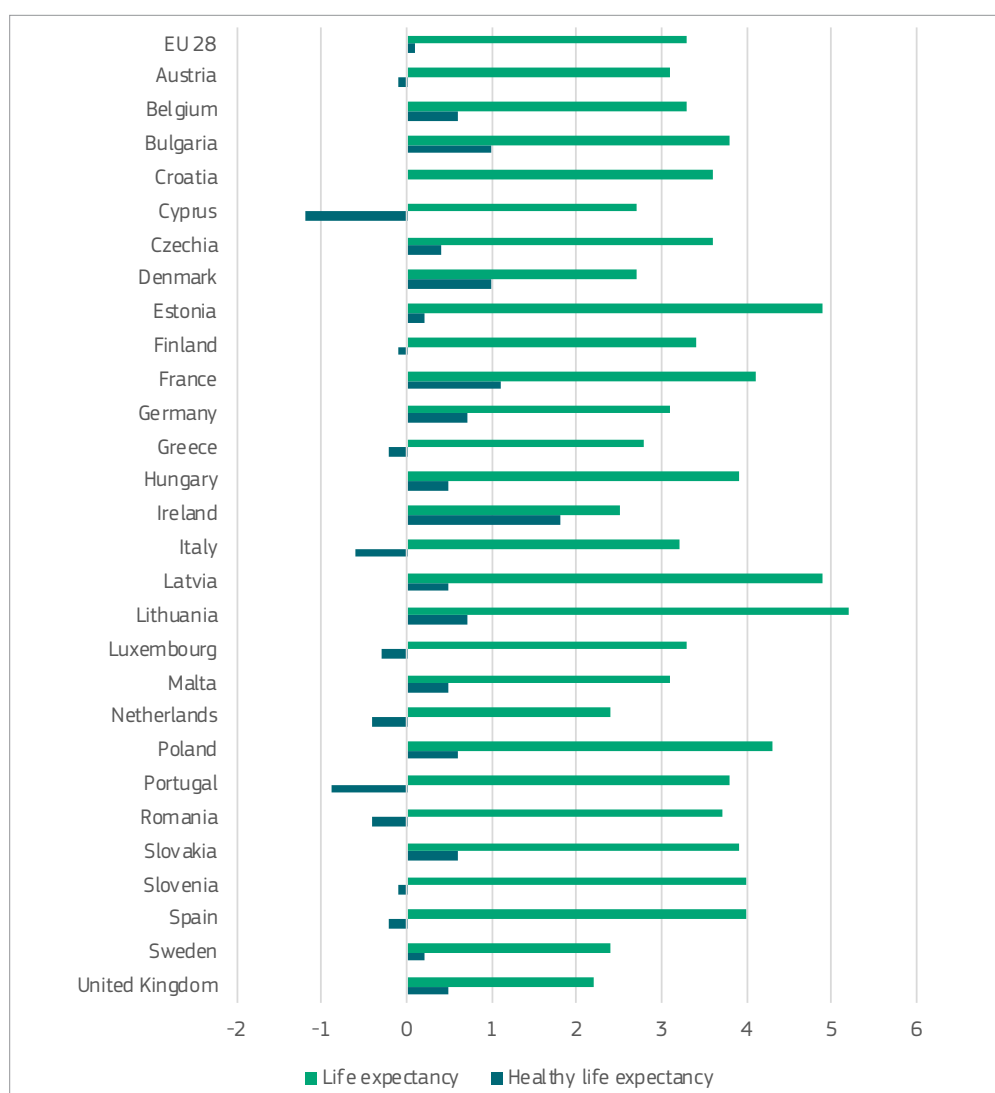
Figure 3 details the gap in life expectancy¹² and healthy life expectancy¹³ at 65 years between men and women across all of the 28 EU Member States in 2018. The average life expectancy gap at 65 years between men and women at the EU level stands at 3.3 years, with life expectancy at 65 an average of 21.5 years for women and 18.2 years for men. **In all 28 EU countries, women have a higher life expectancy at 65 than men.** Life expectancy at 65 years is highest for women in France and lowest in Bulgaria. France similarly has the highest life expectancy at 65 years for men, and Latvia has the lowest. Lithuania has the largest gender gap in life expectancy at 65 years at 5.2 years, and the UK has the smallest gender gap in life expectancy at 65 years at 2.2 years. As with life expectancy at birth, Figure 3 shows the life expectancy gap at 65 years is much larger in eastern European Union countries, with the exception of France and Spain.

Figure 3 also shows cross-national patterns for healthy life expectancy at age 65 (HLE-65). The average gender gap in HLE-65 at the EU level is small and stands at 0.1 years, with HLE-65 an average of 10 years for women and 9.9 years for men. Figure 3 shows that **the gender patterning of HLE-65 is more complicated than that of life expectancy at 65 years**, without clear regional differences. In most countries, the HLE-65 gap favours women, but in some countries the gap is very small (e.g. Croatia has no gender gap in HLE-65, and in countries such as Sweden and Estonia the gap is very small, at 0.2 years) or favouring men: HLE-65 is higher for men than for women in Cyprus and Portugal. HLE-65 is highest for women and men in Sweden and lowest in Slovakia. Ireland has the largest gender gap in HLE-65 at 1.8 years higher for women, while Croatia has no gender gap in HLE (0 years). **The gender gap at age 65 in favour of women is much larger in some western European Union countries (Ireland, Denmark, France and Germany), but more generally in the western part of the European Union this gender gap is either much smaller in favour of women or actually favours men (e.g. the Netherlands, Italy and Portugal). The trend in eastern European countries is for no gap or a small gender gap at age 65 in HLE in favour of women.**

¹² Life expectancy at a given age represents the average number of years of life remaining if a group of persons at that age were to experience the mortality rates for a particular year over the course of their remaining life.

¹³ Healthy life expectancy measures the number of a person's years of life without any severe or moderate health problems. Estimates presented here are based on self-reported limitations in daily activities (Global Activity Limitation Instrument foreseen in the annual EU-SILC survey) in the last six months because of a health problem.

Figure 3. Gap in life expectancy and healthy life expectancy at 65 years between women and men (years) in 28 EU Member States, 2018



Source: Eurostat

Notes: Bars show the difference in excess life expectancy of women over men in years. Life expectancy at a given age represents the average number of years of life remaining if a group of persons at that age were to experience the mortality rates for a particular year over the course of their remaining life. Healthy life expectancy is defined as expected years of life without severe or moderate health problems. Data are shown in Appendix Table III.3.

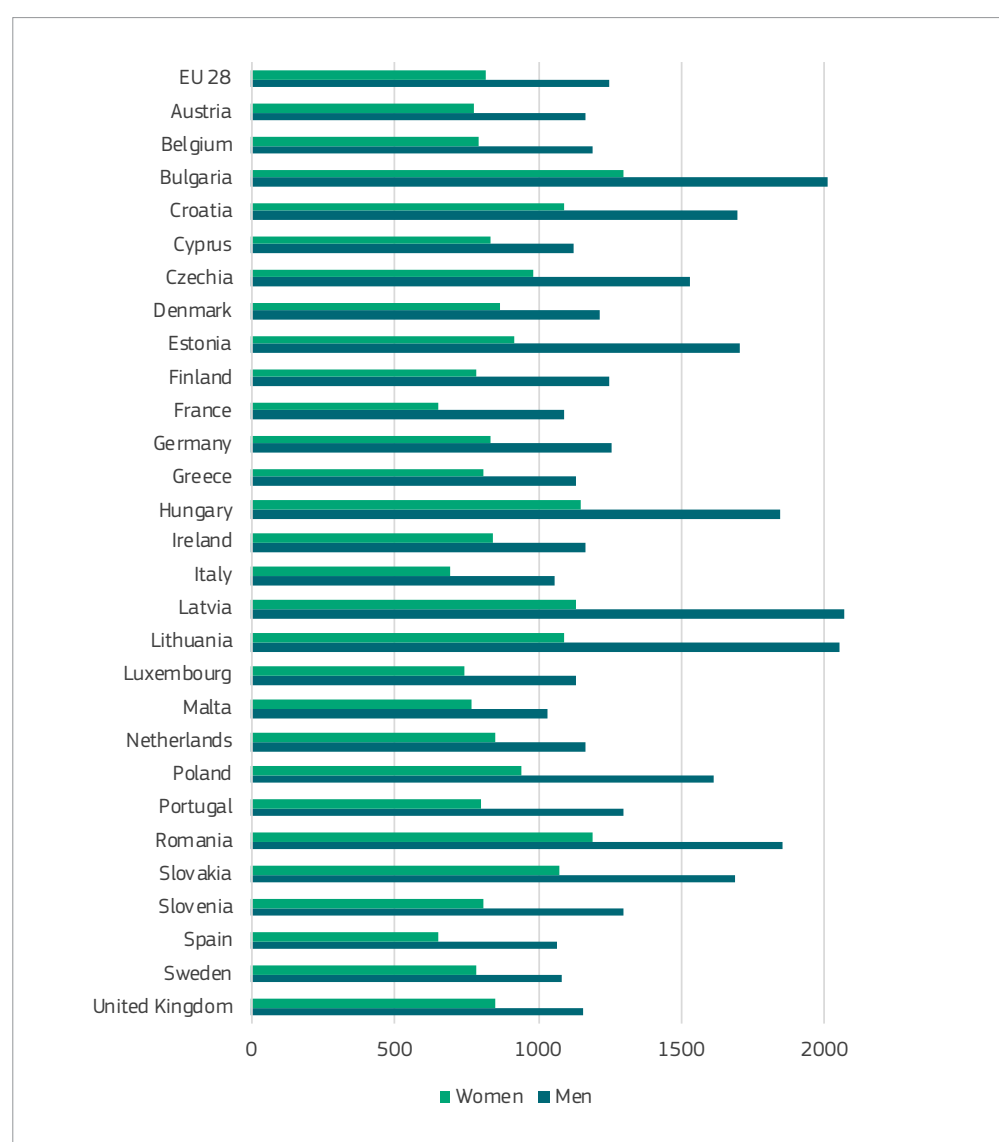
All-cause mortality

Figure 4 shows the gender gap in age-standardised all-cause mortality rates per 100 000¹⁴ by country for all 28 EU Member States in 2016. It shows that **mortality rates are substantially higher for men in all 28 of the EU countries**. Indeed, the all-cause mortality rate for men at the pan-European level stands at 1 246 deaths per 100 000 population while for women it stands at 814 deaths per 100 000 population: a gender gap in all-cause mortality of 432 per 100 000. Latvia (2 072 deaths per 100 000 population) and Lithuania (2 054 deaths per 100 000 population) have the highest mortality rates for men and Malta (1 032 deaths per 100 000 population), Italy (1 060 deaths per 100 000 population) and Spain (1 068

¹⁴ As most causes of death vary significantly with people's age and sex, the use of standardised death rates improves comparability over time and between countries.

deaths per 100 000 population) have the lowest. For women, Croatia (1 696 deaths per 100 000 population), Hungary (1 848 deaths per 100 000 population) and Romania (1 855 deaths per 100 000 population) have the highest mortality rates and France (654 deaths per 100 000 population), Italy (692 deaths per 100 000 population) and Spain (648 deaths per 100 000 population) have the lowest. The largest absolute gender gap in mortality is in Latvia and Lithuania at 936 and 964 deaths per 100 000 population and the smallest absolute gender gap in mortality is in Cyprus at 294 deaths and Malta at 265 deaths per 100 000 population. In keeping with the findings for life expectancy, Figure 3 also shows that **all-cause mortality rates for both men and women and the gender gap in all-cause mortality are the highest in the eastern European Union countries and lowest in the southern European Union countries.**

Figure 4. Age-standardised all-cause mortality rates per 100 000 inhabitants in 28 EU Member States, 2016



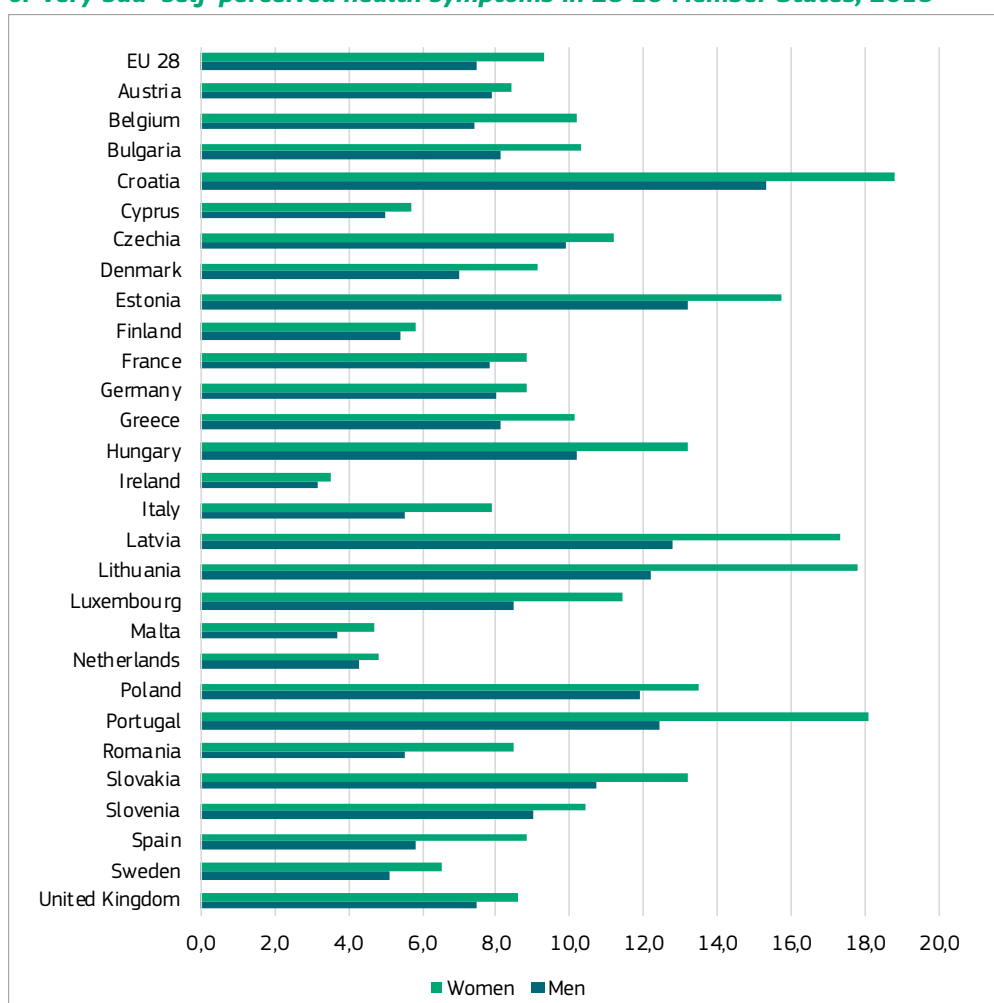
Source: Eurostat. (2016). Causes of death – standardised death rate by residence [hlth_cd_asdr2]. Retrieved from https://ec.europa.eu/eurostat/data/database?node_code=hlth_cd_asdr2.

Notes: Data from causes of death (COD) statistics are based on information derived from the medical certificate of cause of death (ICD-10 definition) in each Member State. Age-standardised mortality rates per 100 000 inhabitants. Weighting factor is based on the standard reference population as the European standard population (Eurostat, revision 2012). Data are shown in Appendix Table III.4.

Self-perceived general health

Figure 5 shows the gender gap in the proportion of women and men reporting 'bad or very bad health' by country for all 28 EU Member States in 2018 and 2019. Data are from the European Statistics on Income and Living Conditions Survey. **For all Member States, there was a higher proportion of women than men reporting 'bad or very bad health'.** At the pan-European level, the proportion of women reporting bad health is 8.4 % and the proportion of men is 7.5 %, with a gender gap of 1.8 percentage points. Croatia has the highest proportion of women (17.1 %) and men (15.3 %) reporting bad health. The lowest proportion of women and men reporting bad health is in Ireland at 3.5 % and 3.2 %, respectively. Reflecting the low proportions in people reporting bad health, Figure 5 shows that Ireland also has the lowest gender gap in percentage points in people reporting bad health (0.3 percentage points). The highest gap occurs in Portugal, at 5.7 percentage points. Moreover, Figure 5 shows that **the largest gaps in the proportion of women over men reporting bad or very bad health are generally seen in countries from Eastern Europe. Similarly, countries from Eastern Europe typically have the highest rates of 'bad and very bad' health for both women and men.**

Figure 5. Proportion (%) of men and women aged 16 years and over reporting 'bad or very bad' self-perceived health symptoms in 28 EU Member States, 2018



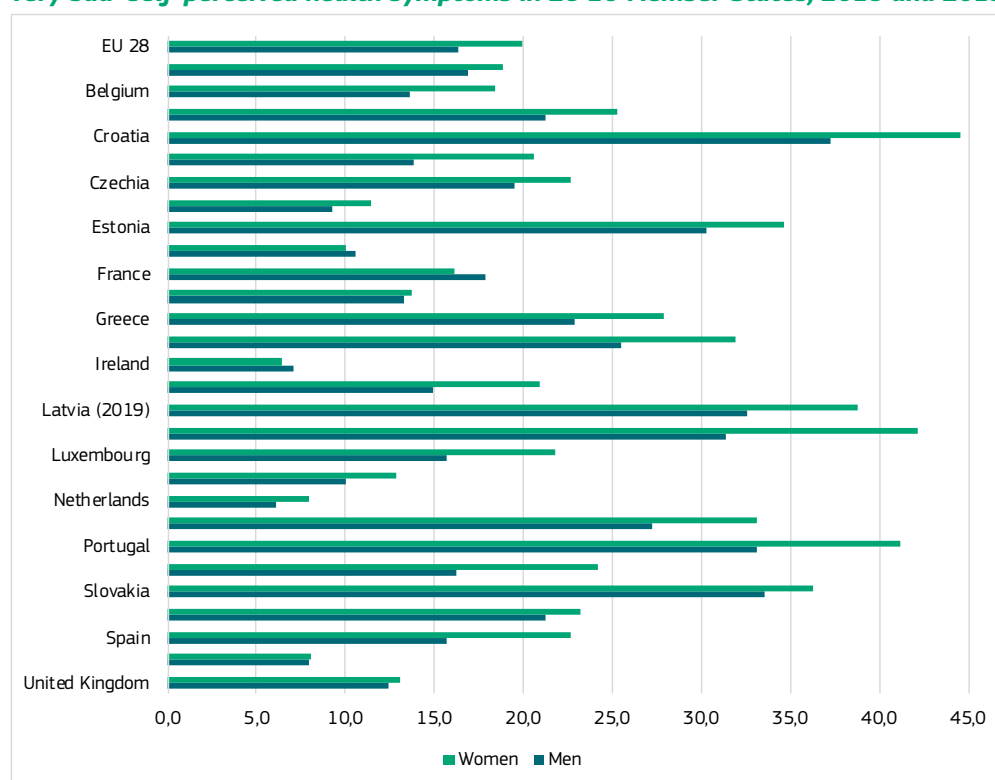
Sources: EU Statistics on Income and Living Conditions (EU SILC); Eurostat. (2018/2019). Self-perceived health by sex, age and educational attainment level [hlth_silc_02]. Retrieved from https://ec.europa.eu/eurostat/data/database?node_code=hlth_silc_02.

Note: Data available in Appendix Table III.5.

Self-perceived general health – aged 65 years and over

Figure 6 shows the gender gap in the proportion of women and men aged 65 years and over reporting 'bad or very bad health' by country for all 28 EU Member States in 2018 and 2019. Data are from the European Statistics on Income and Living Conditions Survey. The graph shows that for this demographic group, although in most countries there is a larger proportion of women reporting bad health compared to men, in some countries there is a greater proportion of men reporting bad health (Finland, France and Ireland) and countries where both genders have very similar rates of self-reported bad health (Sweden). As expected, rates of bad or very bad health in this age group are higher compared to the whole adult population (> 16 years). **Across the entire region, 19.9 % of women and 16.3 % of men report having bad or very bad health, with a gender gap of 3.6 percentage points.** Women and men in Croatia have the highest rate of reported bad health, at 44.6 % and 37.6 % respectively; while Ireland recorded the lowest rate for women (6.4 %) and the Netherlands for men (6.1 %). Notably, for both women and men, rates of reported bad health range from one quarter to two thirds of the population in countries of Eastern Europe. In contrast, similarly high rates of perceived ill-health in Western European countries are only seen in Greece and Portugal. The largest gap in the proportion of women v men reporting bad or very bad health is found in Lithuania at 10.8 percentage points, and the lowest in Sweden, at 0.1 percentage points. In the few countries where more men than women report ill health, France had the highest difference between the genders (1.8 percentage points). With the exception of Belgium, Greece, Italy, Luxembourg and Spain, the smallest gender gaps in self-reported bad health were all seen in Western European countries.

Figure 6. Proportion (%) of men and women aged 65 years and over reporting 'bad or very bad' self-perceived health symptoms in 28 EU Member States, 2018 and 2019



Sources: EU Statistics on Income and Living Conditions (EU SILC); Eurostat. (2018/2019). Self-perceived health by sex, age and educational attainment level [hlth_silc_02]. Retrieved from https://ec.europa.eu/eurostat/data/database?node_code=hlth_silc_02.

Note: Data for Bulgaria, Denmark, Finland, Latvia and Poland are from 2019.

Note: Data are available in Appendix Table III.6.

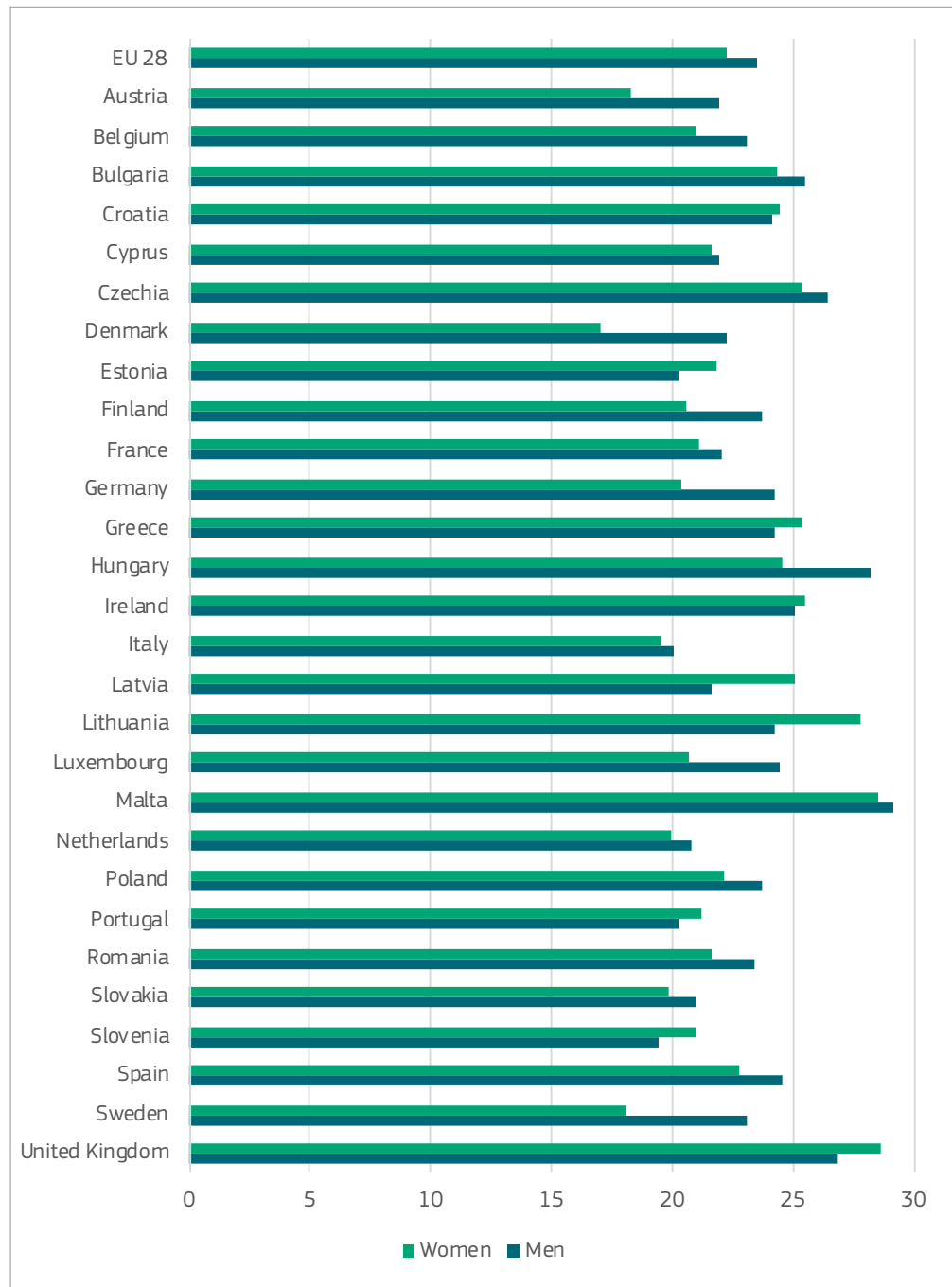
Obesity

Figure 7 shows the age-standardised prevalence of obesity, defined as having a body mass index (BMI) greater than 30 kg/m² for women and men by country in 28 EU Member States.¹⁵ With the exception of a few countries (Slovakia, Italy, Austria, Sweden and Denmark), obesity rates for women in the region surpass 20 % of the population. For men, only in Slovenia are obesity rates below 20 % of the male population. **The EU average proportion of obesity in women is 22.2 % and in men it is 23.5 % (a 1.3 percentage point gap).** In most countries, more men than women are obese, with exceptions seen in Lithuania, UK and Latvia, where more women have obesity than men. Similar rates of obesity between the genders are seen in Italy, Cyprus, Croatia, Ireland and Portugal. The UK is the country with the highest prevalence of obesity in women, at 28.6 %, while Malta ranks first in the case of men, at 29.2 %. In contrast, 19.4 % of men in Slovenia and 17 % of women in Denmark are classed as obese. At the same time, the largest gender gap in obesity in favour of men – more men than women are obese – is seen precisely in Denmark, at 5.3 percentage points. Where more women are obese, the largest gap is in Lithuania (3.6 percentage points). The smallest difference between the genders occurs in Cyprus. Interestingly, there are no obvious regional patterns in obesity rate or in the gender gap in obesity prevalence across countries.

However, **women are disproportionately affected by obesity-related cancers.** Cancers of the endometrium, colon and breast account for almost three quarters (73 %) of all cancers linked to BMI in women. Studies suggest that 10 % of post-menopausal breast cancer, the most common cancer in women worldwide, could be prevented by having a healthy body weight (22). The percentage of cancer cases among women that is attributable to excess body fat is higher than the global average (5.3 %) in almost all European countries: proportions in Czechia and Malta are more than double the global figure (WHO, 2016b).

15 Data are taken from the European Health Interview Survey (EHIS) available at: https://ec.europa.eu/eurostat/cache/metadata/en/hlth_det_esms.htm.

Figure 7. Age-standardized prevalence of obesity (%), men and women 18 years or older in 28 EU Member States, 2016



Source: WHO Global Health Observatory. (2018/2019). Age-standardized prevalence of obesity (defined as BMI equal to 30 kg/m² or higher) in people aged 18 years and over, WHO estimates (%). Retrieved from <https://gateway.euro.who.int/en/datasets/european-health-for-all-database/>

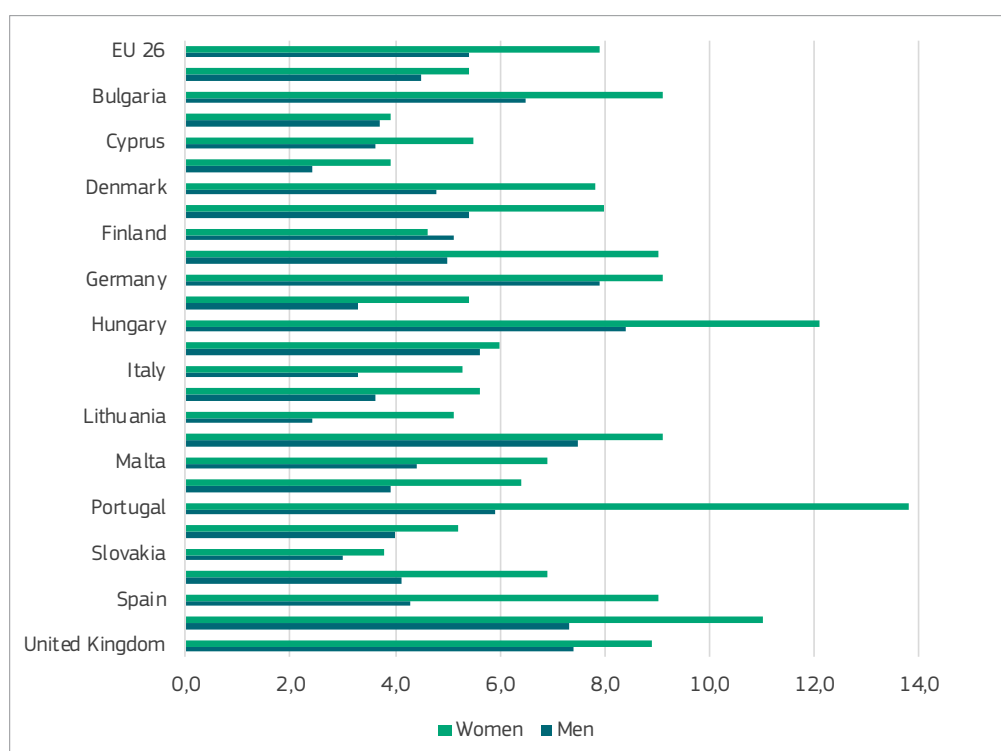
Note: Data are shown in Appendix Table III.7.

2.3 Mental health

Prevalence of self-reported depressive symptoms

Figure 8 plots data from the 2014 European Health Survey Interview (EHIS) looking at self-reported depressive symptoms in men and women aged 15 years and over. The presence of depressive symptoms is assessed using the Patient Health Questionnaire (PHQ-8). With the exception of Finland, where more men than women report depressive symptoms, and Croatia, where the proportion of depressive symptoms is very similar across genders, women have higher prevalence of self-reported depressive symptoms in all European countries. **Across Europe, 7.9 % of women and 5.4 % of men report having depressive symptoms (a gender gap of 2.5 percentage points).** In the case of women, the highest prevalence of depressive symptoms for women is found in Portugal (18.5 %) and the lowest in Slovakia (3.8 %). Men in Hungary have the highest rate of depressive symptoms (8.4 %) and men in Czechia have the lowest (2.4 %). Portugal also shows the largest gender gap in depressive symptoms, with the rate of depression for women 7.9 percentage points higher than that of men, while the gap in the prevalence of depressive symptoms is lowest in Croatia. **There are no clear geographical patterns in the gender gap in depressive symptoms or in the prevalence of depression for women in Europe.** For men, however, with few exceptions, the lowest rates of depressive symptoms are found in Eastern European countries.

Figure 8. Proportion (%) of men and women aged 15 years and over self-reporting depressive symptoms in 26 EU Member States, 2014



Source: Eurostat. (2016). Current depressive symptoms by sex, age and educational attainment level [hlth_ehis_mh1e]. Retrieved from https://ec.europa.eu/eurostat/data/database?node_code=hlth_ehis_mh1e.

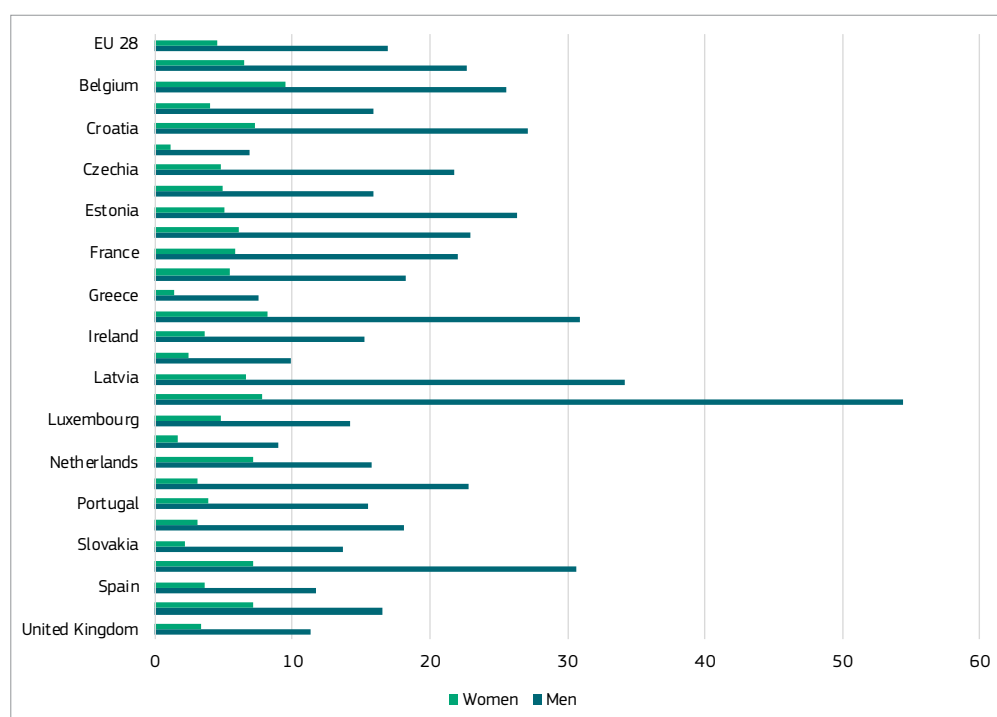
Notes: Patient Health Questionnaire (PHQ-8) 8-item depression screener. Respondent classified as having depressive symptoms if answering yes to any or both items 'Little interest or pleasure in doing things' and 'Feeling down, depressed or hopeless' and two, three or four more items in the PHQ-8. See Eurostat. (2013). European Health Interview Survey (EHIS wave 2) Methodological manual. Luxembourg: Publications Office of the European Union. No data on Belgium and The Netherlands.

Note: Data are shown in Appendix Table III.8

Mortality from suicide and intentional self-harm

Figure 9 shows the age-standardised mortality rate from suicide and intentional self-harm per 100 000 population, by gender, for some of the EU Member States.¹⁶ The graph illustrates that suicide and intentional self-harm are far more often the cause of death for men than for women. **Across the region, the mortality rate from suicide for men is 17 per 100 000 population, while for women the rate is 4.5 per 100 000 population**, almost four times greater for males (gender gap of 12.5 per 100 000 population). Lithuania has the highest mortality from suicide for men (54.5 per 100 000 population), while women in Belgium have the highest rate of mortality from suicide across the region for women (9.5 per 100 000 population). At the same time, for both genders, Cyprus records the lowest rates of suicide and mortality from intentional self-harm, at 6.9 per 100 000 population for men and 1.1 per 100 000 population for women. Not surprisingly, given the high rates of male suicide, the largest absolute difference in female-to-male suicide mortality is seen in Lithuania (46.6 per 100 000 population). The lowest is found in Cyprus (5.8 per 100 000 population). **In women, the rate of suicide does not display a clear regional pattern, but for men and for the gender gap in suicide and intentional self-harm mortality, with few exceptions, countries of Eastern Europe feature higher mortality rates and larger differences between men and women.**

Figure 9. Age-standardised mortality rate from suicide and intentional self-harm by EU Member States with data available, 2016



Source: Eurostat. (2016). *Causes of death – standardised death rate by residence [hlth_cd_asdr2]*. Retrieved from https://ec.europa.eu/eurostat/data/database?node_code=hlth_cd_asdr2.

Notes: Deaths from suicide relate to ICD-10 codes X60–X84 and Y870. Data from causes of death (COD) statistics are based on information derived from the medical certificate of cause of death (ICD-10 definition) in each Member State. Includes purposely self-inflicted poisoning or injury and attempted suicide. Age-standardised mortality rates per 100 000 inhabitants. Weighting factor based on the standard reference population as the European standard population (Eurostat, revision 2012).

Data are shown in Appendix Table III.9.

16 The World Health Organization defines suicide as ‘an act deliberately initiated and performed by a person in the full knowledge or expectation of its fatal outcome’. See https://ec.europa.eu/health/sites/health/files/state/docs/health_glance_2016_rep_en.pdf (p. 68).

2.4 Health of ethnic minority and migrant women

Ethnic minority groups in Europe are quite diverse and there are substantial variations between countries (Eurostat, 2020b). There is evidence that **ethnic minority groups have worse health outcomes than host European populations across all EU countries – particularly in terms of mental health, cardiovascular disease and diabetes** (Modesti et al., 2016). For example, ethnic minority populations in Europe are more affected by diabetes compared with the European host populations. A recent scientific review found that the risk of type II diabetes among ethnic minority groups living in Europe was two to five times higher than among the host European population (Meeks et al., 2016). From the gender perspective, **while women have lower diabetes rates than men overall (regardless of their ethnic background or country of residence), this evidence review found that women from ethnic minority groups in Europe had rates of diabetes 4 to 6 times higher than women from the European host populations** (Meeks et al., 2016). Diabetes is a major risk factor for hypertension, stroke and cardiovascular disease – and indirectly accounts for around 10 % of deaths in Europe (Whiting et al., 2011).

In recent years, the number of asylum seekers in Europe have increased (Eurostat, 2020a). **Refugees, asylum seekers and migrants seem to be at the greatest risk of worse health outcomes** (WHO, undated) – including most non-communicable diseases such as cardiovascular disease, cancer, diabetes and stroke. From a gender perspective, refugee, asylum seeker and migrant women frequently face specific challenges in terms of maternal, newborn and child health, sexual and reproductive health, and violence (WHO, undated). By way of example, a recent scientific review found that **the prevalence of postnatal depression among migrant women (including refugees and asylum seekers) is twice that of women from host countries** (Heslehurst et al., 2018). Similarly, a review found that **maternal mortality rates are also twofold among migrant women in European countries** – an additional 9 maternal deaths per 100 000 deliveries per year for migrant women (Pedersen et al., 2014). Research studies have also found **significantly increased risks of risks of stillbirth** (40 % higher), **perinatal mortality** (35 % higher), **neonatal mortality** (34 % higher) and **infant mortality** (33 % higher) among migrant women in European countries compared with women from the host countries (Gissler et al., 2009).

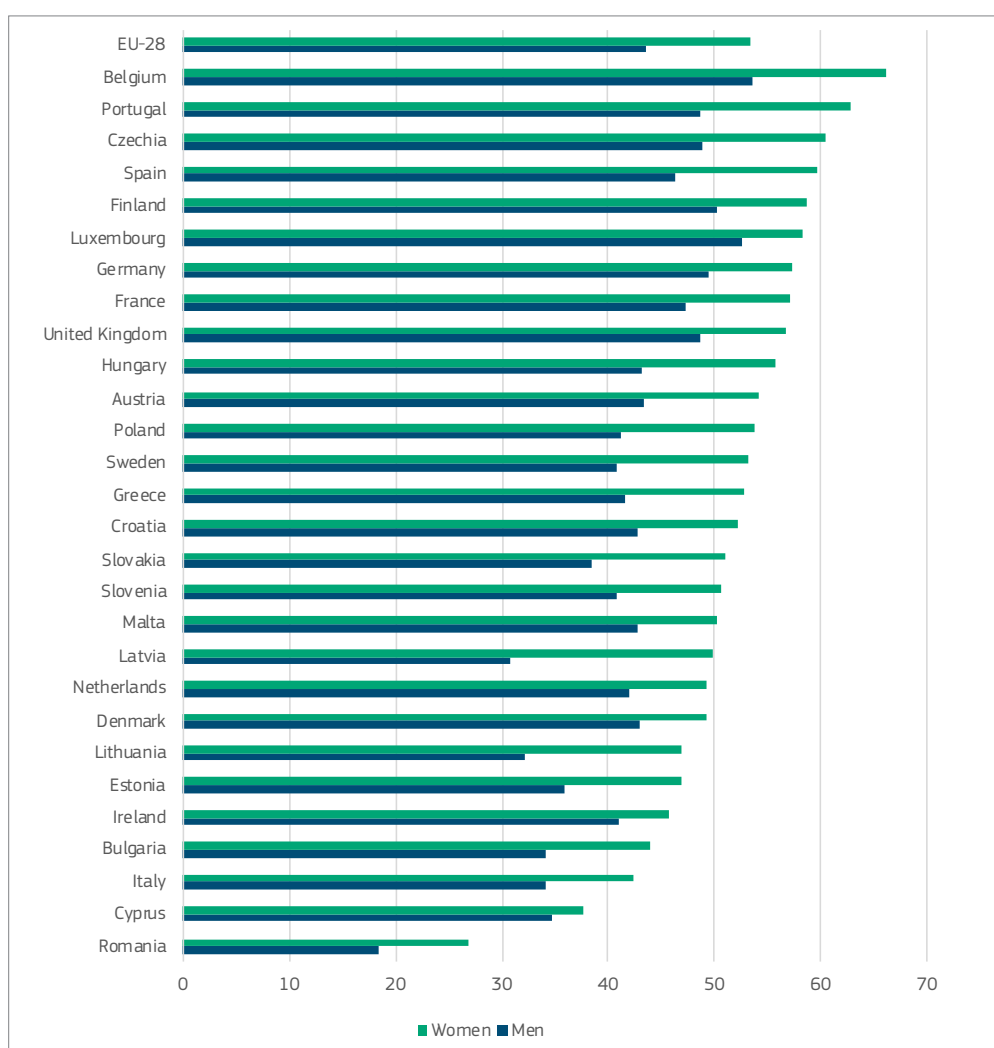
The European Commission 2014 report on Roma health highlights that **compared with the non-Roma population in Europe, Roma have poorer health**. Roma populations in Europe are also frequently socially excluded, suffer discrimination, and consequently face barriers accessing good-quality housing, healthcare and education. The poor health of Roma is closely linked to social determinants of health (European Commission, 2014). According to the EU-FRA Roma Survey (2013), one out of three Roma respondents aged 35 to 54 report health problems limiting their daily activities; and on average, about 20 % of Roma respondents are not covered by medical insurance or do not know if they are covered (FRA, undated). The survey was conducted in 11 countries (Bulgaria, Czechia, France, Greece, Italy, Hungary, Poland, Portugal, Romania, Slovakia and Spain) and provided data on health factors related to the role of women in the Roma community compared with non-Roma women. **Regarding women in ‘bad’ or ‘very bad’ health, all but one of the countries covered reported higher occurrence of these indicators in Roma women (16 years and over) compared with non-Roma women**. When discussing women aged 50 and over, Roma women declared themselves to be in

significantly worse health than their non-Roma counterparts. For instance in Poland, 75 % of Roma women stated that they were in 'bad' or 'very bad' health and in Italy, a 58 % difference exists between the self-declared health status of Roma and non-Roma women. Roma women also encounter greater limitations in their daily activities. **On average, 23 % of Roma women experience limitations compared with 17 % of non-Roma women.** This is most evident in Poland where a 17 % gap exists between the self-declared limitations of Roma women v non-Roma women. Regarding medical insurance, 18 % of Roma women compared with 8 % of non-Roma women declared having no medical insurance. Three countries in particular show large differences in this respect: Bulgaria, Romania and Greece have differences of 37 %, 25 % and 31 % respectively regarding lower coverage of Roma compared with non-Roma women with respect to medical insurance. **Within Roma communities, women have slightly higher levels of medical insurance than men as 82 % of Roma women are covered compared with 80 % of Roma men.** With regard to accessing healthcare, Roma, on the whole, did not encounter any issues as only 5 % of women and 4 % of men declared not receiving medical assistance when it was required (European Commission, 2014). The second European Union Minorities and Discrimination Survey on Roma by FRA (2016) found that in Bulgaria, Czechia, Croatia and Slovakia the share of Roma facing long-term activity limitations is higher than the share of the general population experiencing similar problems. In Romania, this is the case with Roma men, and in Spain, for Roma women. Also, among Roma in six of the nine countries surveyed in 2016, women were more likely than men to say that they have been severely or somewhat limited in their everyday activities due to a health problem. The biggest difference between women's and men's experiences was in Spain, where 17 % of Roma men said that they have been limited in their daily activities, while almost one in three women (30 %) felt that health problems have limited their activities in some way (FRA, 2016).

2.5 Use of medication

Prescribed medicine use is higher among women than in men in the EU Member States. According to data from the European health interview survey, which was conducted between 2013 and 2015, without exception, women were more likely than men to have used prescribed medicines, with this gender difference being narrowest in Cyprus and broadest in Latvia (Figure 10). In part, the difference between men and women can be attributed to the use of contraceptive pills and hormones for menopause.

Figure 10. Self-reported use of prescribed medicines by sex, (%), 2014



Note: ranked on the share of the total population reporting that they had used prescribed medicines.

Source: Eurostat (2014), Self-reported use of prescribed medicines by sex, age and educational attainment level [hlth_egis_md1e].

Retrieved from: https://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=hlth_egis_md1e&lang=en

The data are available in Appendix Table III.10.

The gender difference was particularly strong in the 25–34 age group where at EU level there was closer to 12 percentage points more for women than for men. In the age group 15–24, the gender difference was almost as strong, while it weakened somewhat but remained noticeable in the next two age groups (35–44 and 45–54). The gender difference was considerably weaker in the age groups 55–64 and 65–74 and was lowest at EU level in the oldest age group.

Table 1. Self-reported use of prescribed medicines by age and sex, (%), 2014

GEO/TIME	Men age groups in years							Women age groups in years						
	15-24	25-34	35-44	45-54	55-64	65-74	+75	15-24	25-34	35-44	45-54	55-64	65-74	+75
European Union - 28 countries (2013-2020)	16,7	20,3	27,4	41,5	62,0	76,5	85,8	27,3	32,1	37,5	50,4	66,9	79,4	87,9
Belgium	22,3	27,1	37,6	55,2	74,2	86,8	89,6	42,9	47,8	52,7	63,0	81,4	87,5	93,0
Bulgaria	3,1	8,2	14,4	28,3	55,3	72,7	80,9	10,4	12,9	14,8	37,8	60,6	78,8	85,4
Czechia	15,0	25,3	31,7	47,2	72,8	88,8	95,2	29,5	33,1	43,4	59,5	80,1	89,8	97,0
Denmark	19,3	23,1	28,0	39,7	57,4	75,3	86,5	25,8	28,7	36,4	45,2	62,4	74,6	86,0
Germany	18,6	23,2	31,3	47,9	70,3	82,1	90,0	30,6	33,5	40,4	53,9	68,9	82,1	91,7
Estonia	15,8	18,1	24,4	37,4	52,9	70,0	75,3	21,2	23,5	21,6	39,1	62,6	77,3	85,3
Ireland	23,6	18,6	29,1	40,5	62,1	73,5	86,2	31,3	26,8	33,8	41,8	62,4	77,4	87,5
Greece	11,7	17,7	21,1	35,1	54,0	83,5	88,4	18,0	25,0	31,8	47,5	68,1	87,3	93,3
Spain	17,2	24,2	30,0	48,0	67,0	83,3	92,4	33,2	38,8	45,6	57,0	75,6	88,9	95,4
France	22,0	27,4	33,3	39,3	64,7	79,8	91,1	32,1	39,7	43,5	55,6	69,4	78,6	91,6
Croatia	9,9	15,3	25,7	46,8	62,3	78,4	86,9	12,8	22,5	33,8	50,4	71,7	81,2	91,0
Italy	11,5	13,5	19,4	30,9	44,6	58,0	69,2	16,4	23,8	29,6	36,4	52,5	63,3	71,1
Cyprus	10,0	12,3	21,2	36,5	59,4	79,4	86,3	12,2	15,3	25,2	35,1	64,1	81,5	93,4
Latvia	12,3	12,8	17,4	29,6	48,0	62,4	73,7	25,9	21,9	30,0	44,3	64,3	78,9	81,1
Lithuania	9,8	8,3	17,5	30,4	55,9	71,2	82,7	10,6	13,8	23,5	42,6	69,8	80,4	89,3
Luxembourg	24,7	31,9	38,7	57,5	79,9	85,7	94,2	33,5	42,2	46,5	61,2	75,5	85,0	89,1
Hungary	14,5	15,2	27,3	47,2	69,2	82,4	91,6	27,0	29,1	30,6	55,4	75,1	88,1	93,1
Malta	20,3	18,2	29,4	46,1	65,6	74,6	82,4	23,7	20,7	38,1	52,8	68,6	81,2	89,1
Netherlands	18,2	22,6	28,7	36,6	59,9	73,8	86,7	25,7	27,0	36,9	48,0	62,3	76,4	85,2
Austria	14,5	22,3	31,0	44,6	60,4	77,3	86,4	26,4	34,0	40,9	52,6	67,9	82,7	90,6
Poland	13,8	17,7	26,6	43,8	63,8	79,4	89,9	22,4	29,4	36,3	53,7	72,2	86,8	94,3
Portugal	23,8	18,6	30,7	47,9	68,8	85,3	89,5	32,5	37,3	45,0	59,8	80,0	91,0	94,6
Romania	1,7	2,7	4,9	11,9	32,2	51,1	65,7	3,1	4,9	5,7	20,8	41,9	58,2	69,4
Slovenia	13,1	14,3	21,9	42,6	65,8	80,9	84,8	20,1	19,7	29,2	51,1	67,1	83,5	92,4
Slovakia	14,8	16,3	22,3	43,5	67,1	80,5	89,0	19,0	26,9	33,2	49,8	75,5	89,0	94,6
Finland	24,1	27,0	33,3	50,4	68,3	76,8	87,3	33,3	37,9	46,6	58,2	75,7	81,6	87,9
Sweden	17,6	19,8	24,5	37,6	55,7	74,2	81,4	29,0	33,3	45,3	47,4	61,1	76,6	89,0
United Kingdom	20,5	21,2	32,0	44,9	67,8	80,1	88,4	37,4	39,8	41,8	54,0	67,7	80,2	87,3

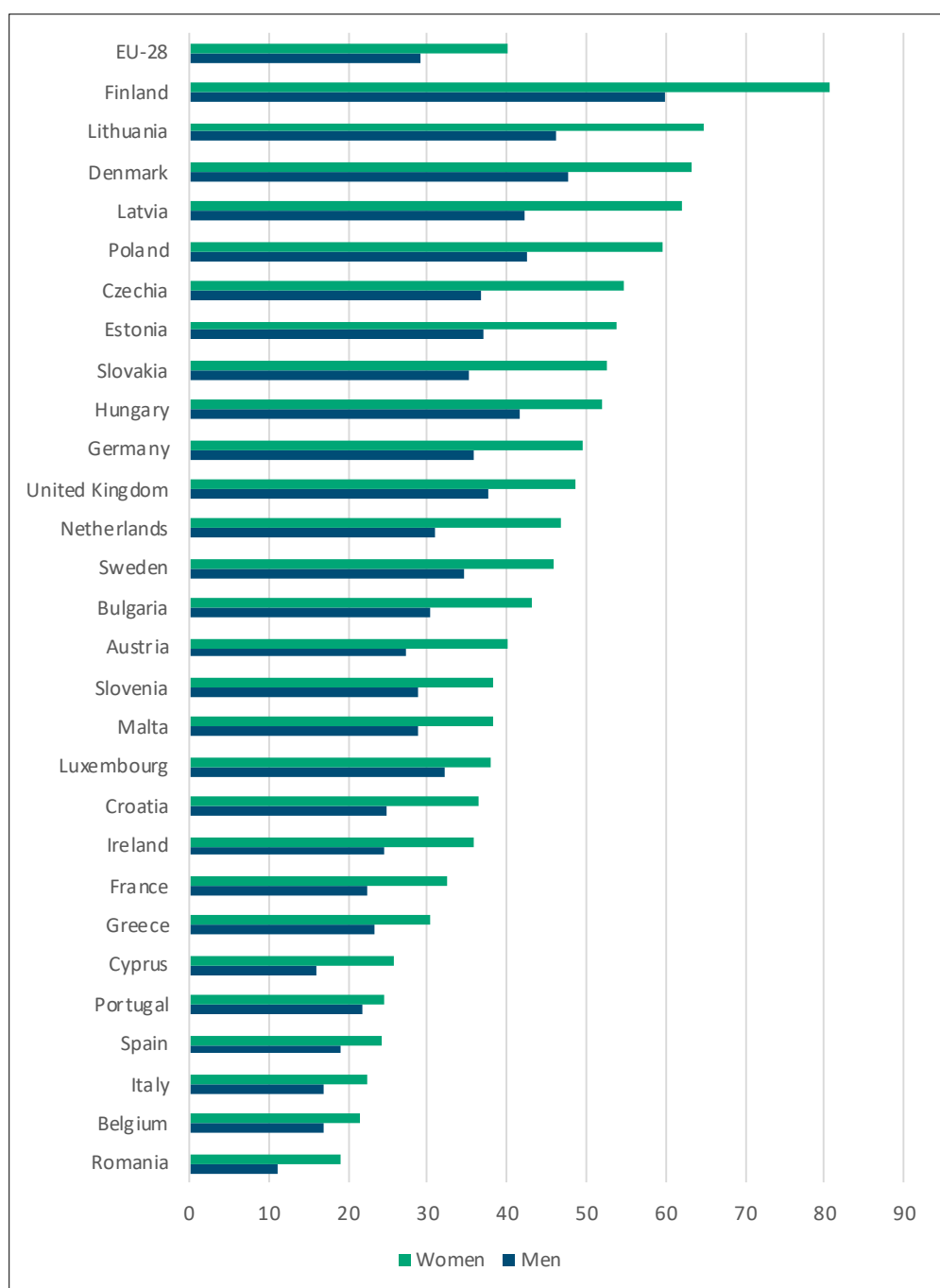
Source: Eurostat (2014), *Self-reported use of prescribed medicines by sex, age and educational attainment level* [hlth_ehis_md1e].

Retrieved from: https://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=hlth_ehis_md1e&lang=en.

Nearly all participating Member States reported that **a lower proportion of women having completed tertiary education used prescribed medicines than did women having completed at most upper secondary or post-secondary non-tertiary education: the only exceptions were Greece, Malta and Portugal. In a majority of the Member States, the pattern was the same for men**, although the differences between the share of men that used prescribed medicines having completed tertiary education compared with the shares of those who completed at most upper secondary or post-secondary non-tertiary education were smaller than in the case of women.

The proportions of people using non-prescribed medicine were lower than those using prescribed medicine, with the exceptions of Lithuania, Finland, Latvia, Denmark, Estonia, and Poland, where the proportions using non-prescribed medicines were higher. An analysis by sex (Figure 11) of **the use of non-prescribed medicines shows a similar pattern to that for prescribed medicines, with a higher proportion of women than men making use of these medicines.**

Figure 11. Self-reported use of non-prescribed medicines by sex, (%), 2014



Source: Eurostat (2014), *Self-reported use of prescribed medicines by sex, age and educational attainment level* [hlth_ehis_md1e].

Retrieved from: https://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=hlth_ehis_md1e&lang=en

The data are available in Appendix Table III.11.

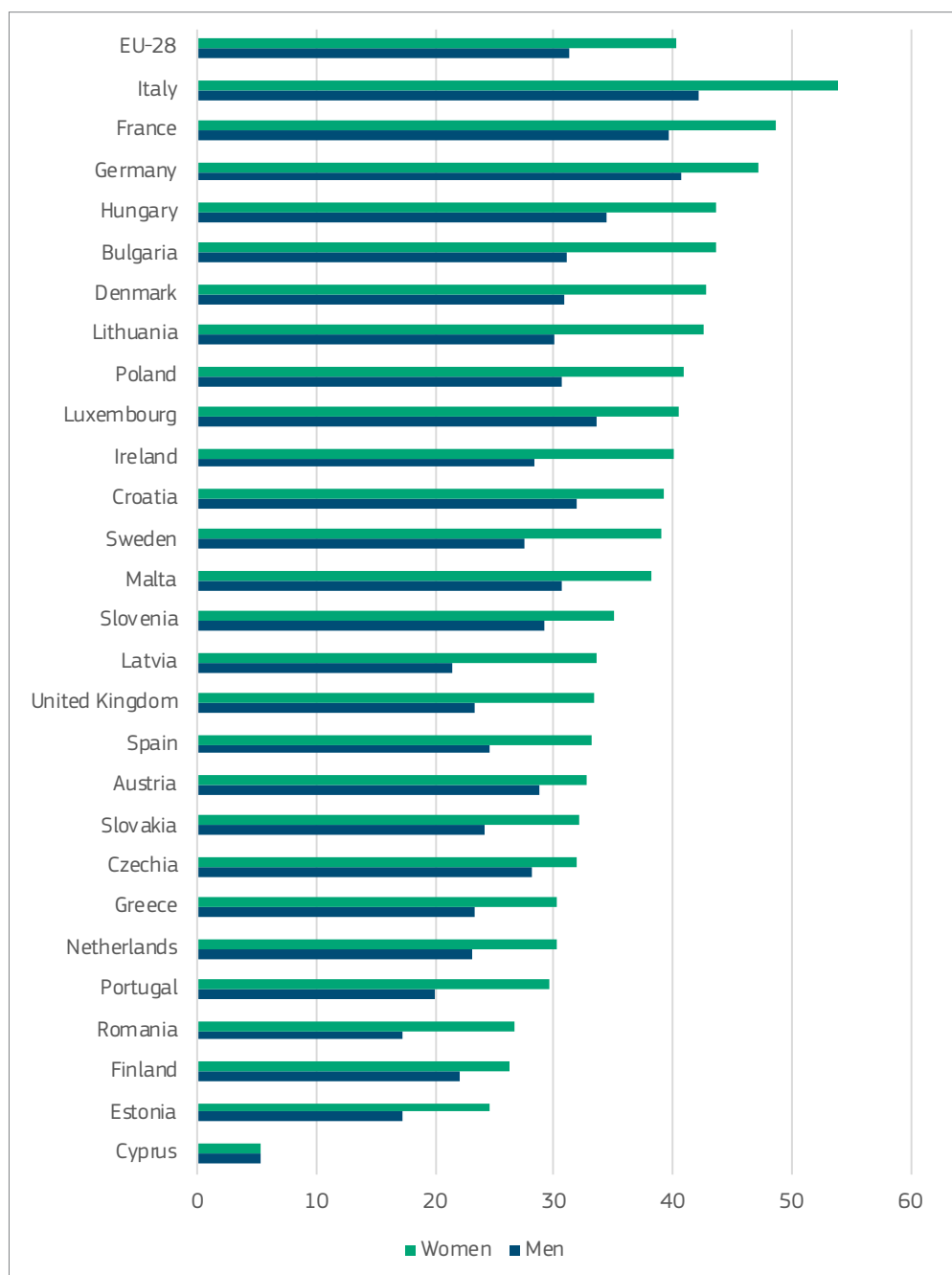
2.6 Use of healthcare services

Evidence shows that **women are more frequent users of healthcare services than men**, including consultations by a generalist medical practitioner, specialist practitioner, dentist, physiotherapist, and psychologist, psychotherapist or psychiatrist.¹⁷

According to the data from the European Health Interview Survey (2014), in all but one (Belgium) of the EU Member States for which data are available, **women were more likely than men to have consulted a general practitioner or a specialist medical practitioner** (Figure 12). For general practitioners, the difference between the sexes was more than 10 percentage points in Poland, Sweden, Ireland, Italy, Denmark, Latvia, Lithuania and Bulgaria (where the largest difference was recorded among the Member States at 12.6 percentage points). By contrast, the gender gap was close to 4 percentage points in Finland, Austria and Czechia, while a slightly higher share of Cypriot men (5.4 %, compared with 5.3 % for Cypriot women) consulted a general practitioner. For **consultations of specialist medical practitioners**, the difference between the sexes ranged from 16.9 percentage points in Croatia and 10 or more percentage points in Estonia and Germany to less than 3 percentage points difference in Malta, Ireland, Romania and the United Kingdom (where the lowest difference was recorded, 1.4 percentage points). On average, the **proportion of persons having visited a dentist or orthodontist within the last year (prior to the survey) was 62.8 % for women and 57.2 % for men** (a difference of 5.6 percentage points between the two sexes). This gender gap in 2014 was consistently in favour of women across each of the EU Member States, with the biggest gaps (upwards of 8 percentage points difference) recorded in Malta, Latvia, the United Kingdom, Estonia and Poland, peaking at 12.4 percentage points in Lithuania (Eurostat, 2020c).

¹⁷ The only exceptions in the consultations by psychologists, psychotherapists or psychiatrists were Croatia and Malta, where the shares recorded for men were higher than those for women, while the two sexes recorded equal shares in Romania.

Figure 12. Self-reported consultations – proportion of people having consulted a generalist medical practitioner during the four weeks prior to the survey, by sex, 2014

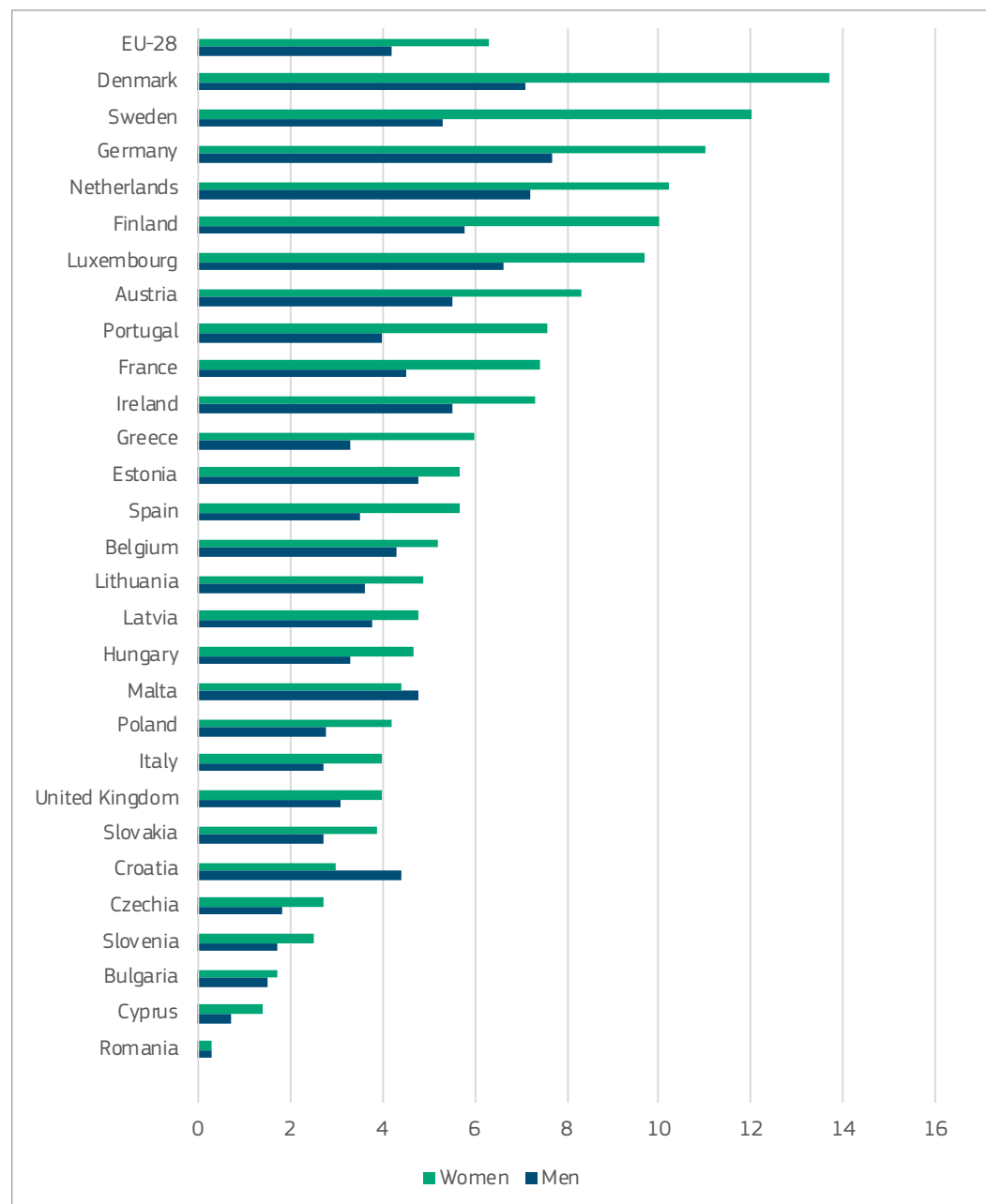


Source: Eurostat (2014), Belgium not available. Self-reported consultations of a medical professional by sex, age and degree of urbanisation [hlth_ehis_am2u]. Retrieved from: https://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=hlth_ehis_am2u&lang=en.

The data are available in Appendix Table III.12.

In 2014, in almost all of the EU Member States the proportion of people (aged 15 or over) having consulted a psychologist, psychotherapist or psychiatrist was higher for women than for men (Figure 13). The only exceptions were Croatia and Malta, where the shares recorded for men were higher than those for women, while the two sexes recorded equal shares in Romania. The share of women was particularly pronounced when compared with the corresponding share for men in Finland, Denmark and Sweden.

Figure 13. Self-reported consultations – proportion of people having consulted a psychologist, psychotherapist or psychiatrist during the 12 months prior to the survey, by sex, 2014



Source: Eurostat (2014), Consultation of a medical doctor (in private practice or as outpatient) per inhabitant [hlth_hc_phys] Retrieved from: https://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=hlth_hc_phys&lang=en.

The data are available in Appendix Table III.13.

There are many factors that can form **barriers to men's use of medical services**, such as a perception that waiting rooms and other services are designed around women's needs; a lack of understanding of how to make appointments; a lack of the vocabulary required to discuss sensitive issues; no knowledge of a good doctor or specialist; wanting to see if a problem got better on its own, fear of examinations, and gender stereotypes (FRA, 2013b; WHO, 2018) (See Appendix II for a description of a practice to improve men's health in Ireland).

2.7 Occupational health and safety

Differences between women's and men's working lives – vertical and horizontal segregation – result in a difference between the hazards and risks that women and men are exposed to, and these differences should be reflected in occupational health and safety (OHS).

Occupational cancers are the primary cause of work-related deaths in industrialised societies, with more than 100 000 people losing their lives each year through being exposed to carcinogens while at work. Latest estimates set the share of work-related cancers at 8 % of all new cancer cases; 6–12 % for men and 3–7 % for women (Musu and Vogel, 2018). In terms of occupational cancers, women are often ignored. A robust literature review on the role of occupational factors in lung cancer, a disease with a high incidence among men and women alike, found that barely 4 % of the articles focused exclusively on women, 45 % on a mixed population and 51 % on men exclusively. In the mixed populations, men were significantly over-represented relative to women (Mengeot et al., 2014).

Although questions regarding the effects of occupational exposures to dangerous substances are not new, **workers' exposure to dangerous substances remains under-assessed** in women-dominated sectors such as healthcare, service sectors like cleaning, hairdressing and cosmetology (ETUI, 2018) and sectors where women make up a large proportion of the workforce, such as agriculture and waste management (Weber and Henke, 2014). For example, in France's heavily women-dominated service and domestic staff sector, 28 % of workers are exposed to carcinogens like formol and chlorinated solvents. But neither of these are included in the regulations on recognised occupational diseases, leaving their health impacts invisible (Mengeot et al., 2014).

Women are in general less likely to be involved in accidents at work (see Figure 14). Nevertheless, female-dominated sectors such as healthcare, social work, education, transport, public administration and retail are highly exposed to **third-party violence** (OSHA, 2013) and **psycho-social risks** (Eurofound, 2020). Violence against women in politics is widely reported, including physical attacks, intimidation, bullying and sexual harassment (European Parliament, 2018a).¹⁸

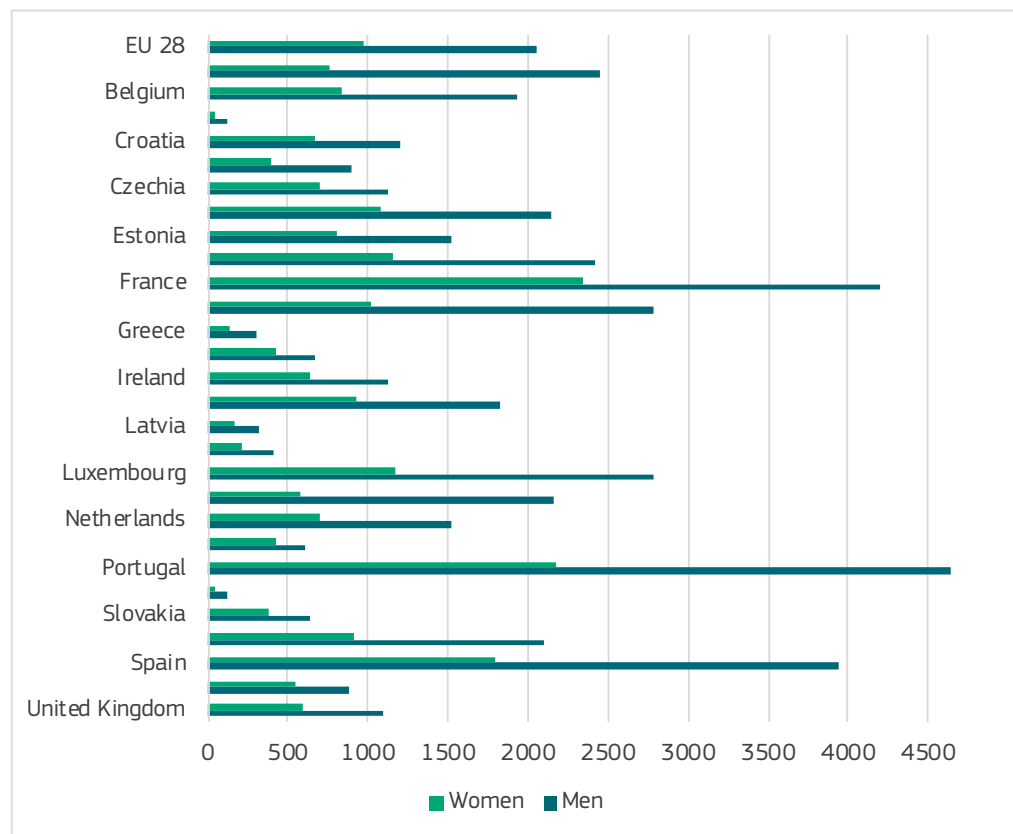
The OSHA 2013 report, *'New risks and trends in the safety and health of women at work'*, furthermore highlights that:

- Work-related risks to women's safety and health have been underestimated and neglected compared to men's, regarding both research and prevention.
- Male workers often seem to be more exposed to specific risks than women, but more in-depth analyses of the data reveal that women may have a higher level of exposure and are particularly affected by multiple exposures, for example, in the hospitality industry, healthcare and cleaning sectors, as well as in the traditional sectors of agriculture, manufacturing and transport.
- Women are more exposed to slips, trips and falls.
- Women are increasingly affected by musculoskeletal disorders (MSDs) and stress.
- Because awareness is low and occupational history poorly monitored and described, under-recognition of women's work-related cancers is likely (OSHA, 2013).

¹⁸ For further information, see also the website of the research project 'Violence against Women in Politics', available at: <https://www.vawpolitics.org/>.

Figure 14 represents the rate of accidents at work, standardised per 100 000 workers, for men and women in 28 EU Member States. Figures refer to accidents that occur as part of the course of work and cause physical and/or mental health harm. The graph shows that **in all countries, accidents are more common among men than among women. The EU average rate of accidents at work for men is 2 047 per 100 000 workers, and 969 per 100 000 workers for women** (a gender gap of 1 078 per 100 000 workers). Portugal shows the greatest incidence rate of accidents at work for men (4 648 per 100 000 workers), while France has the highest incidence of work accidents for women (2 340 per 100 000 workers). The lowest rates are observed in Bulgaria for both men and women, at 114 and 43 per 100 000 workers, respectively. Portugal shows the largest difference in accidents at work, with 2 469 fewer cases in women than in men, while Bulgaria has the smallest gap between the genders at 71 per 100 000 workers more accidents for men compared to women. It is worth noting that, with the exception of Greece, the highest incidence of accidents at work for both men and women, as well as the largest gender gaps in the number of accidents, are seen in Western European countries.

Figure 14. Standardised incidence rate of accidents at work per 100 000 workers for women and men in 28 EU Member States, 2015

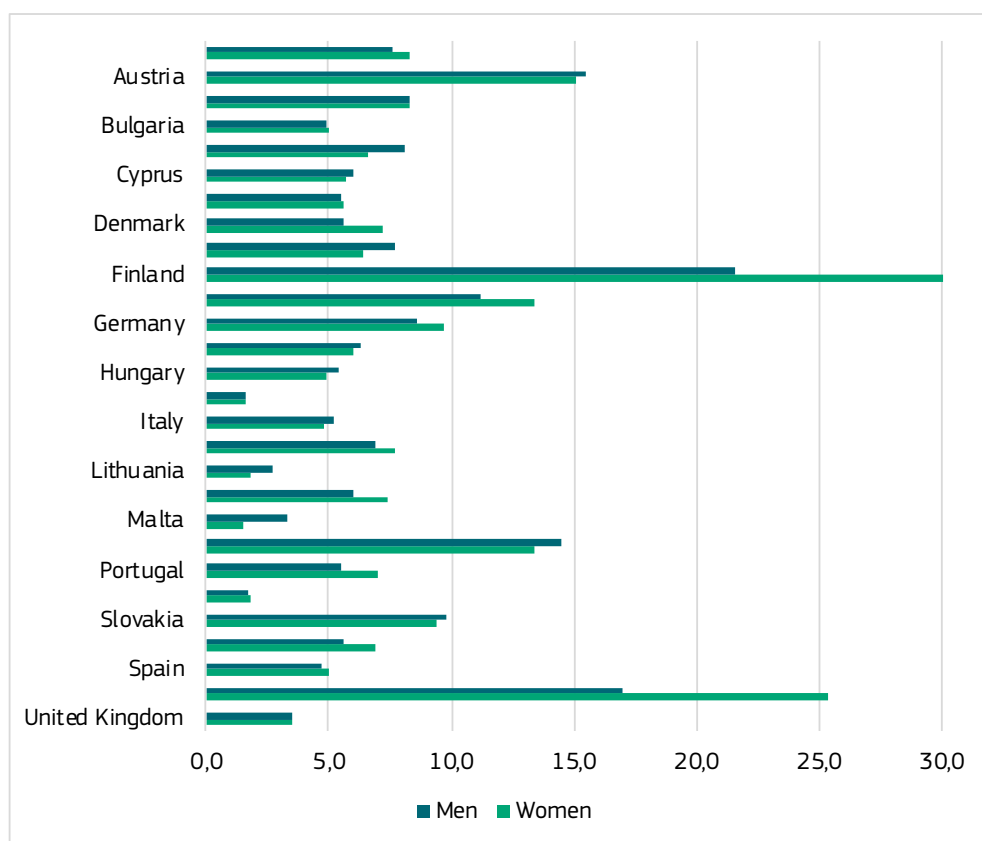


Source: European Core Health Indicators. European Commission. (2015). Standardised incidence rate of accidents at work per 100 000 workers. Retrieved from https://ec.europa.eu/health/indicators_data/indicators_en

Notes: Figures reflect the number of persons involved in accidents at work resulting in more than three days absence (serious accidents) per 100 000 persons in employment. Includes accidents that lead to physical or mental health harm, which happen inside or outside the premises of the employer (including public spaces, roads and the home) as part of the course of work. Excludes accidents on the way to or from work, deliberate self-inflicted injuries, injuries from a medical condition (e.g. heart attack) and occupational diseases. The data are found in Appendix Table III.10.

Figure 15 illustrates the proportion of women and men reporting health problems (physical or mental) related to work in the last 12 months (excluding accidents at work). Data are from the 2013 European Labour Force Survey. **At the overall level of the 28 EU Member States, more women than men report work-related ill-health, at 8.3 % and 7.6 % respectively (a gender gap of 0.7 percentage points).** However, there is variability across countries. In countries like Finland, Sweden and France, more women report work-related health problems than men, while in Malta, Croatia and Estonia results are in the opposite direction. The UK, Ireland and Belgium show similar rates of work-related ill health across women and men. The highest proportion of work-related health problems in women and men is found in Finland, at 30 % and 21.6 %, respectively. The lowest proportion of women self-reporting ill-health from work is in Malta (1.5 %), and in Ireland for men (3.3 %). In the case where more women than men report work-related health problems, the largest gender gap between genders is seen in Finland (8.4 percentage points) and Sweden (8.3 percentage points). The gender gap where more men than women indicate work-related ill health is highest in Malta (1.8 percentage points). Although the pattern is mixed, it is possible to see that the largest shares of work-related ill health, and the largest gender gap, mainly occur in countries from Western Europe, particularly Scandinavian countries.

Figure 15. Proportion (%) of men and women aged 15 to 64 years reporting a work-related health problem in 28 EU Member States, 2013



Source: Eurostat. Labour Force Survey ad-hoc 2013 module. Eurostat. (2013). Persons reporting a work-related health problem by sex, age and educational attainment level [hsw_pb1].

Retrieved from https://ec.europa.eu/eurostat/data/database?node_code=hsw_pb1

Notes: Proportion of persons in employment having had one or more work-related physical or mental health problems in the last 12 months caused or made worse by work. Excludes injured people because of accidents at work in the last 12 months. Health problems include cardiovascular disorders, hearing disorders, pulmonary disorders, musculoskeletal disorders, infectious diseases, stomach, liver, kidney or digestive problem, stress, depression, anxiety, skin problems, headache, and eyestrain. No data on the Netherlands. Data are available in Appendix Table III.11.

2.8 Gender segregation in the human health and social care sector

Women's share of employment in the health and social sector is high; according to the EU Labour Force Survey, in 2018, total employment in the human health and social care sector¹⁹ was 25 266 300, with 76 % of these workers women (EIGE (d)). **In the WHO European Region (53 Member States), 95 % of nurses are women** (WHO, 2020b). **Women make up 86 % of personal care workers in health services. Most of the workers providing home-based professional care to older people and people with disabilities are women;** the estimation is that 4.5 million out of the total of 5.5 million workers in the EU are women. (Additional more recent data are provided in Appendix III, Tables III.15, III.16, III.17, III.18, III.19; the tables suggest that the trends mentioned above also apply to specific professions). Many health and care workers in the EU are migrants, for example, nearly one in five personal care workers in health services (EIGE, 2020c). Carers provide different types of care depending on their qualifications and job functions, including nursing care, basic medical services and helping people to eat, bathe or dress (EIGE (b)). Due to demographic change (European Commission, 2020), this '**care economy**' is growing and must create a high number of jobs in the coming years. However, care work remains characterised by poor working conditions, a void of benefits and protections, low wages or non-compensation, and exposure to physical, mental and, in some cases, sexual harm (ILO, undated). Ensuring decent working conditions for care personnel can be expected to increase the quality of care and patient safety.

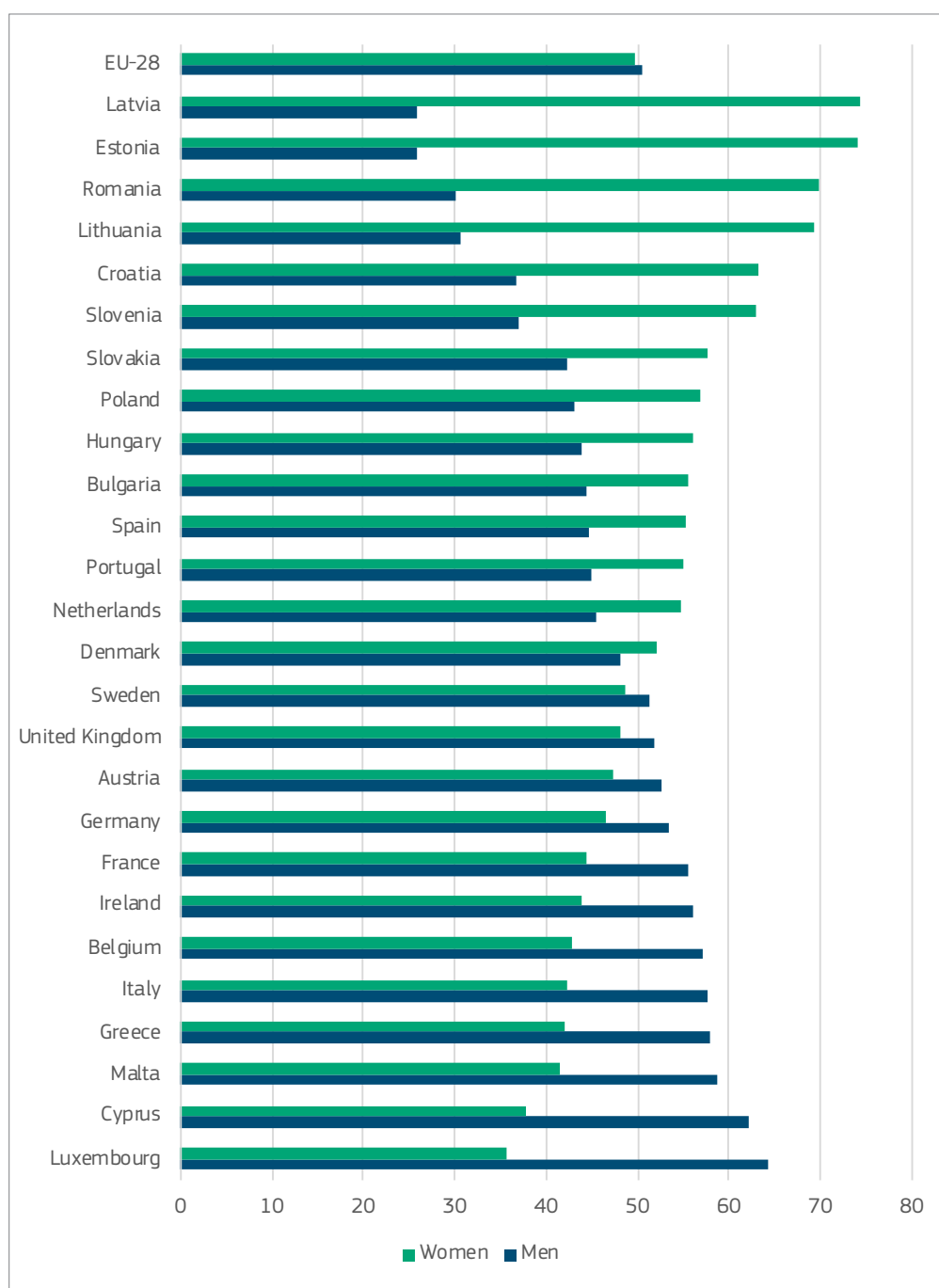
In 2017, there were approximately 1.8 million **practising physicians**²⁰ in the EU-28. There were considerable differences between EU Member States with respect to the share of physicians accounted for by each of the sexes. **Between 2007 and 2017, the proportion of women physicians in the total number of physicians generally rose.** By 2017, a slight majority (15) of the EU Member States reported that they had a higher number of women physicians.²¹ In Croatia and Slovenia, more than three fifths of all physicians were women; in Romania and the Baltic Member States – Estonia, Latvia, and Lithuania – this share passed two thirds, with peaks in Estonia and Latvia (both 74 %). By contrast, the highest share of male physicians (64 %) was recorded in Luxembourg, while relatively high shares for men were also recorded in Cyprus (62 %), as well as Malta, Greece, Italy and Belgium (all within the range of 57–59 %) (see Figure 16) (Eurostat, 2020d).

19 The **human health and social care sector** includes the provision of health and social work activities. This includes healthcare provided by trained medical professionals in hospitals and other facilities, residential care activities that still involve a degree of healthcare activities, and social work activities without any involvement of healthcare professionals. The **human health sub-sector** includes hospitals, general or specialty medical, surgical or psychiatric hospitals, sanatoria, medical nursing homes, asylums, rehabilitation centres, etc. It also includes medical consultation and treatment by general practitioners and medical specialists and surgeons, and dental practices. The **residential care sub-sector** includes the provision of residential care combined with either nursing, supervisory or other types of care as required by the residents. The **social work sub-sector** includes the provision of a variety of social assistance services directly to clients (excluding accommodation services, except on a temporary basis). <https://skillspanorama.cedefop.europa.eu/en/sectors/health-social-care>

20 A practising physician provides services directly to patients as consumers of healthcare. These services include conducting medical examinations and making diagnoses; prescribing medication and treating diagnosed illnesses, disorders or injuries; giving specialised medical or surgical treatment for particular illnesses, disorders or injuries; and giving advice on and applying preventive medical methods and treatments. <https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Glossary:Physician>

21 2016 data for Denmark, Poland and Sweden; 2015 data for Finland; no recent information for Czechia.

Figure 16. Physicians by sex, 2017 (%)



Source: Eurostat (2017), Physicians by sex and age [hlth_rs_phys].

Notes: Czechia and Finland are not available. (1) Estimates, (2) 2016, (3) 2015.

Retrieved from http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=hlth_rs_phys&lang=en

The data are available in Appendix Table III.16.

3. Access to medical services in the EU-28 Member States

This chapter focuses on two areas: a) access to medical services in general,²² and b) access to some specific services, such as health and reproductive services, contraception, maternal care and childbirth. An overview is also provided of evidence regarding access to maternal care for migrants, refugees, asylum seekers and ethnic minorities, and on violence in childbirth.

3.1 Access to medical services in general

The barriers to access to medical services are numerous. **Financial barriers** can affect men and women in different ways – with the latter possessing more often a lower-than average income. Out-of-pocket payments (OOPs) increase inequalities, since men are more likely to be covered by private insurance than women (FRA, 2013b). For example, women in need of mental healthcare services report unmet needs due to finances more frequently than men (Eurostat, 2020e). In terms of availability, **healthcare services can be too far to travel to**, and there can be a **lack of means of transportation**, for example, for women who rely more on public transportation (EIGE (c)). Care duties, mostly undertaken by women, can also be an obstacle to access to medical services (Eurostat, 2019).

Data analyses by Fjær et al. (2017) of the 7th round of the European Social Survey shows that two thirds of all unmet need were due to waiting lists and a lack of appointment **availability**. Women and young age groups reported more unmet need, and financial strain was found to be an important factor for all types of unmet need for healthcare in Europe. Low physician density and high out-of-pocket payments were found to be associated with unmet need due to **accessibility**. **Acceptability**²³ mainly represented a problem for those in paid work.

22 Data on migrant and ethnic minorities' access to healthcare in the EU-28 is scarce. For further information, see EC (2018), Migrant health across Europe: Little structural policies, many encouraging practices; DG JUST (2017), Data collection in the field of ethnicity. <https://ec.europa.eu/migrant-integration/feature/migrant-health-across-europe>.

There is some reporting at the Member State level on migrant and ethnic minority populations' access to healthcare; however, these do not provide sex-disaggregated data and/or analyses. See for example: European Social Policies Network (2018), Inequalities in Access to Healthcare https://ec.europa.eu/social/main.jsp?advSearchKey=ESPNhc_2018&mode=advancedSubmit&catId=22&policyArea=0&policyAreaSub=0&country=0&year=0

23 Respondents were coded as having unmet need due to **acceptability** if they indicated that they were unable to get a medical consultation because they could not take time off work, or had other commitments. The operationalisation of 'acceptability' differs between previous studies, as the study

In terms of **discrimination**, the EU Fundamental Rights Agency (FRA) notes that EU data on healthcare use disaggregated by equality grounds are scarce. Some gender relevant findings are: in Czechia, **Roma women are more likely (21 %) to report discrimination by healthcare personnel than men (15 %)**; for **North Africans in Italy, perceived discrimination by healthcare personnel is higher among men (26 %) than women (20 %)**; and **ill treatment against persons with disabilities** in the healthcare sector is one of the most relevant barriers to healthcare. Results from the World Health Survey conducted by WHO show that in high-income countries, **ill treatment against persons with disabilities in the healthcare sector is one of the most relevant barriers to healthcare**: 39.6 % of the men and 20 % of the women interviewed reported not accessing care because they ‘were previously treated badly’ (FRA, 2013b). According to the FRA 2012 survey, lesbian, gay, bisexual and transgender (LGBT) people report difficulties in accessing healthcare. **30 % of LGBT women and 23 % of LGBT men reported difficulties in using or accessing healthcare services, primarily due to their needs being ignored and actual or feared negative reactions** (FRA, 2013a). The Health4LGBTI study (2017) reported that lesbian, gay and bisexual people are 1.5 times more likely to report unfavourable experiences of primary care provision compared to the general population. Transgender people who had used health services frequently experienced negative interactions with health professionals at gender identity clinics, mental health services and general health services. For transgender people that attended gender identity clinics, long waiting times to access treatment was shown to impact negatively on their emotional wellbeing and mental health (European Commission, 2017c). According to the FRA survey, ‘EU-LGBTI II – A long way to go for LGBTI equality’ (2020), every sixth respondent (16 %) felt discriminated against when in contact with healthcare or social services staff. 52 % of respondents who assessed their general health as ‘very bad’, and 36 % of those who assessed it as ‘bad’, felt discriminated against in healthcare settings. Fewer who assessed their health as ‘very good’ or ‘good’ did so (11 % and 14 %, respectively) (FRA, 2020) (See Appendix II for a description of a practice that aims to reduce health inequalities experienced by LGBTI people).

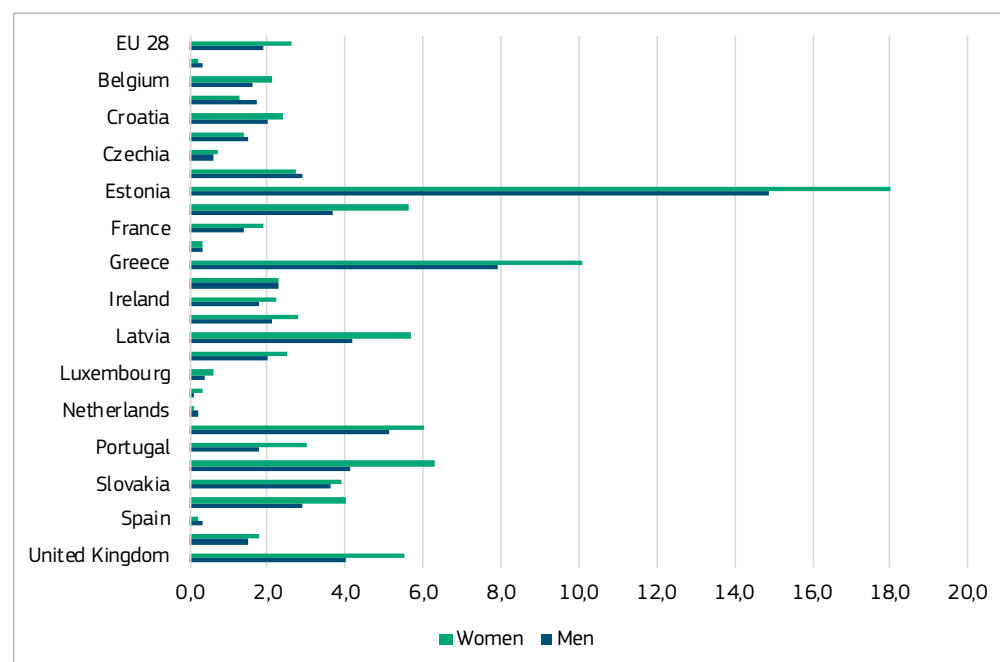
Regarding **information accessibility**, research shows that specific groups of healthcare users are less aware of available healthcare services and their entitlement to use them, specifically, migrants, ethnic minorities, the elderly and the disabled (FRA, 2013b). Sex-differentiated **prevention programmes** and **health education initiatives** mainly target women, while men can face stereotypes that obstruct their access to prevention programmes (European Commission, 2009).

Quality of healthcare is also an element of access to medical services (United Nations Economic and Social Council, 2000). The Organisation for Economic Co-operation and Development (OECD) is currently developing indicators for a survey on patient-reported outcome measures (PROMs) and patient-reported experience measures (PREMs) that are tools for assessing outcomes of and experiences with healthcare from the patient’s perspective. The Patient Reported Indicators Survey (PaRIS) of patients with chronic conditions is being developed and implemented in three phases taking place between 2019 and 2023. It will contain information about patients’ characteristics such as age and sex, healthcare experiences and healthcare outcomes (OECD, 2019a).

did not have specific data on transportation (accessibility) and health knowledge and attitudes (acceptability).

The horizontal bars in Figure 17 illustrate the proportion of women and men reporting unmet medical examination needs because of limitations in access from cost, long waiting lists or their long distance to services. Data also include unmet needs for medical examination from not being able to take time to attend healthcare services. **The proportion of women in EU Member States reporting unmet medical needs is 2.6 %. For men, this figure is 1.9 %. The resulting gender gap is 0.7 percentage points in favour of men.** As suggested by the regional average, **in most EU Member States more women than men report unmet needs for medical examination.** Only in a handful of countries, including Bulgaria, Denmark and Cyprus, the proportion of men reporting unmet medical examination needs exceeds the proportion of women. Estonia has by far the largest proportion of people reporting unmet medical examination needs for both women (18 %) and men (14.9 %). Women in the Netherlands and men in Malta are less likely to report unmet medical examination needs (0.1 % of individuals for both genders). Figure 17 also shows that the largest percentage point gap in the proportion of women over the proportion of men reporting unmet medical needs is recorded in Estonia (3.1), and the smallest in Czechia (0.1). In contrast, the largest gap in favour of men – more men reporting unmet medical need – is seen in Bulgaria (0.4 percentage points) and the smallest in the Netherlands (0.1 percentage points). Men and women are equally likely to have difficulties accessing medical examination services in Germany and Hungary.

Figure 17. Proportion (%) of men and women (aged 16 years and over) self-reporting unmet needs for medical examination in 28 EU Member States, 2018 and 2019

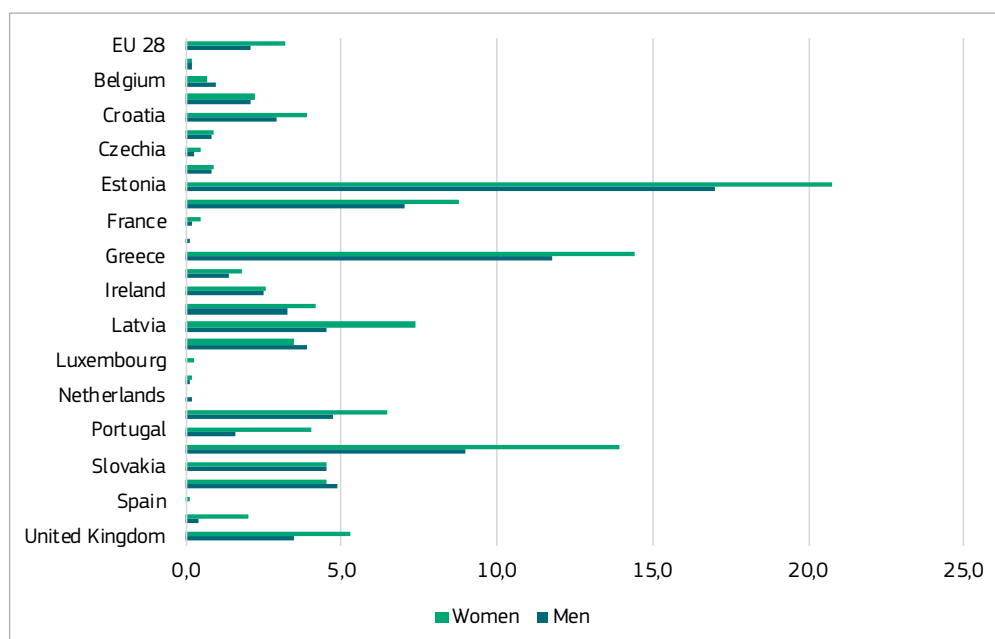


Source: European Statistics of Income and Living Condition (EU-SILC) survey. Eurostat (2018/2019), Self-reported unmet needs for medical examination by sex, age, main reason declared and educational attainment level [hlth_silc_14]. Retrieved from https://ec.europa.eu/eurostat/data/database?node_code=hlth_silc_14.

Notes: n/a: not applicable. Gap, in percentage points, between women and men. Percentage difference between women and men. Respondent's assessment of not getting a needed a medical examination of treatment. Sum of responses across 'Reasons of barriers of access' ('Could not afford to (too expensive)', 'Waiting list' and 'Too far to travel or no means of transportation') and not being able to take time because of work, care for children or for others. Excludes dental examination and treatment. Data for Bulgaria, Denmark, Finland, Latvia and Poland are from 2019. Data are shown in Appendix Table III.12.

Figure 18 shows the proportion of women and men reporting unmet needs for medical examination as in Figure 17, but focusing on **the population of senior residents defined as adults 65 years of age or older. As in the overall adult population, in most of the 28 EU Member States women are more likely than men to report unmet medical examination needs**, with exceptions including Slovenia, Lithuania and Belgium, where men are more likely to report unmet medical examination needs; and in Slovakia and Austria, where the proportion of residents declaring unmet medical examination needs is the same across genders. **The average across the 28 EU Member States is 3.2 % of women and 2.1 % of men reporting unmet medical examination need (a gender gap of 1.1 percentage points).** As in the case of the overall adult population, the highest rates of unmet medical examination need in women and men are in Estonia, at 20.8 % and 17 % respectively. The lowest rates are in Spain for women (0.1 %) and in Malta for men (0.1 %). In terms of the gender gap between men and women, the largest difference in percentage points in favour of women is in Romania (4.9 percentage points), just above Estonia (3.8 percentage points). The smallest gap can be seen in Denmark (0.1 percentage points). Where there is a greater proportion of men compared to women reporting unmet medical examination needs, the largest gender gap is seen in Slovenia and Lithuania, at 0.4 percentage points in both countries. Patterns by region in answers are not immediately obvious; however, it appears that countries from Eastern Europe cluster around higher values of reported unmet medical examination need for both sexes.

Figure 18. Proportion (%) of men and women aged 65 years and over self-reporting unmet needs for medical examination in 28 EU Member States, 2018 and 2019



Source: European Statistics of Income and Living Condition (EU-SILC) survey. Eurostat (2018/2019), Self-reported unmet needs for medical examination by sex, age, main reason declared and educational attainment level [hlth_silc_14]. Retrieved from https://ec.europa.eu/eurostat/data/database?node_code=hlth_silc_14.

Notes: n/a: not applicable. Gap, in percentage points, between women and men. Percentage difference between women and men. Respondent's assessment of not getting a needed a medical examination of treatment. Sum of responses across 'Reasons of barriers of access' ('Could not afford to (too expensive)', 'Waiting list' and 'Too far to travel or no means of transportation') and not being able to take time because of work, care for children or for others. Excludes dental examination and treatment. Data for Bulgaria, Denmark, Finland, Latvia and Poland are from 2019. Data are shown in Appendix Table III.13.

Regarding unmet needs for dental care, 14 % of lone mothers had unmet dental needs (compared to 10 % of lone fathers, and to 6 % of women overall). One third of lone mothers reported unmet dental needs in Greece (34 %), followed by Portugal (30 %) and Latvia (29 %) (EIGE, 2019).

3.2 Access to reproductive health services

Sexual and reproductive health and rights (SRHR) are an essential aspect of gender equality. Women and men need to be empowered to make free and informed choices about their sexuality and sexual and reproductive health to attain the highest standards of health, including maternal care.

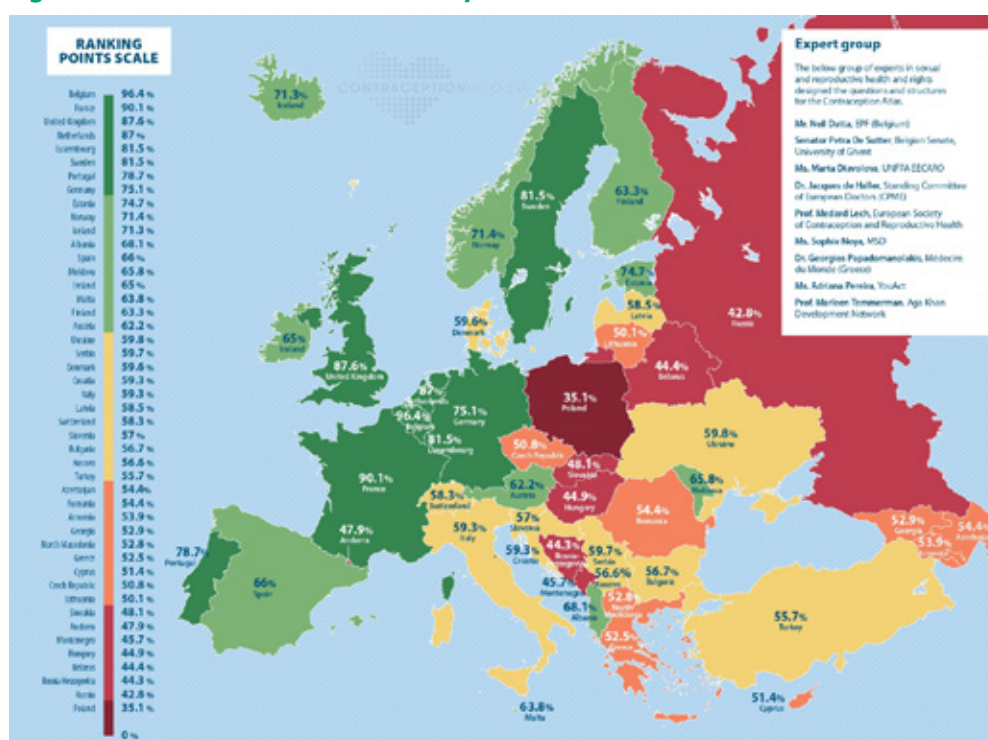
While the EU has done work to increase the access of girls and women living outside the EU to sexual and reproductive health services (e.g. within the EU Gender Action Plan 2016–2020), there has been limited action to promote access to such services within the EU (EIGE, 2020b). The Council of Europe has analysed SRHR in their paper *‘Women’s sexual and reproductive health and rights in Europe’* (2017), and notes that **failures to collect and analyse data and evidence on women’s sexual and reproductive health, and in particular disaggregated data, remain a concern in a number of European countries**. Many health systems do not collect and analyse disaggregated data on sexual and reproductive health, not only with regard to gender, but also with regard to factors such as age, disability, ethnicity, nationality or socioeconomic status. This lack of data collection hampers Member States’ ability to appropriately identify gaps and deficits in women’s access to quality sexual and reproductive healthcare and design effective and responsive strategies (Council of Europe, 2017). A study carried out for the European Commission points to the lack of solid data relating to equality and discrimination limiting the understanding of the extent to which discrimination affects our everyday life and how best to tackle it. For example, national surveys or administrative data are usually not disaggregated by ethnicity due to small sample sizes or incomplete data sets. European sources (e.g. FRA surveys, the European Social Survey, LFS/SILC ad hoc modules) are the only major source on disability, ethnic/racial origin, religion and sexual orientation and gender identity (European Commission, 2017a).

The European Contraception Atlas is an original research project led by the European Parliamentary Forum on Population and Development (EPF) with a group of renowned experts in the field of contraception, which investigates how European public authorities perform in three categories: access to contraceptive supplies, family planning counselling and online information on contraception. The countries are analysed based on 15 criteria, sub-divided into the three categories and allocated an overall score and a colour for ranking their performance. Table 2 below provides an overview of the categories and how they are assessed.

Table 2. The Contraception Atlas categories

	Excellent (>75%)	Very good (60-75%)	Medium (55-60%)	Poor (50-55%)	Very poor (<50%)
Contraceptive supplies	General reimbursement scheme for contraceptive supplies for all, covering also young people and low-income women.	Reimbursement for general population for supplies	No or minimal reimbursement for general population No reimbursement for vulnerable groups	No reimbursement for general population No reimbursement for vulnerable groups	No reimbursement for general population No reimbursement for vulnerable groups
Counselling	Free counselling for family planning	Score high on providing counselling	Score high on providing counselling	Average on providing counselling	Average on providing counselling
Access to on-line information	Government-supported websites with up-to-date information on all modern types of contraception, and how to get it.	Good online information (government or non-governmental supported websites)	Good quality websites (government or non-governmental) Lack logistical or financial information on supplies No minority languages	Government or non-government supported websites Insufficient logistical or financial information	Overall poor performance

According to the European Contraception Atlas 2018, **access to sexual and reproductive health services varies greatly between the Member States**. 69.2 % of European women of childbearing age (between 15 and 49) who are married or living with a partner use a form of contraception, a lower rate than similar populations in both North America and the Latin America and the Caribbean region. This contributes to a high rate of unintended pregnancies (UIP) with over 43 % pregnancies in the European region considered as unplanned. **In 2020, the level of population access to modern forms of contraception** (i.e. access to online information and contraceptive supplies) **ranged from 96.4 % in Belgium and 90.1 % in France to just 35.1 % in Poland** (Figure 19). It is reported that unmet contraceptive needs particularly affect adolescents, people with a low income, people living in rural areas, people with HIV, and refugees and migrants (Ali and Temmerman, 2013; EIGE, 2020a) (see Appendix I for a description of a practice that supports access to contraceptives in Spain).

Figure 19. Access to modern contraception

Source: European Parliamentary Forum on Population & Development (EPF), European Contraception Atlas 2020, <https://www.contraceptioninfo.eu/node/72>

Figure 20 shows the EU Member States according to their classification in the European Contraception Atlas 2020. **Only 6 countries are classified as ‘excellent’, while the largest group of 13 countries, is classified in the lowest ‘very poor’ category.** Access to sexual and reproductive health services in 11 countries are ‘very good’, in 9 ‘medium’, in 7 countries ‘poor’, and in 7 countries ‘poor’.

Figure 20. European Contraception Atlas country classification from ‘Excellent’ to ‘Very poor’:

	Excellent (>75%)	Very good (60-75%)	Medium (55-60%)	Poor (50-55%)	Very poor (<50%)
Contraceptive supplies	6 countries	11 countries	9 countries	7 countries	13 countries
Countries	Belgium Germany France Netherlands Norway UK	Austria Estonia Ireland Kosovo Luxembourg Moldova Portugal Slovenia Spain Sweden Turkey	Croatia Denmark Finland Italy Latvia Romania Serbia Switzerland Ukraine	Albania Armenia Czech Republic FYROM Iceland Lithuania Malta	Andorra Azerbaijan Belarus Bosnia-Herz. Bulgaria Cyprus Georgia Greece Hungary Montenegro Poland Russia Slovakia

Source: European Parliamentary Forum on Population & Development (EPF), European Contraception Atlas 2019, <https://www.contraceptioninfo.eu/node/72>

Unmet need for family planning²⁴ is the percentage of married or in-union women of reproductive age who want to stop or postpone childbearing but who report that they are not using any method of contraception to prevent pregnancy (United Nations, 2017). **The unmet need for family planning** in the EU-28 varies between 4 % in France to some 13 % in Bulgaria (United Nations, 2017). Currently, only three countries in Europe—Belgium, France and the UK—offer sufficient **reimbursement schemes for contraception** (European Contraception Atlas, 2018).

24 Indicator definition: Women with unmet need are those who are fecund and sexually active but are not using any method of contraception, and report not wanting any more children or wanting to delay the next child. The concept of unmet need points to the gap between women’s reproductive intentions and their contraceptive behaviour. See <http://mdgs.un.org/unsd/mi/wiki/5-6-Unmet-need-for-family-planning.ashx#p2>.

Table 3. Unmet need for family planning (%)

Country	Unmet need for family planning (%)
Austria	10.3
Belgium	6.6
Bulgaria	13.5
Croatia	10.8
Cyprus	No data available
Czechia	7.8
Denmark	10.2
Estonia	12
Finland	8
France	4
Germany	9.5
Greece	9.5
Hungary	8.5
Ireland	11.2
Italy	10.5
Latvia	12
Lithuania	13.1
Luxembourg	No data available
Malta	4.8
Netherlands	8.3
Poland	9.7
Portugal	7.6
Romania	9.7
Slovakia	9.1
Slovenia	8.2
Spain	11.6
Sweden	9.7
United Kingdom	5.6

According to the EU Fundamental Rights Agency (FRA) 2017 report, in nine EU Member States, **abortion** is only allowed with parental consent before the age of 18 years (Bulgaria, Denmark, Greece, Hungary, Italy, Luxembourg, Poland, Slovakia and Spain). In some of these Member States, abortion before the age of 18 years may be permissible with judicial or administrative consent. In the other Member States, girls can access abortion services only under specific medical circumstances, depending on the maturity of the pregnant child and on the doctor's assessment. Under a certain age, parental consent might also be needed. Abortion is only possible within a certain time frame, which is also the case for adult women. In France and Luxembourg, if the child expresses the desire to maintain confidentiality, she can designate an adult who is not one of her parents to be given the information and to be with her during the procedure. The lowest minimum age requirement expressly set for abortion without parental consent is 15 years in Slovenia.

Abortion is illegal in Malta (FRA, 2017) (see Appendix I for a description of a practice that supports access to sexual and reproductive health services, including voluntary termination of pregnancy, in Portugal).

3.2.1 Access to maternal care for irregular migrants, refugees, asylum seekers and ethnic minorities

An estimated 500 000 women in the EU will go through their first months of pregnancy with no access to health services. Women belonging to vulnerable social groups are particularly affected by these gaps in availability, access and use of resources and adequate services (European Parliament, 2019). In several Member States, vulnerable groups of pregnant women (i.e. non-resident and irregular resident pregnant women) have only limited access to prenatal and postnatal healthcare or they are provided all necessary care and billed afterwards (European Observatory of Health Systems and Policies, 2017).

In 11 EU Member States, laws and policies provide for undocumented migrant women's access to maternal healthcare throughout pregnancy free of charge or for subsidised fees. The laws and policies in Belgium, Estonia, France, Germany, Greece, Italy, the Netherlands, Portugal, Romania, Spain and Sweden all provide for undocumented migrant women's access to affordable maternal healthcare by providing free or subsidised access to all maternal healthcare, including both antenatal care and care during labour and childbirth. In the other **17 Member States, laws and policies do not provide for undocumented migrant women's access to free or subsidised maternal healthcare throughout pregnancy.** Instead, although approaches differ significantly across these jurisdictions,²⁵ laws and policies in Austria, Bulgaria, Croatia, Cyprus, Czechia, Denmark, Finland, Hungary, Ireland, Latvia, Lithuania, Luxembourg, Malta, Poland, Slovakia, Slovenia and the United Kingdom require undocumented migrant women to cover the costs of some, or in most cases all, maternal healthcare themselves (Center for Reproductive Rights, 2018). Table 4 provides an overview of studies on access of migrants, refugees, asylum seekers and ethnic minorities to maternal care in Europe since 2016, and the main findings.

²⁵ In some countries such as Finland, municipalities are free to adopt divergent and more inclusive policies. In some jurisdictions such as in Denmark, laws and policies specify that health authorities have the discretion to waive fees that would ordinarily be charged for non-emergency hospital care if they deem it reasonable. In some instances, laws and policies specify that where a patient who is liable to cover the costs of healthcare cannot be found or is unable to pay the bill, the healthcare facility can recover the costs from state funds. And in some countries such as Bulgaria, Cyprus and Slovenia, laws and policies do not require undocumented migrant women to cover the costs of care in obstetric emergencies or during labour and childbirth.

Table 4. PubMed search: access to maternal care in Europe since 2016

STUDY	POPULATION AND BACKGROUND	RESULTS AND CONCLUSIONS
<p><i>Migrant women's experiences of pregnancy, childbirth and maternity care in European countries: A systematic review.</i></p> <p>February 2020.</p> <p>https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7012401/</p>	<p>Studies were conducted in 14 European countries and focused on women described as migrants, refugees or asylum seekers. Across Europe, there are increasing numbers of migrant women who are of childbearing age. Migrant women are at risk of poorer pregnancy outcomes.</p>	<p>Migrant women need culturally competent healthcare providers who provide equitable, high quality and trauma-informed maternity care, undergirded by interdisciplinary and cross-agency team-working and continuity of care. New models of maternity care are needed which go beyond clinical care and address migrant women's unique socioeconomic and psychosocial needs. Models of maternity care need to be designed to meet the needs of all women in society to ensure equitable access to services and to address health inequalities.</p>
STUDY	POPULATION AND BACKGROUND	RESULTS AND CONCLUSIONS
<p><i>Maternal and perinatal outcomes of asylum seekers and undocumented migrants in Europe: a systematic review.</i></p> <p>August 2019</p> <p>https://www.ncbi.nlm.nih.gov/pubmed/31098629</p>	<p>A systematic review was conducted on maternal and perinatal outcomes in asylum seekers (AS) and undocumented migrants (UM) in Europe; 11 screened sources were included from 4 European countries. Several studies reported adverse outcomes including higher maternal mortality (AS), severe acute maternal morbidity (AS), preterm birth (UM) and low birthweight (UM). Asylum seekers and undocumented migrants are at risk of adverse pregnancy outcomes due to adverse health determinants and compromised maternal healthcare access and service quality.</p>	<p>Limited evidence is available on pregnancy outcomes in AS and UM in Europe. The adverse outcomes reported imply that removing barriers to high-quality maternal care should be a priority. More research focusing on migrant subpopulations, considering potential risk factors such as ethnicity and legal status, is needed to guide policy and optimise care.</p>
STUDY	POPULATION AND BACKGROUND	RESULTS AND CONCLUSIONS
<p><i>A systematic review of ethnic minority women's experiences of perinatal mental health conditions and services in Europe.</i></p> <p>January 2019</p> <p>https://www.ncbi.nlm.nih.gov/pubmed/30695019</p>	<p>It is important to ensure that services are designed to meet the unique needs of women from diverse backgrounds. Women from ethnic minority groups are at greater risk of developing mental health problems. Poor perinatal mental health impacts on maternal morbidity and mortality and can have a devastating impact on child and family well-being. 15 eligible studies included women from a range of minority ethnic backgrounds and were all undertaken in the United Kingdom.</p>	<p>Lack of awareness about mental ill health, cultural expectations, ongoing stigma, culturally insensitive and fragmented health services and interactions with culturally incompetent and dismissive health providers all impact on ethnic minority women's ability to receive adequate perinatal mental health support in the UK. Future research should focus on in-depth exploration of the experiences of these women across multiple European settings and interventions to reduce health inequalities among vulnerable mothers and families affected by perinatal mental ill health.</p>

STUDY

Barriers to accessing adequate maternal care in Central and Eastern European countries: A systematic literature review.

March 2017

<https://pubmed.ncbi.nlm.nih.gov/28152420/>

POPULATION AND BACKGROUND

Maternal health outcomes in Central and Eastern Europe (CEE) compare unfavourably with those in Western Europe. The study examined service-related indicators of access to maternal care in CEE, including availability, appropriateness, affordability, approachability and acceptability of maternal care. The study used a qualitative systematic literature review, analysing information of peer-reviewed articles published since 2004.

RESULTS AND CONCLUSIONS

Availability of care is limited by outdated equipment and training curricula, and the lack of professionals and pharmaceuticals. Geographical distance to healthcare institutions, inappropriate communication of providers and waiting times are the main approachability barriers. Some mothers are unaware of the importance of care or are discouraged to utilise healthcare services because of cultural aspects. A major barrier in accessing maternal care in the CEE is the inability to pay for it. Major gaps in evidence exist and more representative and better-quality data should be collected. Governments in CEE countries need to establish a reliable system for measuring and monitoring a suitable set of indicators, as well as deal with the general social and economic problem of informality. Medical curricula in the CEE region need to be overhauled and there should be a focus on improving the allocation of medical staff and institutions as well as protecting vulnerable population groups to ensure universal access to care.

STUDY

Discrimination against childbearing Romani women in maternity care in Europe: a mixed-methods systematic review.

January 2017 <https://www.ncbi.nlm.nih.gov/pubmed/28057003>

POPULATION AND BACKGROUND

Many Romani (Roma) women encounter barriers to accessing maternity care. Even when they are able to access care, they can experience discriminatory mistreatment on the basis of their ethnicity, economic status, and place of residence or language.

RESULTS AND CONCLUSIONS

There is evidence of discrimination against Romani women in maternity care in Europe. There were no published research studies examining the effectiveness of interventions to address discrimination against Romani women and their infants in Europe. Interventions to address discrimination against childbearing Romani women and underlying health provider prejudice are urgently needed, alongside analysis of factors predicting the success or failure of such initiatives.

STUDY

Barriers to Accessing Adequate Maternal Care in Latvia: A Mixed-Method Study Among Women, Providers and Decision-Makers.

January 2019

https://pubmed.ncbi.nlm.nih.gov/30391120/?from_term=access+to+maternal+care+latvia&from_filter=ds1.y_5&from_pos=1

POPULATION AND BACKGROUND

Latvia has a high maternal mortality ratio compared with other European countries, as well as major inequities in accessing adequate maternal care. Adequacy refers to the extent to which services are safe, effective, timely, efficient, equitable and people centred. The study explored stakeholder views on access to adequate maternal care in Latvia and the extent to which there was consensus.

RESULTS AND CONCLUSIONS

The study identified barriers to accessing adequate maternal care related to availability (i.e. shortage of human resources, geographical distance) and appropriateness (i.e. inequalities in provider knowledge, care provision and use of clinical guidelines). Other challenges were related to providers' approaches towards women (i.e. communication) and, to a lesser extent, maternal care acceptance by women (i.e. health literacy). The barriers indicate the need for micro-level indicators that can facilitate a comprehensive evaluation of maternal care in Latvia and elsewhere.

COCHRANE LIBRARY SEARCH: IMPROVEMENT OF ACCESS TO SERVICES/ACCESS TO MATERNITY SERVICES

Barriers and facilitators to the implementation of lay health worker programmes to improve access to maternal and child health: a qualitative evidence synthesis.

October 2013

<https://pubmed.ncbi.nlm.nih.gov/24101553/>

Lay health workers (LHWs) perform functions related to healthcare delivery, receive some level of training, but have no formal professional or paraprofessional certificate or tertiary education degree. They provide care for a range of issues, including maternal and child health.

53 studies were included to the synthesis, 17 programmes were based in high-income countries (Australia, Canada, the UK and the USA).

Most of the programmes from high-income countries took place in urban settings and recipients often belonged to particular social groups, such as immigrants or refugees, families living in temporary accommodation, or teenage mothers.

In all the studies from high-income countries, LHWs were used for promotion, counselling and support.

3.2.2 Violence in childbirth (obstetric violence)

The mistreatment²⁶ of women in childbirth has been documented by researchers for over three decades in all global regions (Jewkes and Penn-Kekana, 2015), **and disrespect and abuse of women in childbirth have become critical to the discourse on maternal health in recent years** (Freedman and Kruk, 2014; Sen, Reddy and Iyer, 2018). Mistreatment during childbirth can represent a violation of women's fundamental human rights, in particular rights to human dignity and self-determination, and can serve as a powerful disincentive for women to seek care in facilities for their subsequent deliveries (Bohren et al., 2015). In September 2014, a World Health Organization statement on the '*prevention and elimination of disrespect and abuse during facility-based childbirth*' called for greater research, action, advocacy and dialogue on this important public health issue, in order to ensure safe, timely, respectful care during childbirth for all women (WHO, 2016a).

The systematic review by Bohren et al. (2015) into mistreatment of women during childbirth in health facilities globally found that that 'women's childbirth experiences in health facilities are marred by instances of mistreatment, including physical and verbal abuse, a lack of supportive care, neglect, discrimination, and denial of autonomy.' The authors note that different countries, organisations and authors have adopted different terminology (such as obstetric violence, dehumanized care, and disrespect and abuse) to describe the phenomenon.²⁷ They define 'mistreatment of women' as a broader, more inclusive term that better captures the full range of experiences, that can be active (such as intentional or deliberate physical abuse), passive (such as unintentional neglect due to staffing constraints or overcrowding), related to the behaviour of individuals (verbal abuse by healthcare providers against women), or related to health system conditions (such as a lack of beds compromising basic privacy and confidentiality). These dimensions can all impact on a woman's health, her childbirth experiences, and her rights to respectful, dignified and humane care during childbirth. The authors conclude that **the mistreatment of women during childbirth is a quality of care issue and a human rights violation** (Bohren et al., 2015). In 2019, the United Nations Special Rapporteur on violence against women, its causes and consequences, established a global inquiry on '*Mistreatment and violence against women during reproductive healthcare with a focus on childbirth*'. In August 2020, submissions had been received from organisations active in the following EU countries: Croatia, Czechia, Finland, Hungary, Ireland, Italy, Luxembourg, the Netherlands, Poland, Portugal, Slovakia, Slovenia, Spain, Sweden and the UK, as well as from several other countries and international organisations.²⁸

Research on obstetric violence in EU countries includes the National Observatory on Obstetric Violence (Osservatorio sulla Violenza Ostetrica) survey in **Italy** (2014), which estimated that in the last 14 years about 1 million Italian mothers have experienced obstetric violence during birth and about 6 % of women who gave birth for the first time decided not to have more children on the basis of the negative experience. The survey also found that for 41 % women, childbirth assistance was

26 The terminology between the different studies varies, including 'disrespect and abuse', 'mistreatment during facility-based childbirth', and 'obstetric violence'. <https://pubmed.ncbi.nlm.nih.gov/29073914/>

27 See WHO for examples of laws on 'obstetric violence': https://www.who.int/reproductivehealth/topics/maternal_perinatal/statement-childbirth-govnts-support/en/.

28 The submissions to the inquiry are available at: <https://www.ohchr.org/EN/Issues/Women/SR-Women/Pages/Mistreatment.aspx>.

in some respects detrimental to their dignity and psychophysical integrity.²⁹ Studies in **Germany** note an increase in reported threats and physical violence during birth. This follows a situation where **hospitals and especially obstetric care are under high economic pressure, leading to shortages in personnel**. In addition, high liability insurance costs play an important role when it comes to a delay in the birth process. Against this background, rights to autonomy, self-determination and physical integrity cannot be guaranteed (Deutscher HebammenVerband, 2012). In **Poland**, a survey of 8 378 women who gave birth found that during their hospital stay, 81 % of women in the study experienced violence or abuse from medical staff on at least one occasion, as per the Bohren et al. (2015) typology. The most common abuse was having medical procedures without prior consent (55 %). Inappropriate comments made by staff related to their own or a woman's situation were reported in 25 % of situations, while 20 % of women experienced nonchalant treatment (Doroszewska, 2018).

In **Bulgaria**, the maternity hospital association 'Rodilnitsa' conducted a study on 'Violence against women giving birth' in 2013. They concluded that the most common manifestations of violence against mothers were negligence or refusal of care when women are left to give birth without support within the medical institution and physical, verbal and emotional violence. The report recommends dissemination of information about the problem to healthcare givers and the possible legal consequences of their behaviour, awareness-raising on the rights of women giving birth, and education of doctors and midwives on violence against mothers to change attitudes and practices at hospitals (Rodilnitsa, 2013). In **Croatia**, the 'Parents in Action' organisation called in 2018 for women to send their testimonials of procedures in reproductive health conducted without anaesthesia, using the hashtag #PrekinimoŠutnju (#BreakTheSilence). 401 complaints were collected and submitted to the Ministry of Health that established a working group to analyse the complaints. As a result, several measures were put in place, including the right of every woman to adequate analgesia and anaesthesia; zero tolerance for inappropriate and/or unprofessional behaviour with a reporting system within healthcare institutions; and harmonisation of medical records keeping. In **Lithuania**, Association Women's House has prepared an online publication that provides information for women on birth violence, abuse, dehumanisation etc. (Vakrinaitė, undated). Qualitative research into women's experience of violence in childbirth in Slovakia (Debrečéniová, 2015), Slovenia (Drglin and Šimnovec, forthcoming) and Sweden (2018) provides reports on mistreatment of women during childbirth.

The literature review by Freire Barja et al. (2016) of studies published in Spanish and English on the prevention and detection of 'obstetric violence' concludes that health professionals should promote the humanisation of labour and health institutions should implement protocols to guide the practice of health professionals involved in the care of women during labour. The protocols should be based on the WHO recommendations. Historical research into obstetric violence in **Ireland** notes that it is important to include a reproductive justice perspective into the issue (Delay and Sundstrom, 2020). In 2017, Council of Europe noted that 'failures to ensure adequate standards of care and respect for women's rights, dignity and autonomy in childbirth affect women from all backgrounds in a range of European countries'. **In 2019, WHO stressed that further research is needed to understand how institutional structures and processes can be reorganised to provide better women-centred care** (WHO, 2019d).

29 For further information, see the website of the Italian Observatory on Obstetric Violence, available at: <https://ovoitalia.wordpress.com/2020/05/>.

4. Gender sensitivity in healthcare

This chapter provides information on measures to increase gender sensitivity in healthcare, including a) gendered diagnosis and gender awareness in treatment, b) guidelines for healthcare professionals on recognising and managing the effects of sexual violence, and c) sex and gender in the curriculum for training of healthcare professionals.

4.1 Gendered diagnosis and gender awareness in treatment

Medical research has historically shown limited gender sensitivity. Clinical trials should be representative of the expected target population (i.e. treatments that are expected to be used by both women and men should be tested on both women and men), but pharmaceuticals are primarily tested on men. This means that adverse side effects that are more common or appear only in women are not identified (EIGE, 2020a). An important step forward in this area is the Clinical Trials Regulation of the European Commission (2014), which requires the consideration of **gender in clinical trials, which addresses concerns about drugs being mainly tested on men, and thus possibly ignoring adverse side effects that are more common among or exclusive to women.** The regulation is yet to enter into application (EIGE, 2020b).

Sex- and gender-sensitive medicine (SGSM) focuses on the role that biological differences ('sex') and socio-cultural power structures ('gender') play in healthcare. Both sex and gender affect health behaviour, the development of diseases, their diagnosis, management and long-term effects. SGSM can also focus on the structure of the healthcare system, on how traditions impact the make-up of the workforce and its opportunities. SGSM has emerged over the couple of decades. Initially, its focus was on differences in incidence of mortality between women and men, specifically, on filling the gap of knowledge about female symptoms and needs in a medical world focused on male standards. This was followed by research with the objective to identify the causes of sex differences in disease development and progression, and gender in health and medicine (Oertelt-Prigione, 2020). An example of a health condition affecting women that often goes under-diagnosed and/or not treated is endometriosis. Endometriosis is a chronic and disabling gynaecological disease affecting 10 % of women of reproductive age. It is associated with acute symptoms, mainly consisting of severe pelvic pain and infertility, imposing an annual economic burden estimated at EUR \$7 746 billion in 9 European countries.³⁰ In endometriosis, women's symptoms are not always taken seriously and are often normalised or not recognised by doctors, which leads to delays in diagnosis and treatment (van der Zanden and Nap, 2016; Constantine et al., 2016).

³⁰ For further information, see the website of the EndoSearch project at: <https://cordis.europa.eu/project/id/767720>.

The **EUGenMed project (2013–2015)** was started in order to introduce sex and gender aspects into medicine to improve **biomedical and health research**. The project provided a broad overview on gender within clinical medicine and pharmacology, public health and prevention, basic biomedical research, medicines regulations and medical education.

The findings include:

- There is a need for a more stringent consideration of sex and gender differences in cardiovascular diseases that leads to better understanding of pathophysiology and more personalized therapeutic approaches.
- Sex and gender differences in diabetes, stroke, asthma and lung cancer need attention.
- Gender is an important factor in modifiable risk factors contributing to the major non-communicable diseases (NCDs), such as tobacco smoking, physical inactivity and alcohol use, obesity, and mental and occupational health.
- Sex and gender must be included in medicines regulation and medical education at multiple levels to provide the best treatment for and care of patients.
- The EUGenMed project emphasises the need for well-educated health professionals and health workforce (European Gender Medicine Network, 2016).

Another example of EU-funded research that explores and develops gendered diagnosis is the **GenCAD project (2015–2017)** on coronary artery disease (CAD). GenCAD aimed to improve the knowledge and awareness of sex and gender differences in chronic diseases, using coronary artery disease as an example to highlight differences between women and men in prevention and treatment of CAD in European countries.

The GenCAD literature analysis found significant gender differences in chronic diseases, for example, diabetes and smoking have a greater weight as risk factors in women than in men. Gender differences in mental health, autoimmune and inflammatory diseases, and disturbances of sex hormones and sexual function were also emerging. In addition, it was recorded that men develop earlier and more easily atherosclerosis of large coronary arteries, and women are frequently affected by disturbances of small vessel function. The lack of awareness by women and their doctors remains a major problem that limits both a fast reaction in cases of acute coronary syndromes and a willingness to take action in prevention. Many cardiovascular drugs act differently in women and men. Further gender differences were found in diagnosis, in treatment responses and outcomes. The project researched numerous **databases and highlighted that most have a limited sensitivity** for analysing sex and gender differences. A ‘true gender score’, reflecting a psychosocial construct for gender was not found in any database. Gender-related covariates, pregnancy-related complications, hormonal status and sexual function were frequently not included in the databases.

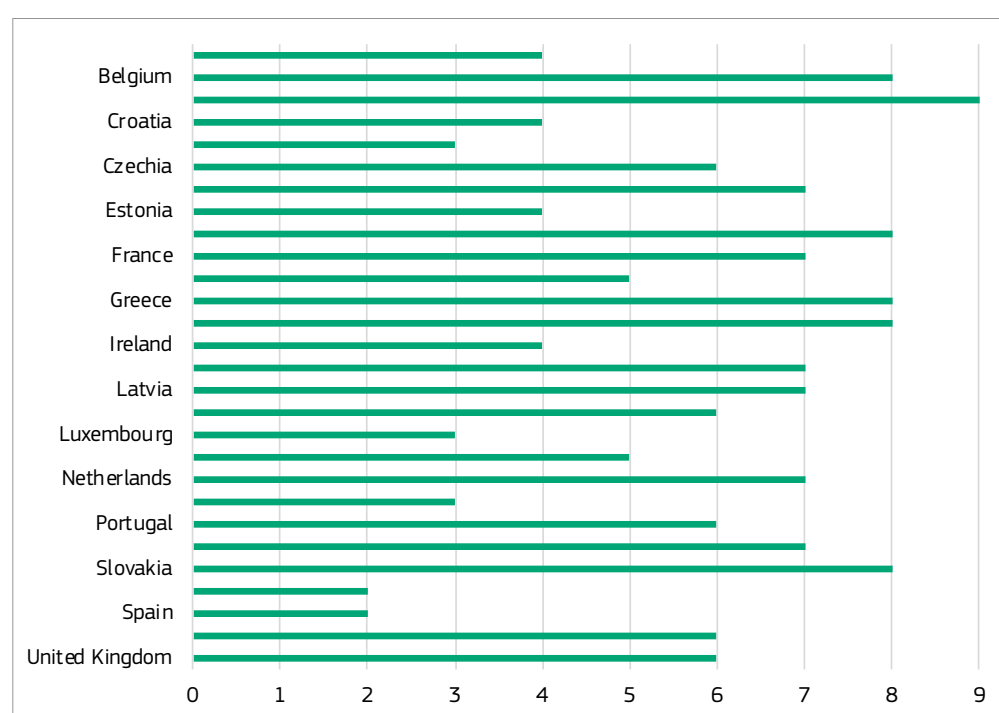
The project also included a survey of healthcare professionals’ knowledge on **gender-specific disease manifestations, diagnostic and therapeutic approaches**. Critical deficits in knowledge were shown in all European countries, thus gender-sensitive information campaigns for physicians and the general public are necessary (European Commission, 2017b).

4.2 Guidelines for healthcare professionals on recognising and managing the effects of sexual violence

According to the FRA 2014 survey on violence against women, in the 28 European Union Member States: 1 in 3 women reported having experienced physical and/or sexual violence at least once since she was 15, and 8 % of women in the last 12 months; 22 % of women had experienced physical or sexual violence by a partner; 11 % of women had experienced some form of sexual violence; 5 % of women had been raped; and 1 in 2 women has been sexually harassed and as many as 1 in 5 in the last 12 months (FRA, 2015).

Figure 21 summarises data on women's responses to questions on physical and sexual violence from a past or current partner asked as part of the 2014 European Union Agency for Fundamental Rights (FRA) Violence against Women survey. Women were asked to report on incidents occurring in the last 12 months. The highest rate of intimate physical and sexual violence is seen in Bulgaria, where almost 1 in 10 women report being a victim of gender-based violence (9 %), followed closely by rates in Belgium (8 %). The lowest rates of gender-based violence in the region are seen in Spain and Slovenia, at 2 % of women reporting intimate physical or sexual violence. As these data suggest, there are no clear patterns by EU region in the proportion of women reporting intimate partner violence.

Figure 21. Proportion of women aged 18–49 ever having been the victim of physical or sexual violence by a partner in 28 EU Member States, 2012



Sources: European Union Agency for Fundamental Rights (FRA) Violence against women: an EU-wide survey; WHO (2012). Intimate partner violence prevalence. Data by country. Retrieved from <https://apps.who.int/gho/data/view.main.IPVv?lang=en>

Notes: Proportion of ever-partnered women and girls aged 18 to 49 subjected to physical and/or sexual violence by a current or former intimate partner in the previous 12 months. Observations for Croatia, Cyprus, Denmark, Estonia, Ireland, Luxembourg, Poland, Slovenia and Spain are based on fewer than 30 responses. Data are available in Appendix Table III.14.

Violence against women is a pervasive problem that is under-reported in the EU. According to the FRA survey, only one in three victims of partner violence and one in four victims of non-partner violence report their most recent serious incident to the police or some other service. **A healthcare provider is likely to be the first professional contact for survivors of violence against women, including intimate partner violence and sexual assault.** 22 % of the survey respondents said that they had contacted a doctor or a healthcare centre after the most serious incident of sexual violence by a partner. WHO clinical and policy guidelines (2013) on '*Responding to intimate partner violence and sexual violence against women*' notes that women who have been subjected to violence often seek healthcare, but might not disclose the associated abuse or violence. This stresses the importance of training for healthcare professionals on recognising and managing the effects of sexual violence. In the FRA survey, victims of sexual violence perpetrated by a partner who say they were satisfied with the assistance they received in a **hospital** was 84 %. The percentage for satisfaction with the assistance provided by a **doctor, health centre or other healthcare institution** was 77 %. For sexual violence perpetrated by a non-partner, the reported percentages were 65 % and 81 % respectively. In 2019, WHO published a curriculum for training healthcare providers in caring for women subjected to violence (WHO, 2019a) (See Appendix I for a description of a practice on sexual and reproductive health that supports women who have experienced sexual and emotional violence in Latvia).

Female genital mutilation (FGM) is a severe form of gender-based violence that deeply affects the lives of women and girls. EIGE (2018) has estimated the number of girls at risk of FGM in the EU to be significant, and stresses that **it is important that professionals, including immigration officers, healthcare practitioners and teachers, who are in contact with female asylum seekers from FGM-affected countries, are properly trained to notice and assess the potential risk of female genital mutilation.** The recent changes to the Common European Asylum System (CEAS) place a greater emphasis on gender-sensitive asylum procedures, so that women and girls making asylum claims on the grounds of female genital mutilation feel safe. However, the degree to which these provisions are implemented in practice differs among Member States, and depends on the resources available to deal with the pressure of ongoing migratory flows (EIGE, 2018). The European Union has funded the development of training packages to healthcare professionals on FGM as a specific topic, as well as part of the wider aim of improving the quality of and access to health services for migrant and ethnic minorities³¹ (See Appendix I for a description of a practice on prevention of violence against women, including FGM, in Bilbao, Spain). The EU also funds projects on the organisation of support services to victims of gender-based violence and domestic violence, including the provision of health services, under its Rights, Citizenship and Equality (REC) programme and its successor.

³¹ For further information see the website of the project 'Training packages for health professionals to improve access and quality of health services for migrants and ethnic minorities, including the Roma (MEM-TP)' at: <https://www.mem-tp.org/>.

As part of the Gender Equality Strategy 2020–2025, the EU will table a Recommendation on the prevention of harmful practices, including the need for effective preventive measures and acknowledging the importance of education. The recommendation will also address the strengthening of public services, prevention and support measures, capacity-building of professionals and victim-centred access to justice.³²

4.3 Sex and gender in the curriculum for training healthcare professionals

Consideration of sex and gender in clinical practice is necessary to redress health inequities and provide relevant care. Despite this, inclusion of gender in the training of healthcare professionals is not a widespread practice (see, for example, Kling et al., 2016). As all health professionals must maintain and update their skills throughout their career, developing education programmes that integrate sex and gender issues should be considered (Légaré et al., 2018).

Miller et al. (2016) note that ‘[i]ncorporating and translating new discoveries in sex and gender research into programmes to train the next generation of scientists and healthcare providers is challenging but provides opportunities to improve and modernise educational approaches, which will ultimately result in improved patient care’. Incorporation of **sex and gender medicine into medical and interprofessional education in Europe is sparse, but some examples are emerging**. In **Austria**, the Medical University of Innsbruck has implemented gender medicine as a cross-sectional and compulsory topic for all students. The Medical University of Vienna aims at the integration of gender medicine in its curriculum and has developed a ‘Guideline for gender and diversity in medicine’. In Berlin, **Germany** (2009–2011), the Institute of Gender in Medicine (GiM) and Charité University Hospital developed the GenderMed open access database with more than 11 000 publications that deal with sex and gender in medicine and research (Miller et al., 2016), and developed learning modules on gender medicine (Ludwig et al., 2015). In Nijmegen, **the Netherlands**, undergraduate medical education has been inclusive of a gender perspective over the past decade (van der Meulen et al., 2017). In **Sweden**, the Center for Gender Medicine (CfGM) at Karolinska Institutet was the first in Europe to establish the web-based educational course ‘Health and Disease from a Gender Perspective’ in 2010. The course is also being utilised by students from Lodz Medical University in **Poland** (Miller et al., 2016; Maquibar et al., 2017). Initiatives on integrating sex and gender-based medicine into medical education are also taking place in the **US** (McGregor et al., 2015; Song, Jones and Casanova, 2016; Rojek and Jenkins, 2016), **Canada** (Miller et al., 2013) and **Australia** (Micheal and Marjadi, 2018) (See Appendix II for a description of a training handbook on gender mainstreaming in health).

³² Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions, ‘A Union of equality: Gender Equality Strategy 2020–2025. Brussels, 5.3.2020 COM(2020) 152 final, available at: <https://ec.europa.eu/transparency/regdoc/rep/1/2020/EN/COM-2020-152-F1-EN-MAIN-PART-1.PDF>.

5. Gender issues in the COVID-19 pandemic³³

Data monitoring from the European Centre for Disease Prevention and Control (ECDC) shows that between 1 January and 2 August 2020, **European Union/European Economic Area (EU/EEA) countries and the United Kingdom (UK) have reported over 1.7 million cases** (10 % of global cases), including **over 182 000 deaths** (27 % of all global deaths) (ECDC, 2020a). As of 2 August 2020, the largest proportion of cases were reported among 50 to 59-year-olds. There was, however, a higher representation of older people among hospitalised patients and deaths. The male-to-female case ratio overall was 0.9 (men slightly less likely to be infected) but more men than women were admitted to hospital (ratio of 1.2) , requiring intensive care (ratio of 2.1) and men had higher death rates (ratio of 1.4).

The age and sex distribution of cases, severity and deaths from 1 January to 2 August 2020 in the EU/EEA and the UK.

There are already indications that the **impact of the pandemic is gendered**:

Gender and COVID-19 mortality and morbidity

- In Europe, **women appear to be slightly more likely to be diagnosed with COVID-19** (ECDC shows a male-to-female case ratio of 0.9 from 1 January to 2 August 2020), which may in part be due to the fact that **women account for the majority of healthcare workers** in Europe and are more inclined to access healthcare services. For example, up to 1 June 2020, in Germany, women accounted for 52 % of confirmed cases and men 48 %. However, data from France and the UK show that **men were more likely to be admitted to intensive care with COVID-19** – reflecting more severe illness and disease complications.
- **There are early signs that the mortality rate from COVID-19 in Europe and elsewhere may be higher among men.** Early evidence from China suggested that the death rate (number of deaths compared to number of cases) was 2.8 % among men and 1.7 % among women (CCDC Weekly, 2020). This higher probability of dying from COVID-19 has also been evident in Europe and other countries such as the United States.³⁴ For example, the 8 252 deaths in Germany were split into 4 572 for men and 3 680 for women (Statista, *Number of coronavirus (COVID-19) deaths in Germany in 2020, by gender and age*). In the UK, deaths from COVID-19 among men were 50.6 per 100 000 compared to 25.5 per 100 000 for women (Office for National Statistics, 2020). The UK data suggest this sex difference in mortality is consistent across socio-economic groups.

³³ This chapter is based on Bambra, Albani and Franklin (2020)..

³⁴ For further information, compare with the data provided by the City of New York on its website (<https://www1.nyc.gov>).

- Indeed, the most recent ECDC data (covering the period from 1 January to 2 August 2020) show that in the EU/EEA and the UK, the male-to-female case ratio overall was 0.9 (men slightly less likely to be infected) but **more men than women were admitted to hospital** (ratio of 1.2), requiring intensive care (ratio of 2.1) and men had higher death rates (ratio of 1.4).
- **Sex differences in smoking rates** in China was initially considered to be the main factor behind these different death rates – as smoking is very high among older Chinese men and very low among older Chinese women – reflecting their stage in the global smoking epidemic (WHO, 2020a). Smoking increases the risks of respiratory complications.
- However, the European data suggest that it is wider than just smoking and **men's higher mortality is considered to be due to their higher rates of the key clinical risk factors for COVID-19**. European men have higher rates of cardiovascular disease, diabetes, chronic respiratory disease, hypertension and cancer. There has also been speculation that the differential death rates may be as a result of immunity differences between men and women.
- It should be noted though that the **increase in excess mortality among men and women in spring 2020 is similar** – suggesting that while men might be dying more in terms of absolute numbers of deaths, the relative increase in mortality is the same for women (Krieger, Chen and Waterman, 2020).
- It should also be noted that sex-disaggregated COVID-19 mortality and morbidity rates are not routinely being published by all Member States.

Gender and the lockdowns in Europe

- The pandemic has led to unprecedented measures in peace time – with national lockdowns enacted in almost all EU Member States.
- **Lockdown policies have led to higher rates of intimate partner violence, mental ill health, and reduced healthcare access** – particularly affecting women and children.
- Within the first few weeks of lockdown, charities across Europe already started to **report increased cases of intimate partner violence**, with higher rates of calls to their helplines and website visits (*The Guardian*, 2020b).
- For example, the Catalan regional government in Spain reported that **calls to its helpline had risen by 20 %** in the first few days of the confinement period and in Cyprus, calls to a similar hotline rose 30 % in the first week.
- More alarmingly, reports have suggested that **deaths from intimate partner violence doubled** in the UK during the first month of lockdown: usually there are 5 to 6 deaths per month of women and children, but during the first four weeks of lockdown, this increased to 16 (*The Guardian*, 2020a).
- The lockdown has proved particularly **challenging for mental health** – with concerns expressed by medical professionals from across Europe about the impact of extended isolation and lack of social contact.
- This is **particularly challenging for people who already have mental ill-health** – and given that women are more likely to suffer from anxiety and depression; it is possible that **women's psychological wellbeing has suffered disproportionately** as a result of the lockdown (Gunnell et al., 2020).

- Lockdown and travel restrictions complicate access to essential sexual and reproductive health information, services and goods for women and girls. In particular, abortion care is essential and time-sensitive, but access to it has become more difficult (Council of Europe, 2020).
- As a result of health services having to focus on combating the pandemic, there has been a significant **reduction in healthcare access for people with existing chronic conditions** such as cancer or cardiovascular disease (*BBC News*, 2020). This will **disproportionately impact women** as they are more likely to be living with such diseases.
- Access to preventative care such as **breast cancer and cervical cancer screening has also been restricted** in many European countries as a result of healthcare system pressures and the need for social distancing (*BBC News*, 2020). It is possible that this will **increase mortality and morbidity for women** from such diseases in the short to medium term.

Ethnic minority and migrant women and men and COVID-19

- There are emerging data from various European countries suggesting that **minority ethnic groups have higher COVID-19 mortality rates** (ICNARC, 2020).
- This may be as a result of **greater exposure** as they are **more likely than majority ethnic groups to work as key workers** in healthcare and food and retail services and therefore not to have been as protected by the lockdown restrictions. They are also more likely to be reliant on public transport and be exposed to other **high-risk environments** such as other crowded houses or urban neighbourhoods where the virus transmission is higher.
- They might also have **greater susceptibility due to underlying chronic health conditions**. For example, in the UK, minority ethnic groups have higher rates of almost all of the known underlying clinical risk factors that increase the severity and mortality of COVID-19 including hypertension, diabetes, severe respiratory diseases, cancer, obesity and heart, liver, renal and cardiovascular disease.
- **Ethnic minority and migrant women may be particularly vulnerable** to COVID-19 infection, complications, and mortality through greater exposure as key workers, and lack of access to healthcare (Bambra et al., 2020).
- Another issue for ethnic minority and migrant women and men is **reduced access to healthcare services** due to entitlement restrictions and language and cultural barriers – this will matter in terms of COVID-19 treatment.

Health and social care workers and COVID-19

- **Women are disproportionately represented in the health and social care workforce whose exposure to the SARS-CoV-2 virus is high.** Women hold on average 90 % of the jobs in the long-term care sector (LTC) (OECD, 2019b). A high proportion of LTC facilities across Europe and globally have reported COVID-19 outbreaks, with high rates of morbidity and case fatality in residents and high rates of staff absenteeism (ECDC, 2020b).
- **Confirmed cases among healthcare workers show that women are being infected in higher numbers than men:** in Italy 68 % of the infected are women, in the USA 73 %, Spain 75 % and Germany 72 %. Very little national-

level data on the sex-breakdown of deaths in healthcare workers are available at the time of writing (Global Health 50/50, *The COVID-19 Sex-Disaggregated Data Tracker*).

Economic consequences of COVID-19

- **The longer-term economic fallout from the pandemic may also be worse for women.** The **European and world economy has been severely impacted by COVID-19** with almost daily record stock market falls, crashing oil prices and record levels of unemployment. Many countries including **France and Germany are already in recession**. This is despite the unprecedented interventionist measures undertaken by many European governments and central banks (*The Economist*, 2020).
- Economists fear that the **economic impact will be far greater than the global financial crisis** of 2007 and 2008 and they say that it is likely to be as bad as – or worse than – the Great Depression of the 1930s (Valero, 2020).
- The impacts of **the COVID-19 economic fallout will be gendered** – as the sectors of the economy most hard-hit include retail, tourism and restaurants – all of which disproportionately employ women (Eurofound, 2012).
- **Poverty levels are likely to increase in some European countries.** As women are already more likely to live in poverty, it is feasible that the **rising poverty rates** in some European countries **might be adversely impacting on women and children** – especially the case in countries already impacted by austerity and rising poverty such as the UK (Taylor-Robinson et al., 2019).
- There will also be huge health consequences from this economic crisis – which will impact men and women differently. For example, previous research has found that **recessions lead to increases in morbidity, mental ill health, and – particularly among men – suicide** (Haw et al., 2014).
- However, research into the global financial crisis has shown that **health inequalities were less negatively impacted in countries that maintained a strong social security safety net** compared with those such as Greece, Spain and the UK, which pursued austerity (Stuckler and Basu, 2013).
- So, it is likely that the post-COVID-19 global economic slump will **exacerbate the economic – and health – inequalities between men and women.**

6. Conclusions and recommendations

6.1 Conclusions

Gender intersects with social, economic, environmental, political and cultural determinants of health, influencing exposure to risk factors and interactions with health systems (WHO, 2018).

Higher mortality rates among men v higher morbidity rates among women

The data, research and policy reviewed in this report highlight the gendered health situation: men have higher rates of mortality, while women have higher rates of morbidity. This means that men have lower life expectancies than women. Women on the other hand more often report 'bad' or 'very bad' general health and have higher rates of chronic diseases.

Women and men differ in terms of the diseases they are more likely to develop

There appear to be some gender differences in chronic diseases, for example, diabetes and smoking have a greater weight as risk factors in men than in women. Gender differences in mental health are also evident as women have higher psychiatric morbidity yet men have higher rates of suicide and intentional self-harm. Obesity rates are slightly higher in men than in women, but women are disproportionately affected by obesity-related cancers.

Social and economic factors influence health and health differences between women and men

Besides biological differences, scientific research shows the major impact that social and economic factors and public policies have on health. The statistical evidence presented in Sections 2.2 to 2.4 confirm the importance of social and economic explanations. The lower life expectancy of men is particularly the case in Eastern Europe and among men from lower **socioeconomic backgrounds** in all European countries. The gender life expectancy gap decreases as **education increases** in most European Union countries and is particularly large in the lowest educated groups in all countries. The gender difference in prescribed medicine use on the other hand is particularly strong – as women are more likely to use medication than men, especially in the **25–34 age group (reflecting their higher morbidity and as they are more likely to access healthcare services)**. There is strong evidence that **ethnic minority groups** have worse health outcomes than host European populations across all EU countries – particularly in terms of mental health, cardiovascular disease and diabetes. **Refugees, asylum seekers and migrants** seem to be at a particularly high risk of poor health, and this can especially impact

on women of reproductive age. Research furthermore points to the fact that men have been traditionally more exposed to negative health effects from workplace hierarchies, unemployment, and the need to be the main breadwinner – potentially resulting in their increased mortality. Women on the other hand have to deal with work-family strain from the dual burden of employment and caring and may therefore be more likely to experience physical and mental health problems.

Occupational health and safety

Women are in general less likely to be involved in accidents at work and somewhat less often report work-related ill health. Nevertheless, female-dominated sectors such as healthcare, social work, education, transport, public administration and retail are highly exposed to third-party violence and psycho-social risks. New forms of harassment, such as cyber-harassment, are an emerging issue in some sectors, for example in education and in politics; teleworking during the COVID-19 pandemic has potentially increased this risk to many. The effects of occupational exposure to dangerous substances have been less analysed for female-dominated sectors. Furthermore, an EU-OSHA (2014) report pointed out that work-related risks to women's safety and health have been underestimated and neglected compared with men's. Male workers often seem to be more exposed to specific risks, but women may have a higher level of exposure and are particularly affected by multiple exposures. Women are more exposed to slips, trips and falls, and increasingly affected by musculoskeletal disorders (MSDs) and stress. The cases of women's work-related cancers are likely to be underestimated.

Women more often use medication and health facilities

The use of prescribed as well as non-prescribed medicine use is higher among women than in men in the EU Member States. Evidence also shows that women are more frequent users of healthcare services than men, including consultations by a generalist medical practitioner, specialist practitioner, dentist, physiotherapist, and psychologist, psychotherapist or psychiatrist.

Women as well as men face barriers in accessing healthcare

In most EU Member States, more women than men report unmet needs for medical examination. Both women and men continue to face a number of difficulties when accessing healthcare. Financial barriers are more important for women in as much as they often have lower incomes. Distance and lack of a means of transportation may affect women more as they rely more often on public transportation. Care duties, mostly undertaken by women, can also be an obstacle to access to medical services. Barriers more often affecting men's use of medical services include a perception that using such services does not tally with the stereotype of masculine behaviour. Waiting lists and appointment availability are often the direct reason why medical needs are not met. Low physician density and high out-of-pocket payments are two other common explanations reported by both men and women. It should be noted that many ethnic minority and migrant women continue to lack access to necessary prenatal and maternal healthcare.

Reproductive health services

Sexual and reproductive health and rights are an essential aspect of gender equality. Nevertheless, not all EU Member States collect sex- and gender-disaggregated data and evidence on peoples' sexual and reproductive health. Access to sexual and reproductive health services is classified as very poor in almost half of the EU Member States according to the European Contraception Atlas (2019). In nine EU Member States, abortion is still only allowed without parental consent from the age of 18 years, according to the EU Fundamental Rights Agency 2017 report. In 17 EU Member States, laws and policies do not provide for undocumented migrant women's access to free or subsidised maternal healthcare throughout pregnancy. Systematic EU-wide evidence on obstetric violence is missing to date, but data on individual countries show that high incidences exist in at least some.

Health and social care sector

The health and social care sector is women dominated. This care economy suffers from employment conditions that are relatively poor and difficult due to governmental budgetary restrictions, and lack of valuing of care work.

Gender sensitivity in healthcare institutions

A lack of healthcare professionals' awareness of gender-specific symptoms, for example in acute coronary syndrome, limits fast reaction and the delivery of timely and appropriate care for women. Further, the recognition that many cardiovascular drugs act differently in females and males is still low. Sex and gender differences in cardiovascular diseases, but also diabetes, stroke, asthma and lung cancer are insufficiently researched. In fact, most medical trials have a limited sensitivity for analysing sex and gender differences as they usually use healthy, young, male volunteers. Research into female-specific conditions such as endometriosis and menopause are also under-resourced. The deficits in knowledge on gender-specific disease manifestations, diagnostic and therapeutic approaches call for gender-sensitive information campaigns for physicians and the general public, training for healthcare professionals and guidelines.

COVID-19 is already having a gendered impact

Gender differences in health are also evident in the emerging data from the COVID-19 pandemic. Although the mortality rate from COVID-19 may be higher among men, the lockdown policies may have led to higher rates of intimate partner violence, mental ill health, and reduced healthcare access for women, and ethnic minority and migrant women may be particularly vulnerable. The longer-term economic fallout from the pandemic may also be worse for women. Therefore, while it is still too early to say with certainty, it does appear likely that the pandemic will exacerbate existing gender inequalities in health, acting in an intersectional manner alongside ethnicity, migrant status and socioeconomic status (Bambra et al., 2020).

6.2 Recommendations

At the **European Union level**, the following recommendations are made to address the issues raised in the conclusions above. Priority recommendations are highlighted in bold.

Improving people's health by taking account of gender specificities

- **Ensure swift implementation of the IT system that would permit the clinical trials regulation to become applicable and monitor the progress that follows.**
- **Set up a gender and health inquiry to investigate the continuing inequalities – such as men's mortality disadvantage and women's morbidity disadvantage, COVID-19 and gender – and how public policies can promote equity.**
- Promote the inclusion of gender-specific information on the differential gendered consequences and symptoms of diseases among health professionals, as well as the general public.
- Continue to promote gender equity in health across Member States – promoting understandings of the social, economic, cultural and policy factors and promoting policies (such as public childcare provision) that support gender health equity.

Decrease the gender health gap by developing targeted gender-sensitive health policies

- Promote and support the development of health programmes for ethnic minorities and immigrant groups that address language and cultural barriers, and gender-specific services.
- Promote and support the provision of health and gender education within compulsory education.

Improve women's health and safety at the workplace

- **Ensure the renewal of the EU Strategic Framework for Health and Safety at Work after 2020 with gender and equality dimensions fully included.**
- Prioritise the identification of gender specificities in risks (e.g. psycho-social risks, gender-based violence and harassment) and measures to address them in the new strategic framework.

Increase knowledge on gender differences in the use and effects of medication

- Review existing research funding programmes with a gender perspective and enlarge funding possibilities for research on gendered medicine.

Ensure a gender dimension when further improving access to healthcare

- **Build on the 2018 DG Employment report on inequalities in access to healthcare (European Commission, 2018c) and the national reports to monitor the situation in Member States, identify areas for change and publish the results.**

- **Ensure that all actions undertaken under Principle 16 of the European Pillar of Social Rights and those agreed in the framework of the Open Method of Coordination in the field of health clearly distinguish between the situation and needs of women and men.**

Strengthen research on and responses to gender-based violence

- **Update EU legislation (EU Directive 2012/29/EU) in line with social, economic and healthcare system changes in recent years, and with the aim to coordinate the Member States' provision of protection and support services to victims of gender-based violence in an efficient and rights-based way.**
- **Assess the implementation and efficiency of existing training for healthcare workers on responding to sexual violence.**
- Elaborate a coherent strategy for research using a women-centred analysis of domestic, sexual and gender-based violence (DSGBV).
- Consider violence against women, human trafficking for sexual purposes, and female genital mutilation in all EU health guidelines as human rights violations.
- Support research into obstetric violence.

Improve working conditions in the care economy

- **Pilot equal pay and pay transparency measures in the health and social care sector to raise awareness about labour market segregation and pay inequities.**
- **Use the role of the healthcare sector in fighting the impact of COVID-19 to draw attention to working conditions and issues such as back pay.**
- Fund research on the 'care economy', specifically on working conditions and job quality, with the aim of informing evidence-based policymaking at the level of Member States.
- Initiate an EU-level evaluation and development of guidelines for the improvement of working conditions and occupational safety and health in the health and social care sector.

Improve gender sensitivity in healthcare services

- **Earmark resources within the EU4Health Programme (2021–2027) to develop materials for the Member States to strengthen the integration of sex and gender in the curriculum for training of healthcare professionals.**
- **Support and promote the development of guidelines and other materials for healthcare professionals in diagnosing and treating patients in a gender-sensitive manner.**
- Encourage networking among experts and health professionals in this area.
- Conduct seminars for sharing good practices on gender-sensitive healthcare services.

Combat the negative impacts on women of the social and economic consequences of COVID-19 and the measures taken to fight it

- **Promote exchange of information in the EU on mitigating the impact of COVID-19 on intimate partner violence, mental ill health, and reduced healthcare access for women.**
- **Launch a study on gendered differences in the long-term impacts of the virus and the policy measures taken.**

Improve data and research on gender and health

- Establish EU-level strategic priorities on gender and health through multidisciplinary research collaboration.
- Improve data collection and analysis on gender disparities regarding access to healthcare and on the quality of healthcare provided for women and men across the life course.
- Provide data and data analyses on gender segregation in health and social care by occupational groups.
- Develop and implement methodologies for studying gender and health across the Member States, publish annual reports and monitor progress in this area.
- Strengthen the gender perspective at the EU level in health research and reports.

It is recommended that **Member State governments**:

Gender-mainstream policies

- Routinely conduct gender equity assessments of health policies.
- Focus on transforming structures and policies so that they engage men in key areas such as self-care, fatherhood, unpaid care, preventing violence, and sexual and reproductive health.
- Ensure gender mainstreaming in economic and employment policies in general and in relation to the COVID-19 crisis.
- Integrate a gender perspective into health emergency response plans.
- Improve financing to address women's health and integrate gender budgeting across health policies and programmes.

Guarantee universal access to healthcare

- Provide universal access to healthcare for all – including ethnic minority and migrant groups.

Guarantee sexual and reproductive health rights

- Guarantee basic reproductive rights, such as the right to decide over one's body, family planning and abortion.
- Provide universal reproductive health services.
- Provide comprehensive and evidence-based gender and sex education at schools.
- Strengthen inclusive young peoples' services in relation to sexual and reproductive health.

Strengthen data collection and research

- Strengthen data collection on migrants' and ethnic minorities' health status and access to healthcare and ensure disaggregation of the data by sex.
- Strengthen research on obstetric violence and engage with civil society and women's organisations to support health institutions in this area.
- Include sex and occupational data in COVID-19 morbidity and mortality statistics to monitor occupational health and safety (OSH) across sectors.

Ensure gender-sensitive healthcare and health professional education

- Promote gender equity within the healthcare system. Improve gender parity in decision-making bodies and other collective bodies in the health sector, and address the gender pay gap and low salaries.
- Gender mainstream medical studies acknowledging peoples' diversity and the intersectionality of gender with other health determinants.
- Develop training materials and introduce formal training programmes for health-care professionals on recognising and managing the effects of domestic, sexual and gender-based violence.
- Inform and train healthcare professionals on human rights issues relevant to gender minorities, i.e. de-pathologising of trans identities.

Act to eliminate gender-based violence

- Ratify the Istanbul Convention if not done so yet.
- Ratify the ILO Convention 190 and Recommendation 260 on Eliminating Violence and Harassment in the World of Work.

APPENDICES

APPENDIX I. Illustrative practices on access to services

Promoting access to contraceptives in Spain

In Spain, their national health system, the *Sistema Nacional de Salud* (SNS), covers all residents and is administered on a regional level by the country's Autonomous Communities (ACs), which each have their own regulations regarding contraceptive subsidisation. However, both male and female condoms are generally available free of charge or at subsidized prices. Additionally, all pharmacies in Spain are required to dispense emergency contraception without a prescription and with no age restrictions. Emergency contraception typically costs around EUR 18, although some ACs provide it for free in public health clinics. In March 2010, a new law on reproductive health led to the Ministry of Health for the first time subsidising hormonal contraceptives as birth control. The law covers three types of hormonal contraceptives. As a result, all women covered by the SNS are now able to obtain some contraceptives at reduced prices (around EUR 6 to 7 for one packet of hormonal contraceptives) (Center for Reproductive Rights, 2012).

Access to sexual and reproductive health services in Portugal

Portugal provides free access to publicly run family planning consultations, contraceptive methods and voluntary termination of pregnancy services. During the first consultation with pregnant women considering voluntary termination of pregnancy, providers must give clear, verbal and written information on existing social supports. Foreigners who are legally resident in Portugal can also access health services and, under certain conditions, foreigners without authorisation to stay can also access services (European Parliament, 2018b).

Improving sexual, reproductive and maternal health for women in Latvia

The Latvian Cabinet of Ministers approved a mother and child health improvement plan for 2018 to 2020. The plan aims to improve maternal and child health through better disease prevention, earlier diagnosis and timely treatment. It includes measures to support vulnerable women: from 2020 onwards, women at risk of social exclusion will receive state-funded contraception services, reaching, for example, women with low incomes, inadequate education, or physical and mental health problems, or who experience sexual and emotional violence, among others (EIGE (a)).

Empowerment of and prevention of violence against women in Bilbao, Spain

The empowerment of women and prevention of violence against women and health promotion programme seeks to empower migrant women in Bilbao, Spain through the promotion of health and the prevention of gender-based violence. It aims to fight against the multiple discrimination to which migrant women are subjected. The

programme also aims to empower individual women to participate in and become leaders in their own communities. There are four activities within the programme: 1) Training of women as 'Community Agents For Empowerment', 2) Specific workshops for local stakeholders to spread information and raise awareness on women's health, 3) Pilot experience on FGM (female genital mutilation) by learning from African mothers coming from the countries where this gender-violent practice is still in use, and 4) Production and distribution of the 'Guide For Women' translated into eight languages (Council of Europe, '*Intercultural cities: good practice examples*').³⁵

APPENDIX II. Illustrative practices on gender-sensitivity among healthcare professionals

Training handbook on gender mainstreaming in health

In Ireland, the Health Service Executive (HSE) and National Women's Council of Ireland (NWCI) have developed a training handbook for gender mainstreaming in health. It is one of the actions set out in the framework on gender mainstreaming drawn up by the HSE/NWCI in 2012, 'Equal but Different: A framework for integrating gender equality in health service policy, planning and service delivery'. A specific focus is given in the training to how policymakers, service planners, managers and front-line staff can build their knowledge and understanding of gender-related health issues and how they impact on the health and wellbeing of women and men. It looks at how gender norms, gender roles and gender relations play a part in determining women's and men's health and their access to health services. With this understanding, policy, planning and service delivery can provide services that are responsive to the needs and experiences of women and men (NWCI, 2014).

Reducing health inequalities experienced by LGBTI people: what is your role as a health professional?

This Trainers Manual was developed as part of a European Parliament-funded pilot project 'Health4LGBTI' that was implemented between March 2016 and March 2018. The aim of the project was to improve the understanding of how best to reduce specific health inequalities experienced by lesbian, gay, bisexual, trans and intersex (LGBTI) people. It focused on overlapping inequalities stemming from discrimination and unfair treatment on other grounds (e.g. age, status and income).³⁶ The training course has been designed for healthcare professionals (medical doctors – GPs and specialists – nurses, psychologists, social workers and others) across all disciplines of healthcare and can be implemented at any stage of the education and working life, from undergraduate level to continuing professional education. It is suitable also for support staff working in healthcare environments (e.g. secreta-

³⁵ For further information compare with the website of the programme 'Women's Health in Women's Hands', available at: <http://www.eu-mia.eu/cases/programa-mujer-salud-y-violencia-women2019s-health-in-women2019s-hands>.

³⁶ For further information, compare with the fiche about the project 'Health4LGBTI: Reducing health inequalities experienced by LGBTI people', available at: https://ec.europa.eu/health/social_determinants/projects/ep_funded_projects_en#fragment2.

ries, administrative staff) who come into contact with patients/clients on a regular basis (European Commission, 2018d).

Improving men's health in Ireland: Building capacity among front-line health workers to engage men

Ireland's National Men's Health Policy (2008–2013) identified building capacity among front-line service providers as an essential but neglected component of developing effective strategies for engaging men in self-care. In order to tackle this deficit in gender-sensitive service provision for men, ENGAGE, Ireland's National Men's Health Training programme, was developed. The comprehensive one-day training is based on an experiential learning and reflective practice approach, combined with mechanisms for feedback and peer support during and beyond training. ENGAGE has improved service providers' knowledge, skills and capacity to engage and work with men and to deliver more gender-competent health services and programmes; boosted community outreach programmes to priority groups of men; and influenced the development of gender-sensitive service provision (Richardson and Aguirre, 2018).

APPENDIX III. Data tables

Grid III.1: Available data on gender inequalities in physical and mental health across the EU*

	Gender data	By socioeconomic status	Data source
Life expectancy	✓	✓	Eurostat
Disability free/ healthy life expectancy	✓	✓	Eurostat
All-cause mortality	✓	✗	Eurostat
CVD mortality	✓	✗	Eurostat
Cancer mortality	✓	✗	Eurostat
Injuries mortality	✓	✗	Eurostat
Violence mortality	✓	✗	Eurostat
Depression	✓	✓	European Health Interview Survey (EHIS)
Suicide	✓	✗	Eurostat
Self-rated health	✓	✓	EU Statistics on Income and Living Conditions (EU SILC)
Cancer prevalence	✓	✗	WHO. European Health for All Database
CVD prevalence	✓	✗	Eurostat
Obesity	✓	✗	WHO Global Health Observatory
Diabetes	✓	✗	European Health Interview Survey (EHIS)
Musculoskeletal conditions	✓	✓	European social survey (special module)
Unmet needs for medical examination	✓	✓	European Statistics of Income and Living Condition (EU-SILC) survey
Smoking rates	✓	✓	European social survey (special module)
Alcohol consumption	✓	✓	European social survey (special module)
Physical activity rates	✓	✓	European social survey (special module)
Vegetable consumption	✓	✓	European social survey (special module)
Accidents at work	✓	✗	European Core Health Indicators (ECHI)
Ill health related to work	✓	✓	Labour Force Survey special module and European Survey of Working Conditions

* Variables in **bold** are included in the report.

Table III.1. Gap in life expectancy and healthy life expectancy at birth between women and men (years) in 28 EU Member States, 2018

Region/ Country	Life expectancy		Healthy life expectancy			
	Women	Men	Gender Gap	Women	Men	Gender gap
EU-28	83.6	78.3	5.3	63.8	63.4	0.4
Austria	84.1	79.4	4.7	57.0	56.8	0.2
Belgium	83.9	79.4	4.5	63.8	63.2	0.6
Bulgaria	78.6	71.5	7.1	67.6	64	3.6
Croatia	81.5	74.9	6.6	58.5	56.5	2.0
Cyprus	84.8	80.9	3.9	62.4	62	0.4
Czechia	82.0	76.2	5.8	63.4	62.2	1.2
Denmark	82.9	79.1	3.8	59.1	62.5	-3.4
Estonia	82.7	74.0	8.7	55.0	52.7	2.3
Finland	84.5	79.1	5.4	55.7	58.8	-3.1
France	85.9	79.7	6.2	64.5	63.4	1.1
Germany	83.3	78.6	4.7	66.3	65.1	1.2
Greece	84.4	79.3	5.1	65.9	65	0.9
Hungary	79.6	72.7	6.9	61.8	60.4	1.4
Ireland	84.1	80.5	3.6	70.4	68.4	2.0
Italy	85.6	81.2	4.4	66.9	66.8	0.1
Latvia	79.7	70.1	9.6	53.7	51	2.7
Lithuania	80.7	70.9	9.8	59.1	56.3	2.8
Luxembourg	84.6	80.1	4.5	59.8	61.4	-1.6
Malta	84.6	80.4	4.2	73.4	71.9	1.5
Netherlands	83.4	80.3	3.1	57.2	61.1	-3.9
Poland	81.7	73.7	8.0	64.3	60.5	3.8
Portugal	84.5	78.3	6.2	57.5	59.8	-2.3
Romania	79.2	71.7	7.5	59.6	59.2	0.4
Slovakia	80.8	73.9	6.9	56.6	55.5	1.1
Slovenia	84.4	78.5	5.9	54.6	56.3	-1.7
Spain	86.3	80.7	5.6	68.0	68	0.0
Sweden	84.3	80.9	3.4	72.0	73.7	-1.7
United Kingdom	83.1	79.5	3.6	60.8	61.5	-0.7

Source: EU Sustainable Development Goals (SDG) indicator set, European Statistical System (ESS).

Eurostat. (2018). Life expectancy by age and sex [demo_mlexpec].

Retrieved from https://ec.europa.eu/eurostat/data/database?node_code=demo_mlexpec.

Eurostat. (2018). Healthy life years by sex (from 2004 onwards) [hlth_hlye].

Retrieved from https://ec.europa.eu/eurostat/data/database?node_code=hlth_hlye.

Figures show the difference in excess life expectancy of women over men in years. Life expectancy at birth represents the mean number of years that a new-born child can expect to live if subjected throughout his life to the current mortality conditions (age specific probabilities of dying). Healthy life expectancy defined as expected years of life without severe or moderate health problems.

Table III. 2. Gap in life expectancy at birth (years) between women and men by level of education. 15 EU Member States

Region/Country	Gender Gap by Education level		
	Low	Medium	High
Average	8.5	5.8	4.3
Bulgaria	8.9	6.7	5.9
Croatia	7.6	6.5	4.3
Czechia	13.1	5.7	4.6
Denmark	4.5	3.9	2.7
Estonia	10.1	9.0	7.0
Finland	6.4	6.0	4.0
Greece	6.3	5.0	2.8
Hungary	10.8	6.6	4.5
Italy	5.4	3.6	3.7
Poland	12.4	7.9	5.0
Portugal	6.9	4.2	4.0
Romania	11.0	6.6	5.2
Slovakia	12.2	6.9	4.1
Slovenia	7.8	6.0	4.4
Sweden	4.1	3.4	2.7

European Core Health Indicators. (2016). Life expectancy by educational attainment.

Retrieved from https://ec.europa.eu/health/indicators_data/indicators_en.

The table shows the difference between excess of women's life expectancy at birth compared with men in years. Education level based on the International Standard Classification of Education (ISCED): "low educational level" is less than primary, primary and lower secondary education (levels 0-2), "medium educational level" is upper secondary and post-secondary non-tertiary education (levels 3 and 4) and "high educational level" is tertiary education (levels 5-8).

Table III. 3. Gap in life expectancy and healthy life expectancy at the age of 65 between women and men (years) in 28 EU Member States, 2018

Region/Country	Life expectancy			Healthy life expectancy		
	Women	Men	Gender Gap	Women	Men	Gender gap
EU-28	21.5	18.2	3.3	10.0	9.9	0.1
Austria	21.6	18.5	3.1	7.4	7.5	-0.1
Belgium	21.9	18.6	3.3	11.4	10.8	0.6
Bulgaria	18.0	14.2	3.8	10.2	9.2	1
Croatia	19.3	15.7	3.6	5.0	5.0	0
Cyprus	21.8	19.1	2.7	6.9	8.1	-1.2
Czechia	19.8	16.2	3.6	8.5	8.1	0.4
Denmark	20.7	18.0	2.7	11.8	10.8	1
Estonia	20.6	15.7	4.9	5.8	5.6	0.2
Finland	22.0	18.6	3.4	9.4	9.5	-0.1
France	23.8	19.7	4.1	11.3	10.2	1.1
Germany	21.1	18.0	3.1	12.2	11.5	0.7
Greece	21.9	19.1	2.8	7.2	7.4	-0.2
Hungary	18.5	14.6	3.9	7.4	6.9	0.5
Ireland	21.6	19.1	2.5	13.8	12.0	1.8
Italy	22.8	19.6	3.2	9.2	9.8	-0.6
Latvia	19.0	14.1	4.9	4.7	4.2	0.5
Lithuania	19.7	14.5	5.2	6.3	5.6	0.7
Luxembourg	22.1	18.8	3.3	8.8	9.1	-0.3
Malta	22.3	19.2	3.1	14.5	14.0	0.5
Netherlands	21.1	18.7	2.4	9.5	9.9	-0.4
Poland	20.1	15.8	4.3	8.8	8.2	0.6
Portugal	22.0	18.2	3.8	6.9	7.8	-0.9
Romania	18.4	14.7	3.7	5.9	6.3	-0.4
Slovakia	19.3	15.4	3.9	4.6	4.0	0.6
Slovenia	21.8	17.8	4.0	7.4	7.5	-0.1
Spain	23.5	19.5	4.0	11.3	11.5	-0.2
Sweden	21.6	19.2	2.4	15.8	15.6	0.2
United Kingdom	21.1	18.9	2.2	10.7	10.2	0.5

Source: EU Sustainable Development Goals (SDG) indicator set, European Statistical System (ESS). Eurostat. (2017). Life expectancy by age and sex [demo_mlexpec].

Retrieved from https://ec.europa.eu/eurostat/data/database?node_code=demo_mlexpec.

Eurostat. (2018). Healthy life years by sex (from 2004 onwards) [hlth_hlye].

Retrieved from https://ec.europa.eu/eurostat/data/database?node_code=hlth_hlye.

Life expectancy at a given age represents the average number of years of life remaining if a group of persons at that age were to experience the mortality rates for a particular year over the course of their remaining life. Healthy life expectancy defined as expected years of life without severe or moderate health problems. Limitations in daily activities because of health problems based on answers to the EU Statistics on Income and Living Conditions (EU-SILC Survey) "Limitation in activities people usually do because of health problems for at least the last 6 months".

Table III. 4. Age-standardised all-cause mortality rates per 100,000 by country. 28 EU Member States, 2016

Region/Country	Men	Women	Gap
EU-28	1,246	814	432
Austria	1,164	779	385
Bulgaria	2,007	1,300	-707
Belgium	1,194	789	405
Croatia	1,696	1,089	607
Cyprus	1,126	832	294
Czechia	1,529	979	550
Denmark	1,219	867	352
Estonia	1,701	917	784
Finland	1,245	782	463
France	1,093	654	439
Germany	1,259	837	422
Greece	1,134	806	328
Hungary	1,848	1,147	701
Ireland	1,167	840	327
Italy	1,060	692	368
Latvia	2,072	1,136	936
Lithuania	2,054	1,090	964
Luxembourg	1,134	739	395
Malta	1,032	767	265
Netherlands	1,164	849	315
Poland	1,616	941	675
Portugal	1,301	797	504
Romania	1,855	1,190	665
Slovakia	1,689	1,071	618
Slovenia	1,302	811	491
Spain	1,068	648	420
Sweden	1,087	783	304
United Kingdom	1,158	853	305

Source: Eurostat. (2016). Causes of death - standardised death rate by residence [hlth_cd_asdr2]. Retrieved from https://ec.europa.eu/eurostat/data/database?node_code=hlth_cd_asdr2. (Accessed 01/04/2020).

Data from causes of death (COD) statistics are based on information derived from the medical certificate of cause of death (ICD-10 definition) in each member country. Age-standardised mortality rates per 100,000 inhabitants. Weighting factor based on standard reference population as the European standard population (Eurostat, revision 2012).

Table III. 5. Proportion (%) of men and women aged 16 years and over reporting “bad or very bad” self-perceived health symptoms in 28 EU Member States, 2018/2019

Region/Country	Total	Women	Men	Gap	% Difference
EU-28	8.4	9.3	7.5	1.8	24%
Belgium	8.8	10.2	7.4	2.8	38%
Bulgaria	9.2	10.3	8.1	2.2	27%
Czechia	10.7	11.2	9.9	1.3	13%
Denmark	8.1	9.1	7.0	2.1	30%
Germany	8.4	8.8	8.0	0.8	10%
Estonia	14.6	15.7	13.2	2.5	19%
Ireland	3.3	3.5	3.2	0.3	9%
Greece	9.2	10.1	8.1	2.0	25%
Spain	7.3	8.8	5.8	3.0	52%
France	8.3	8.8	7.8	1.0	13%
Croatia	17.1	18.8	15.3	3.5	23%
Italy	6.8	7.9	5.5	2.4	44%
Cyprus	5.4	5.7	5.0	0.7	14%
Latvia	15.3	17.3	12.8	4.5	35%
Lithuania	15.7	17.8	12.2	5.6	46%
Luxembourg	10.0	11.4	8.5	2.9	34%
Hungary	11.8	13.2	10.2	3.0	29%
Malta	4.2	4.7	3.7	1.0	27%
Netherlands	4.5	4.8	4.3	0.5	12%
Austria	8.1	8.4	7.9	0.5	6%
Poland	12.8	13.5	11.9	1.6	13%
Portugal	15.5	18.1	12.4	5.7	46%
Romania	7.1	8.5	5.5	3.0	55%
Slovenia	9.7	10.4	9.0	1.4	16%
Slovakia	12.0	13.2	10.7	2.5	23%
Finland	5.6	5.8	5.4	0.4	7%
Sweden	5.8	6.5	5.1	1.4	27%
United Kingdom	8.1	8.6	7.5	1.1	15%

Source: EU Statistics on Income and Living Conditions (EU SILC)

Eurostat. (2018/2019). Self-perceived health by sex, age and educational attainment level [hlth_silc_02]. Retrieved from https://ec.europa.eu/eurostat/data/database?node_code=hlth_silc_02.

Table III. 6. Proportion (%) of men and women aged 65 years and over reporting “bad or very bad” self-perceived health symptoms 28 EU Member States, 2018/2019

Region/Country	Total	Women	Men	Gap	% Difference
EU-28	18.3	19.9	16.3	3.6	22%
Belgium	16.3	18.4	13.6	4.8	35%
Bulgaria	23.7	25.3	21.2	4.1	19%
Czechia	21.5	22.7	19.5	3.2	16%
Denmark	10.4	11.4	9.3	2.1	23%
Germany	13.5	13.7	13.3	0.4	3%
Estonia	33.3	34.6	30.3	4.3	14%
Ireland	6.7	6.4	7.1	-0.7	-10%
Greece	25.7	27.9	22.9	5.0	22%
Spain	19.6	22.7	15.7	7.0	45%
France	16.9	16.1	17.9	-1.8	-10%
Croatia	41.6	44.6	37.3	7.3	20%
Italy	18.3	20.9	14.9	6.0	40%
Cyprus	17.4	20.6	13.8	6.8	49%
Latvia	36.8	38.8	32.6	6.2	19%
Lithuania	39.1	42.2	31.4	10.8	34%
Luxembourg	18.7	21.8	15.7	6.1	39%
Hungary	29.4	31.9	25.5	6.4	25%
Malta	11.6	12.9	10.0	2.9	29%
Netherlands	7.1	7.9	6.1	1.8	30%
Austria	18.0	18.8	16.9	1.9	11%
Poland	30.8	33.1	27.2	5.9	22%
Portugal	37.8	41.2	33.1	8.1	24%
Romania	21.0	24.2	16.2	8.0	49%
Slovenia	22.4	23.2	21.2	2.0	9%
Slovakia	35.3	36.3	33.6	2.7	8%
Finland	10.3	10.0	10.6	-0.6	-6%
Sweden	8.1	8.1	8.0	0.1	1%
United Kingdom	12.8	13.1	12.4	0.7	6%

Source: EU Statistics on Income and Living Conditions (EU SILC)

Eurostat. (2018/2019). Self-perceived health by sex, age and educational attainment level [hlth_silc_02]. Data for Bulgaria, Denmark, Finland, Latvia and Poland are from 2019.

Retrieved from https://ec.europa.eu/eurostat/data/database?node_code=hlth_silc_02.

Table III. 7. Age-standardized prevalence of obesity (%). Men and women 18 years or older. 28 EU Member States, 2016

Region/Country	Women	Men	Gap	% Difference
EU-28	22.2	23.5	-1.3	-5%
Austria	18.3	21.9	-3.6	-16%
Belgium	21.0	23.1	-2.1	-9%
Bulgaria	24.3	25.5	-1.2	-5%
Croatia	24.5	24.1	0.4	2%
Cyprus	21.6	21.9	-0.3	-1%
Czechia	25.4	26.4	-1.0	-4%
Denmark	17.0	22.3	-5.3	-24%
Estonia	21.8	20.3	1.5	7%
Finland	20.6	23.7	-3.1	-13%
France	21.1	22.0	-0.9	-4%
Germany	20.4	24.2	-3.8	-16%
Greece	25.4	24.2	1.2	5%
Hungary	24.6	28.2	-3.6	-13%
Ireland	25.5	25.1	0.4	2%
Italy	19.5	20.1	-0.6	-3%
Latvia	25.1	21.6	3.5	16%
Lithuania	27.8	24.2	3.6	15%
Luxembourg	20.7	24.5	-3.8	-16%
Malta	28.5	29.2	-0.7	-2%
Netherlands	20.0	20.8	-0.8	-4%
Poland	22.2	23.7	-1.5	-6%
Portugal	21.2	20.3	0.9	4%
Romania	21.6	23.4	-1.8	-8%
Slovakia	19.9	21.0	-1.1	-5%
Slovenia	21.0	19.4	1.6	8%
Spain	22.8	24.6	-1.8	-7%
Sweden	18.1	23.1	-5.0	-22%
United Kingdom	28.6	26.9	1.7	6%

WHO Global Health Observatory. (2018/2019). Age-standardized prevalence of obesity (defined as BMI = 30 kg/m²) in people aged 18 years and over, WHO estimates (%).

Retrieved from <https://gateway.euro.who.int/en/datasets/european-health-for-all-database/>

Age-standardized prevalence of obesity defined as BMI = 30 kg/m² in people aged 18 years and over.

Table III. 8. Proportion (%) of men and women aged 15 years and over self-reporting depressive symptoms. 26 EU Member States, 2014

Region/Country	Total	Women	Men	Gap	% Difference
Average	6.7	7.9	5.4	2.5	46%
Austria	5.0	5.4	4.5	0.9	20%
Bulgaria	7.9	9.1	6.5	2.6	40%
Croatia	3.8	3.9	3.7	0.2	5%
Cyprus	4.6	5.5	3.6	1.9	53%
Czechia	3.2	3.9	2.4	1.5	63%
Denmark	6.3	7.8	4.8	3.0	63%
Estonia	6.9	8.0	5.4	2.6	48%
Finland	4.8	4.6	5.1	-0.5	-10%
France	7.0	9.0	5.0	4.0	80%
Germany	8.5	9.1	7.9	1.2	15%
Greece	4.4	5.4	3.3	2.1	64%
Hungary	10.3	12.1	8.4	3.7	44%
Ireland	5.8	6.0	5.6	0.4	7%
Italy	4.3	5.3	3.3	2.0	61%
Latvia	4.7	5.6	3.6	2.0	56%
Lithuania	3.9	5.1	2.4	2.7	113%
Luxembourg	8.3	9.1	7.5	1.6	21%
Malta	5.7	6.9	4.4	2.5	57%
Poland	5.3	6.4	3.9	2.5	64%
Portugal	10.1	13.8	5.9	7.9	134%
Romania	4.6	5.2	4.0	1.2	30%
Slovakia	3.4	3.8	3.0	0.8	27%
Slovenia	5.5	6.9	4.1	2.8	68%
Spain	6.7	9.0	4.3	4.7	109%
Sweden	9.2	11.0	7.3	3.7	51%
United Kingdom	8.2	8.9	7.4	1.5	20%

Source: Eurostat. (2016). Current depressive symptoms by sex, age and educational attainment level [hlth_ehis_mh1e].

Retrieved from https://ec.europa.eu/eurostat/data/database?node_code=hlth_ehis_mh1e.

Patient Health Questionnaire (PHQ-8) 8-item depression screener. Respondent classified as having depressive symptoms if answering yes to any or both items “Little interest or pleasure in doing things” and “Feeling down, depressed or hopeless” and two, three or four more items in the PHQ-8. See Eurostat. (2013). European Health Interview Survey (EHIS wave 2) Methodological manual. Luxembourg: Publications Office of the European Union. No data on Belgium and The Netherlands.

Table III. 9. Age-standardised mortality rate from suicide and intentional self-harm per 100,000 inhabitants. 28 EU Member States, 2016

Region/Country	Men	Women	Gap	% Difference
EU-28	16.96	4.51	-12.45	-73%
Austria	22.72	6.42	-16.30	-72%
Belgium	25.53	9.51	-16.02	-63%
Bulgaria	15.84	4.00	-11.84	-75%
Croatia	27.10	7.22	-19.88	-73%
Cyprus	6.87	1.12	-5.75	-84%
Czechia	21.78	4.75	-17.03	-78%
Denmark	15.82	4.96	-10.86	-69%
Estonia	26.35	5.10	-21.25	-81%
Finland	22.98	6.06	-16.92	-74%
France	21.97	5.86	-16.11	-73%
Germany	18.21	5.37	-12.84	-71%
Greece	7.55	1.41	-6.14	-81%
Hungary	30.86	8.21	-22.65	-73%
Ireland	15.23	3.65	-11.58	-76%
Italy	9.83	2.40	-7.43	-76%
Latvia	34.17	6.62	-27.55	-81%
Lithuania	54.45	7.84	-46.61	-86%
Luxembourg	14.23	4.75	-9.48	-67%
Malta	8.92	1.69	-7.23	-81%
Netherlands	15.74	7.12	-8.62	-55%
Poland	22.84	3.02	-19.82	-87%
Portugal	15.44	3.82	-11.62	-75%
Romania	18.16	3.06	-15.10	-83%
Slovakia	13.69	2.15	-11.54	-84%
Slovenia	30.70	7.12	-23.58	-77%
Spain	11.74	3.65	-8.09	-69%
Sweden	16.50	7.14	-9.36	-57%
United Kingdom	11.31	3.33	-7.98	-71%

Eurostat. (2016). Causes of death - standardised death rate by residence [hlth_cd_asdr2].

Retrieved from https://ec.europa.eu/eurostat/data/database?node_code=hlth_cd_asdr2.

Data from causes of death (COD) statistics are based on information derived from the medical certificate of cause of death (ICD-10 definition) in each member country.

Includes purposely self-inflicted poisoning or injury and attempted suicide. Age-standardised mortality rates per 100,000 inhabitants. Weighting factor based on standard reference population as the European standard population (Eurostat, revision 2012).

Table III. 10. Self-reported use of prescribed medicines by sex, (%), 2014, 28 EU Member States

Region/Country	Men	Women	Gap
EU-28	43.5	53.3	9.8
Austria	43.4	54.2	10.8
Belgium	53.6	66.2	12.6
Bulgaria	34.1	44.0	9.9
Croatia	42.7	52.2	9.5
Cyprus	34.7	37.7	3.0
Czechia	48.8	60.5	11.7
Denmark	42.9	49.2	6.3
Estonia	35.9	46.8	10.9
Finland	50.2	58.7	8.5
France	47.3	57.1	9.8
Germany	49.4	57.2	7.8
Greece	41.5	52.8	11.3
Hungary	43.2	55.7	12.5
Ireland	40.9	45.8	4.9
Italy	34.1	42.3	8.2
Latvia	30.7	49.9	19.2
Lithuania	32.1	46.8	14.7
Luxembourg	52.6	58.2	5.6
Malta	42.8	50.2	7.4
Netherlands	42.0	49.2	7.2
Poland	41.2	53.7	12.5
Portugal	48.6	62.7	14.1
Romania	18.3	26.9	8.6
Slovakia	38.5	51.0	12.5
Slovenia	40.8	50.6	9.8
Spain	46.2	59.6	13.4
Sweden	40.7	53.1	12.4
United Kingdom	48.6	56.8	8.2

Source: Eurostat (2014), *Self-reported use of prescribed medicines by sex, age and educational attainment level* [hlth_ehis_md1e].

Retrieved from: https://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=hlth_ehis_md1e&lang=en

The data are found in Eurostat (2020c).

Table III. 11. Self-reported use of non-prescribed medicines by sex, (%), 2014, 28 EU Member States

Region/Country	Men	Women	Gap
EU-28	29.1	40.1	11.0
Austria	27.2	40.1	12.9
Belgium	17	21.4	4.4
Bulgaria	30.3	43.2	12.9
Croatia	24.9	36.3	11.4
Cyprus	15.9	25.6	9.7
Czechia	36.7	54.7	18.0
Denmark	47.7	63.2	15.5
Estonia	37.1	53.9	16.8
Finland	59.9	80.5	20.6
France	22.3	32.6	10.3
Germany	35.7	49.5	13.8
Greece	23.3	30.3	7.0
Hungary	41.5	52.1	10.6
Ireland	24.5	35.8	11.3
Italy	16.8	22.3	5.5
Latvia	42.1	62	19.9
Lithuania	46.3	64.9	18.6
Luxembourg	32.1	38	5.9
Malta	28.8	38.1	9.3
Netherlands	30.8	46.7	15.9
Poland	42.6	59.5	16.9
Portugal	21.9	24.4	2.5
Romania	11	19.1	8.1
Slovakia	35.2	52.6	17.4
Slovenia	28.8	38.2	9.4
Spain	19	24.1	5.1
Sweden	34.6	45.9	11.3
United Kingdom	37.7	48.5	10.8

Source: Eurostat (2014), *Self-reported use of prescribed medicines by sex, age and educational attainment level* [hlth_ehis_md1e].

Retrieved from: https://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=hlth_ehis_md1e&lang=en

The data are found in Eurostat (2020c).

Table III. 12. Self-reported consultations – proportion of people having consulted a generalist medical practitioner during the four weeks prior to the survey, by sex, 2014, 28 EU Member States

Region/Country	Men	Women	Gap
EU-28	31.3	40.2	8.9
Austria	28.8	32.8	4.0
Bulgaria	31.1	43.7	12.6
Croatia	31.8	39.2	7.4
Cyprus	5.4	5.3	-0.1
Czechia	28.1	31.9	3.8
Denmark	30.8	42.8	12.0
Estonia	17.3	24.6	7.3
Finland	22.0	26.3	4.3
France	39.7	48.6	8.9
Germany	40.7	47.1	6.4
Greece	23.3	30.3	7.0
Hungary	34.5	43.7	9.2
Ireland	28.4	40.0	11.6
Italy	42.1	53.8	11.7
Latvia	21.5	33.5	12.0
Lithuania	30.0	42.5	12.5
Luxembourg	33.5	40.4	6.9
Malta	30.7	38.2	7.5
Netherlands	23.1	30.3	7.2
Poland	30.7	41.0	10.3
Portugal	20.0	29.5	9.5
Romania	17.2	26.6	9.4
Slovakia	24.1	32.1	8.0
Slovenia	29.2	35.0	5.8
Spain	24.6	33.2	8.6
Sweden	27.6	39.1	11.5
United Kingdom	23.4	33.3	9.9

Source: Eurostat (2014), Belgium not available. Self-reported consultations of a medical professional by sex, age and degree of urbanisation [hlth_ehis_am2u].

Retrieved from: https://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=hlth_ehis_am2u&lang=en.

The data are found in Eurostat (2020c).

Table III. 13. Self-reported consultations – proportion of people having consulted a psychologist, psychotherapist or psychiatrist during the 12 months prior to the survey, by sex, 2014, 28 EU Member States

Region/Country	Men	Women	Gap
EU-28	4.2	6.3	2.1
Austria	5.5	8.3	2.8
Belgium	4.3	5.2	0.9
Bulgaria	1.5	1.7	0.2
Croatia	4.4	3.0	-1.4
Cyprus	0.7	1.4	0.7
Czechia	1.8	2.7	0.9
Denmark	7.1	13.7	6.6
Estonia	4.8	5.7	0.9
Finland	5.8	10.0	4.2
France	4.5	7.4	2.9
Germany	7.7	11.0	3.3
Greece	3.3	6.0	2.7
Hungary	3.3	4.7	1.4
Ireland	5.5	7.3	1.8
Italy	2.7	4.0	1.3
Latvia	3.8	4.8	1.0
Lithuania	3.6	4.9	1.3
Luxembourg	6.6	9.7	3.1
Malta	4.8	4.4	-0.4
Netherlands	7.2	10.2	3.0
Poland	2.8	4.2	1.4
Portugal	4.0	7.6	3.6
Romania	0.3	0.3	0.0
Slovakia	2.7	3.9	1.2
Slovenia	1.7	2.5	0.8
Spain	3.5	5.7	2.2
Sweden	5.3	12.0	6.7
United Kingdom	3.1	4.0	0.9

Source: Eurostat (2014), Consultation of a medical doctor (in private practice or as outpatient) per inhabitant [hlth_hc_phys] Retrieved from: https://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=hlth_hc_phys&lang=en. The data are found in Eurostat (2020c)..

Table III. 14. Standardised incidence rate of accidents at work per 100,000 workers for women and men. 28 EU Member States

Region/Country	Total	Women	Men	Gap	% Difference
EU-28	1642	969	2047	-1078	-53%
Austria	1750	766	2450	-1684	-69%
Belgium	1519	838	1931	-1093	-57%
Bulgaria	83	43	114	-71	-62%
Croatia	989	669	903	-234	-26%
Cyprus	697	389	1126	-737	-65%
Czechia	953	706	2788	-2082	-75%
Denmark	1788	1074	2140	-1066	-50%
Estonia	1204	813	1520	-707	-47%
Finland	1964	1163	300	862	287%
France	3490	2340	3948	-1608	-41%
Germany	2091	1024	2415	-1391	-58%
Greece	241	140	4198	-4058	-97%
Hungary	569	426	1208	-783	-65%
Ireland	924	641	676	-35	-5%
Italy	1516	923	1120	-198	-18%
Latvia	248	160	1831	-1670	-91%
Lithuania	314	205	409	-204	-50%
Luxembourg	2256	1163	2786	-1623	-58%
Malta	1675	583	316	267	84%
Netherlands	1241	695	2164	-1469	-68%
Poland	535	420	1522	-1103	-72%
Portugal	3677	2179	610	1569	257%
Romania	86	44	4648	-4604	-99%
Slovakia	526	380	119	261	220%
Slovenia	1659	917	887	30	3%
Spain	3151	1797	2103	-307	-15%
Sweden	769	551	642	-91	-14%
United Kingdom	918	592	1097	-505	-46%

Source: European Core Health Indicators. (2015). Standardised incidence rate of accidents at work per 100,000 workers. Retrieved from https://ec.europa.eu/health/indicators_data/indicators_en

Figures reflect the number of persons involved in accidents at work resulting in more than 3 days absence (serious accidents) per 100,000 persons in employment. Includes accidents that lead to physical or mental health harm, which happen inside or outside the premises of the employer (including public spaces, roads and the home) as part of the course of work. Excludes: accidents on the way to or from work, deliberate self-inflicted injuries, injuries from a medical condition (e.g. heart attack) and occupational diseases.

Table III. 15. Proportion (%) of men and women aged 15 to 64 years reporting a work-related health problem. 28 EU Member States, 2013

Region/Country	Total	Women	Men	Gap	% Difference
EU-28	7.9	8.3	7.6	0.7	9%
Austria	15.3	15.1	15.5	-0.4	-3%
Belgium	8.3	8.3	8.3	0.0	0%
Bulgaria	4.9	5.0	4.9	0.1	2%
Croatia	7.4	6.6	8.1	-1.5	-19%
Cyprus	5.9	5.7	6.0	-0.3	-5%
Czechia	5.5	5.6	5.5	0.1	2%
Denmark	6.4	7.2	5.6	1.6	29%
Estonia	7.1	6.4	7.7	-1.3	-17%
Finland	25.8	30.0	21.6	8.4	39%
France	12.3	13.4	11.2	2.2	20%
Germany	9.1	9.7	8.6	1.1	13%
Greece	6.2	6.0	6.3	-0.3	-5%
Hungary	5.1	4.9	5.4	-0.5	-9%
Ireland	1.6	1.6	1.6	0.0	0%
Italy	5.0	4.8	5.2	-0.4	-8%
Latvia	7.3	7.7	6.9	0.8	12%
Lithuania	2.2	1.8	2.7	-0.9	-33%
Luxembourg	6.7	7.4	6.0	1.4	23%
Malta	2.5	1.5	3.3	-1.8	-55%
Netherlands	n/a	n/a	n/a	n/a	n/a
Poland	14.0	13.4	14.5	-1.1	-8%
Portugal	6.3	7.0	5.5	1.5	27%
Romania	1.7	1.8	1.7	0.1	6%
Slovakia	9.6	9.4	9.8	-0.4	-4%
Slovenia	6.2	6.9	5.6	1.3	23%
Spain	4.8	5.0	4.7	0.3	6%
Sweden	21.1	25.3	17.0	8.3	49%
United Kingdom	3.5	3.5	3.5	0.0	0%

Source: Eurostat. Labour Force Survey ad-hoc 2013 module Source: Labour Force Survey ad-hoc 2013 module. Eurostat. (2013). Persons reporting a work-related health problem by sex, age and educational attainment level [hsw_pb1]. Retrieved from https://ec.europa.eu/eurostat/data/database?node_code=hsw_pb1

Proportion of persons in employment having had one or more work-related physical or mental health problems in the last 12 months caused or made worse by work. Excludes injured people because of accidents at work in the last 12 months. Health problems include cardiovascular disorders, hearing disorders, pulmonary disorders, musculo-skeletal disorders, infectious diseases, stomach, liver, kidney or digestive problem, stress, depression, anxiety, skin problems, headache, and eyestrain. No data on The Netherlands.

Table III. 16. Physicians by sex, (%), 201, 28 EU Member States

Region/Country	Men	Women	Gap
EU-28	50.4	49.6	-0.8
Austria	52.6	47.4	-5.3
Belgium	57.1	42.9	-14.2
Bulgaria	44.5	55.5	11.0
Croatia	36.8	63.2	26.4
Cyprus	62.2	37.8	-24.5
Denmark	48.1	51.9	3.9
Estonia	26.0	74.0	48.0
France	55.5	44.5	-11.0
Germany	53.4	46.6	-6.7
Greece	58.0	42.0	-16.0
Hungary	43.9	56.1	12.2
Ireland	56.1	43.9	-12.2
Italy	57.7	42.3	-15.4
Latvia	25.7	74.3	48.5
Lithuania	30.6	69.4	38.7
Luxembourg	64.3	35.7	-28.7
Malta	58.7	41.3	-17.3
Netherlands	45.4	54.6	9.2
Poland	43.2	56.8	13.7
Portugal	44.9	55.1	10.2
Romania	30.2	69.8	39.7
Slovakia	42.2	57.8	15.5
Slovenia	37.0	63.0	26.0
Spain	44.7	55.3	10.6
Sweden	51.3	48.7	-2.6
United Kingdom	51.9	48.1	-3.7

Source: Eurostat (2017), Physicians by sex and age [hlth_rs_phys].

Notes: Czechia and Finland are not available. (1) Estimates, (2) 2016, (3) 2015.

Retrieved from http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=hlth_rs_phys&lang=en

The data are found in Eurostat (2020c).

Table III. 17. Proportion (%) of men and women aged 16 years and over self-reporting unmet needs for medical examination. 28 EU Member States, 2018/2019

Region/Country	Total	Women	Men	Gap	% Difference
EU-28	2.3	2.6	1.9	0.7	37%
Austria	0.2	0.2	0.3	-0.1	-33%
Belgium	1.9	2.1	1.6	0.5	31%
Bulgaria	1.5	1.3	1.7	-0.4	-24%
Croatia	2.2	2.4	2.0	0.4	20%
Cyprus	1.4	1.4	1.5	-0.1	-7%
Czechia	0.7	0.7	0.6	0.1	17%
Denmark	2.7	2.7	2.9	-0.2	-7%
Estonia	16.7	18.0	14.9	3.1	21%
Finland	4.6	5.6	3.7	1.9	51%
France	1.7	1.9	1.4	0.5	36%
Germany	0.3	0.3	0.3	0.0	0%
Greece	9.0	10.1	7.9	2.2	28%
Hungary	2.3	2.3	2.3	0.0	0%
Ireland	2.1	2.2	1.8	0.4	22%
Italy	2.5	2.8	2.1	0.7	33%
Latvia	5.0	5.7	4.2	1.5	36%
Lithuania	2.3	2.5	2.0	0.5	25%
Luxembourg	0.5	0.6	0.4	0.2	50%
Malta	0.2	0.3	0.1	0.2	200%
Netherlands	0.2	0.1	0.2	-0.1	-50%
Poland	5.6	6.0	5.1	0.9	18%
Portugal	2.5	3.0	1.8	1.2	67%
Romania	5.3	6.3	4.1	2.2	54%
Slovakia	3.7	3.9	3.6	0.3	8%
Slovenia	3.4	4.0	2.9	1.1	38%
Spain	0.3	0.2	0.3	-0.1	-33%
Sweden	1.7	1.8	1.5	0.3	20%
United Kingdom	4.8	5.5	4.0	1.5	38%

Source: European Statistics of Income and Living Condition (EU-SILC) survey. Eurostat. (2018/2019). Self-reported unmet needs for medical examination by sex, age, main reason declared and educational attainment level [hlth_silc_14]. Data for Poland, Latvia, Finland, Denmark and Bulgaria are from 2019.

Retrieved from https://ec.europa.eu/eurostat/data/database?node_code=hlth_silc_14.

n/a: not applicable. Gap, in percentage points, between women and men. Percentage difference between women and men. Data for Poland, Latvia, Finland, Denmark and Bulgaria are for 2019. Respondent's assessment of not getting a needed a medical examination of treatment. Sum of responses across "Reasons of barriers of access" ('Could not afford to (too expensive)', 'Waiting list' and 'Too far to travel or no means of transportation') and not being able to take time because of work, care for children or for others. Excludes dental examination and treatment.

Table III. 18. Proportion (%) of men and women aged 65 years and over self-reporting unmet needs for medical examination. 28 EU Member States, 2018/2019

Region/Country	Total	Women	Men	Gap	% Difference
EU-28	2.7	3.2	2.1	1.1	52%
Austria	0.1	0.2	0.2	0.0	0%
Belgium	0.9	0.7	1.0	-0.3	-30%
Bulgaria	2.1	2.2	2.1	0.1	5%
Croatia	3.6	3.9	2.9	1.0	34%
Cyprus	0.8	0.9	0.8	0.1	13%
Czechia	0.4	0.5	0.3	0.2	67%
Denmark	0.8	0.9	0.8	0.1	13%
Estonia	19.6	20.8	17.0	3.8	22%
Finland	8.0	8.8	7.0	1.8	26%
France	0.4	0.5	0.2	0.3	150%
Germany	0.0	0.0	0.1	-0.1	-100%
Greece	13.2	14.4	11.8	2.6	22%
Hungary	1.7	1.8	1.4	0.4	29%
Ireland	2.5	2.6	2.5	0.1	4%
Italy	3.8	4.2	3.3	0.9	27%
Latvia	6.5	7.4	4.5	2.9	64%
Lithuania	3.6	3.5	3.9	-0.4	-10%
Luxembourg	0.1	0.3	0.0	0.3	n/a
Malta	0.2	0.2	0.1	0.1	100%
Netherlands	0.1	0.0	0.2	-0.2	-100%
Poland	5.8	6.5	4.7	1.8	38%
Portugal	3.1	4.0	1.6	2.4	150%
Romania	12.0	13.9	9.0	4.9	54%
Slovakia	4.5	4.5	4.5	0.0	0%
Slovenia	4.7	4.5	4.9	-0.4	-8%
Spain	0.1	0.1	0.0	0.1	n/a
Sweden	1.3	2.0	0.4	1.6	400%
United Kingdom	4.5	5.3	3.5	1.8	51%

Source: Eurostat. European Statistics of Income and Living Condition (EU-SILC) survey. Data for Bulgaria, Denmark, Finland, Latvia and Poland are from 2019.

n/a: not applicable. Gap, in percentage points, between women and men. Percentage difference between women and men. Data for Poland, Latvia, Finland, Denmark and Bulgaria are for 2019. Respondent's assessment of not getting a needed a medical examination of treatment. Sum of responses across "Reasons of barriers of access" ('Could not afford to (too expensive)', 'Waiting list' and 'Too far to travel or no means of transportation') and not being able to take time because of work, care for children or for others. Excludes dental examination and treatment.

Table III. 19. Proportion of women aged 18–49 years ever having been the victim of physical or sexual violence by a partner. 28 EU Member States, 2012

Country	Proportion
Austria	4
Belgium	8
Bulgaria	9
Croatia	4
Cyprus	3
Czechia	6
Denmark	7
Estonia	4
Finland	8
France	7
Germany	5
Greece	8
Hungary	8
Ireland	4
Italy	7
Latvia	7
Lithuania	6
Luxembourg	3
Malta	5
Netherlands	7
Poland	3
Portugal	6
Romania	7
Slovakia	8
Slovenia	2
Spain	2
Sweden	6
United Kingdom	6

Source: 2012 European Union Agency for Fundamental Rights (FRA) Violence against women: an EU-wide survey.

WHO. (2012). Intimate partner violence prevalence.

Data by country. Retrieved from <https://apps.who.int/gho/data/view.main.IPVv?lang=en>

Proportion of ever-partnered women and girls aged 18–49 years subjected to physical and/or sexual violence by a current or former intimate partner in the previous 12 months. Observations for Croatia, Cyprus, Denmark, Estonia, Ireland, Luxembourg, Poland, Slovenia, Spain are based on fewer than 30 responses.

Table III. 20. Persons employed ISCO3D: 532, Personal care workers in health services, year 2019.

Region/ Country	Total	Women	Men	Ratio of women to men	Women share of total
EU-28	5,339.5	4,577.1	762.3	6.0	86%
Austria	101.3	87.3	14.0	6.2	86%
Belgium	111.3	104.1	7.2	14.4	94%
Bulgaria	42.0	37.0	5.0 ^u	7.4 ^u	88%
Croatia	19.6	19.1	n/a	n/a	97%
Cyprus	2.3	2.2	n/a	n/a	96%
Czechia	101.7	84.3	17.4	4.8	83%
Denmark	126.5	105.8	20.7	5.1	84%
Estonia	11.9	11.0	n/a	n/a	93%
Finland	120.7	103.3	17.3	6.0	86%
France	642.5	566.3	76.2	7.4	88%
Germany	426.0	348.2	77.8	4.5	82%
Greece	14.6	11.4	3.3 ^u	3.5 ^u	78%
Hungary	31.1	23.4	7.7	3.1	75%
Ireland	74.9	59.0	15.9	3.7	79%
Italy	694.5	606.6	87.9	6.9	87%
Latvia	10.7	9.8	n/a	n/a	92%
Lithuania	13.1	11.8	1.4 ^u	8.6 ^u	90%
Luxembourg	4.1	3.7	n/a	n/a	90%
Malta	7.1	5.0	2.1	2.3	70%
Netherlands	265.3	245.2	20.1	12.2	92%
Poland	48.5	43.9	n/a	n/a	90%
Portugal	124.4	119.1	5.2	22.8	96%
Romania	104.5	91.5	13.1	7.0	88%
Slovakia	64.5	55.8	8.7	6.4	87%
Slovenia	8.2	7.2	0.9 ^u	7.9 ^u	89%
Spain	547.9	491.9	56.1	8.8	90%
Sweden	351.7	281.7	70.1	4.0	80%
United Kingdom	1,268.6	1,041.6	227.0	4.6	82%

^u= low reliability.. n/a: not available. As of 1 February 2020, the United Kingdom is no longer part of the European Union

Table III. 21. Persons employed ISCO3D: 322, Nursing and midwifery associate professionals, year 2019

Region/Country	Total	Women	Men	Ratio of women to men	Women share of total
EU-28	2,835.9	2,383.1	452.9	5.3	84%
Austria	n/a	n/a	n/a	n/a	n/a
Belgium	52.1	47.8	4.3 ^u	11.3 ^u	92%
Bulgaria	n/a	n/a	n/a	n/a	n/a
Croatia	25.4	22.5	2.9 ^u	7.7 ^u	89%
Cyprus	n/a	n/a	n/a	n/a	n/a
Czechia	51.0	50.5	0.6 ^u	85.8 ^u	99%
Denmark	n/a	n/a	n/a	n/a	n/a
Estonia	4.1	3.9	n/a	n/a	97%
Finland	71.5	64.3	7.2	9.0	90%
France	515.3	434.3	81.0	5.4	84%
Germany	1,418.2	1,195.1	223.1	5.4	84%
Greece	42.5	37.1	5.4	6.9	87%
Hungary	49.3	44.1	5.2	8.5	89%
Ireland	n/a	n/a	n/a	n/a	n/a
Italy	411.4	308.0	103.4	3.0	75%
Latvia	4.7	4.7	n/a	n/a	100%
Lithuania	n/a	n/a	n/a	n/a	n/a
Luxembourg	2.0	1.6	n/a	n/a	80%
Malta	2.2	0.9 ^u	1.3	0.7 ^u	41% ^u
Netherlands	70.2	61.6	8.5	7.2	88%
Poland	n/a	n/a	n/a	n/a	n/a
Portugal	n/a	n/a	n/a	n/a	n/a
Romania	46.3	42.6	n/a	n/a	92%
Slovakia	50.6	48.9	n/a	n/a	97%
Slovenia	14.3	11.1	3.2 ^u	3.5 ^u	78%
Spain	n/a	n/a	n/a	n/a	n/a
Sweden	n/a	n/a	n/a	n/a	n/a
United Kingdom	n/a	n/a	n/a	n/a	n/a

^u= low reliability.. n/a: not available. As of 1 February 2020, the United Kingdom is no longer part of the European Union

Table III. 22. Persons employed ISCO3D: 226, Other health professionals including Dentists, Pharmacists, year 2019

Region/Country	Total	Women	Men	Ratio of women to men	Women share of total
EU-28	2,283.6	1,611.6	672.0	2.4	71%
Austria	37.3	27.5	9.8	2.8	74%
Belgium	87.5	62.2	25.3	2.5	71%
Bulgaria	21.1	15.0	6.2 ^u	2.4 ^u	71%
Croatia	8.0 ^u	5.9 ^u	2.0 ^u	2.9 ^u	74% ^u
Cyprus	3.6	2.1	1.5	1.3	57%
Czechia	28.9	20.1	8.8	2.3	69%
Denmark	42.0	32.3	9.7	3.3	77%
Estonia	4.7	4.1	n/a	n/a	86%
Finland	14.0	11.3	2.7 ^u	4.1 ^u	80%
France	255.4	164.6	90.8	1.8	64%
Germany	492.8	356.0	136.8	2.6	72%
Greece	41.5	23.8	17.7	1.3	57%
Hungary	28.1	22.0	6.0	3.6	78%
Ireland	21.0	15.8	5.2 ^u	3.0 ^u	75%
Italy	147.4	72.0	75.4	1.0	49%
Latvia	5.1	4.9	n/a	n/a	96%
Lithuania	10.8	10.0	n/a	n/a	92%
Luxembourg	2.7	1.8	0.9 ^u	2.1 ^u	68%
Malta	2.1	1.5	0.6 ^u	0.6 ^u	70%
Netherlands	98.7	67.7	31.0	2.2	69%
Poland	175.7	142.9	32.9	4.3	81%
Portugal	55.1	43.2	11.9	3.6	78%
Romania	43.6	33.5	10.1 ^u	3.3 ^u	77%
Slovakia	14.1	10.6	3.5 ^u	3.0 ^u	75%
Slovenia	11.6	8.8	2.7 ^u	3.2 ^u	76%
Spain	215.9	150.7	65.3	2.3	70%
Sweden	64.7	47.6	16.9	2.8	74%
United Kingdom	350.1	253.6	96.4	2.6	72%

^u= low reliability.. n/a: not available. As of 1 February 2020, the United Kingdom is no longer part of the European Union

Table III. 23. Persons employed ISCO3D: 222, Nursing and midwifery professionals, year 2019

Region/Country	Total	Women	Men	Ratio of women to men	Women share of total
EU-28	2,333.9	2,070.5	263.4	7.9	89%
Austria	96.1	84.1	12.0	7.0	88%
Belgium	87.7	76.6	11.0	6.9	87%
Bulgaria	36.7	36.4	n/a	n/a	99%
Cyprus	5.2	3.5	1.6	2.2	68%
Czechia	50.5	48.4	2.1 ^u	23.1 ^u	96%
Germany	38.1	34.2	n/a	n/a	90%
Denmark	68.3	65.0	3.3 ^u	19.8 ^u	95%
Estonia	4.9	4.6	n/a	n/a	94%
Spain	287.0	236.4	50.7	4.7	82%
Finland	4.9	4.5	n/a	n/a	91%
France	141.2	122.5	18.7	6.6	87%
Greece	13.3	10.8	2.4 ^u	4.4 ^u	82%
Croatia	13.2	10.9	2.3 ^u	4.8 ^u	83%
Hungary	8.9	8.1	n/a	n/a	91%
Ireland	65.7	58.4	7.4	7.9	89%
Italy	n/a	n/a	n/a	n/a	n/a
Lithuania	22.4	22.3	n/a	n/a	99%
Luxembourg	1.5	1.3	n/a	n/a	88%
Latvia	5.8	5.8	n/a	n/a	n/a
Malta	4.0	2.5	1.5	1.7	63%
Netherlands	137.9	120.3	17.6	6.8	87%
Poland	227.8	223.7	n/a	n/a	98%
Portugal	74.6	60.3	14.3	4.2	81%
Romania	80.2	70.3	9.9 ^u	7.1 ^u	88%
Sweden	121.9	109.0	13.0	8.4	89%
Slovenia	5.8	5.3	n/a	n/a	92%
Slovakia	7.3	6.5	n/a	n/a	90%
United Kingdom	722.8	638.7	84.1	7.6	88%

^u= low reliability. n/a: not available. As of 1 February 2020, the United Kingdom is no longer part of the European Union

Table III. 24. Persons employed ISCO3D: 221, Medical Doctors: including Generalist medical practitioners and Specialist medical practitioners, year 2019

Region/Country	Total	Women	Men	Ratio of women to men	Women share of total
EU-28	2,120.6	1,095.3	1,025.3	1.1	52%
Austria	47.8	21.6	26.2	0.8	45%
Belgium	35.5	18.8	16.6	1.1	53%
Bulgaria	27.5	15.2	12.2	1.2	55%
Croatia	15.8	12.5	3.2 ^u	3.9 ^u	80%
Cyprus	2.2	0.9 ^u	1.3 ^u	0.7 ^u	40% ^u
Czechia	42.9	24.1	18.7	1.3	56%
Denmark	26.6	14.6	11.9	1.2	55%
Estonia	3.9	3.1	n/a	n/a	80%
Finland	24.9	14.5	10.3	1.4	58%
France	248.8	123.3	125.4	1.0	50%
Germany	402.5	189.4	213.1	0.9	47%
Greece	58.4	24.9	33.5	0.7	43%
Hungary	30.7	18.5	12.2	1.5	60%
Ireland	16.4	7.4	9.0	0.8	45%
Italy	245.2	111.8	133.4	0.8	46%
Latvia	5.4	4.7	n/a	n/a	86%
Lithuania	14.9	9.9	4.9	2.0	67%
Luxembourg	2.5	1.0	1.5	0.7	40%
Malta	1.9	1.0 ^u	0.9 ^u	1.2 ^u	54% ^u
Netherlands	101.4	61.9	39.5	1.6	61%
Poland	99.5	60.0	39.5	1.5	60%
Portugal	40.4	24.3	16.0	1.5	60%
Romania	50.8	32.8	18.0	1.8	65%
Slovakia	18.2	11.6	6.5	1.8	64%
Slovenia	7.0	4.3	2.6 ^u	1.6 ^u	62%
Spain	218.0	123.6	94.5	1.3	57%
Sweden	51.9	26.6	25.2	1.1	51%
United Kingdom	279.9	132.5	147.4	0.9	47%

^u= low reliability.. n/a: not available.

As of 1 February 2020, the United Kingdom is no longer part of the European Union

REFERENCES

Artazcoz, L., Borrell, C., Benach, J., Cortès, I., Rohlfs, I. (2004), 'Women, family demands and health: the importance of employment status and socio-economic position', *Social Science & Medicine*, Vol. 59, No 2, pp. 263–274.

Austad, S. and Fischer, K. (2016), 'Sex differences in life span', *Cell Metabolism*, Vol. 23, No 6, pp. 1022–1033.

Backhans, M.C., Lundberg, M. and Månsdotter, A. (2007), 'Does increased gender equality lead to a convergence of health outcomes for men and women? A study of Swedish municipalities', *Social Science & Medicine*, Vol. 64, No 9, pp. 1892–1903.

Bambra, C. (2010), 'Yesterday once more? Unemployment and health in the 21st century', *Journal of Epidemiology & Community Health*, Vol. 64, No 3, pp. 213–215.

Bambra, C. (2019), *Health in hard times: Austerity and health inequalities*, Policy Press, Bristol.

Bambra, C., Pope, D., Swami, V., Stanistreet, D., Roskam, A., Kunst, A. and Scott-Samuel, A. (2009), 'Gender, health inequality and welfare state regimes: A cross-national study of thirteen European countries', *Journal of Epidemiology & Community Health*, Vol. 63, No 1, pp. 4–11.

Bambra, C., Albani, V. & Franklin, P. (2020) COVID-19 and the gender health paradox. *Scandinavian Journal of Public Health* 1-10. Available at <https://doi.org/10.1177%2F1403494820975604>

Bambra, C., Riordan, R., Ford, J. and Matthews, F. (2020), 'The COVID-19 pandemic and health inequalities', *Journal of Epidemiology and Community Health*, advance online publication, available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7298201/>.

BBC News (2020), *Thousands missing out on cancer diagnosis*, available at: <https://www.bbc.co.uk/news/health-52382303>.

Beckfield, J., Morris, K.A. and Bambra, C. (2017), 'How social policy contributes to the distribution of population health: the case of gender health equity', *Scandinavian Journal of Public Health*, Vol. 46, No 1, pp. 6–17.

Benach, J., Vives, A., Amable, M., Vanroelen, C., Tarafa, G. and Muntaner, C. (2014), 'Precarious employment: Understanding an emerging social determinant of health', *Annual Review of Public Health*, Vol. 35, No 1, pp. 229–253.

Bird, C.E. and Rieker, P.P. (2008), *Gender and health: The effects of constrained choices and social policies*, Cambridge University Press, Cambridge.

Boerma, T., Hosseinpoor, A.R., Verdes, E. and Chatterji, S. (2016), 'A global assessment of the gender gap in self-reported health with survey data from 59 countries', *BMC Public Health*, Vol. 16, pp. 1–9.

Bohren, M.A., Vogel, J.P., Hunter, E.C., Lutsiv, O., Makh, S.K., Souza, J.P., Aguiar, C., Saraiva Coneglian, F., Araújo Diniz, A.L., Tunçalp, Ö., Javadi, D., Oladapo, O.T., Khosla, R., Hindin, M.J. and Gülmezoglu, A.M. (2015), 'The mistreatment of women during childbirth in health facilities globally: A mixed-methods systematic review', *PLOS Medicine*, Vol. 12, No 6, available at: <https://doi.org/10.1371/journal.pmed.1001847>.

Bratberg, G.H., Wilsnack, S.C., Wilsnack, R., Håvås Haugland, S., Krokstad, S., Reidar Sund E. and Haakon Bjørngaard, J. (2016), 'Gender differences and gender convergence in alcohol use over the past three decades (1984–2008), The HUNT Study, Norway', *BMC Public Health*, Vol. 16, available at: <https://bmcpublichealth.biomed-central.com/articles/10.1186/s12889-016-3384-3>.

CCDC weekly (2020), *Vital surveillances: The epidemiological characteristics of an outbreak of 2019 novel Coronavirus diseases (COVID-19) — China, 2020*, available at: <http://weekly.chinacdc.cn/en/article/id/e53946e2-c6c4-41e9-9a9b-fea8d-b1a8f51>.

Center for Reproductive Rights (2012), *Access to Contraceptives in the European Union. Human Rights, Barriers and Good Practices*, available at: https://reproductiverights.org/sites/default/files/documents/crr_eu_contraception_factsheet_v2.pdf.

Center for Reproductive Rights (2018), *Perilous journeys: Barriers in access to affordable maternal healthcare for undocumented migrant women in the European Union*, available at: <https://reproductiverights.org/sites/default/files/documents/Perilous-Pregnancies-Health-Care-For-Undocumented-Migrant-Women-EU.pdf>.

Constantine, G.D., Graham, S., Clerinx, C., Bernick, B.A., Krassan, M., Mirkin, S. and Currie, H. (2016), 'Behaviours and attitudes influencing treatment decisions for menopausal symptoms in five European countries', *Post Reproductive Health*, Vol. 22, No 3, pp. 112–122.

Contraception Atlas (2018), *Limited access: Europe's contraception deficit. White paper*, available at: https://www.contraceptioninfo.eu/sites/contraceptioninfo.eu/files/786209755_epf_contraception-in-europe_white-paper_cc03_002.pdf.

Contraception Atlas (2019), *Tracking government policies on access to contraceptive supplies, family planning counselling and the provision of online information on contraception*, available at: https://www.contraceptioninfo.eu/sites/contraceptioninfo.eu/files/map_cci-english_english_v9-web.pdf.

Council of Europe (2017), *Women's sexual and reproductive health and rights in Europe*, Council of Europe, Strasbourg, available at: <https://rm.coe.int/women-s-sexual-and-reproductive-health-and-rights-in-europe-issue-pape/168076dead>.

Council of Europe (2020), *COVID-19: Ensure women's access to sexual and reproductive health and rights. Statement*, available at: <https://www.coe.int/en/web/commissioner/-/Covid-19-ensure-women-s-access-to-sexual-and-reproductive-health-and-rights>.

Council of Europe (undated), 'Intercultural cities: good practice examples', available at: <https://www.coe.int/en/web/interculturalcities/-/women-health-and-violence>. Debrečéniová, J. (ed.) (2015), *Ženy. Matky. Telá*, Občan, demokracia a zodpovednosť.

Delay, C. and Sundstrom, B. (2019), 'The legacy of symphysiotomy in Ireland: A reproductive justice approach to obstetric violence, reproduction, health, and medicine', *Advances in Medical Sociology*, Vol. 20, pp. 197–218.

Deutscher HebammenVerband e.V. (2012), *Empfehlungen für traumasensible Begleitung durch Hebammen*, available at: https://www.hebammenverband.de/index.php?eID=tx_securedownloads&p=2718&u=0&g=0&t=1609156943&hash=1212145804e3f22ec3c55d08a0645918a89a73d8&file=/fileadmin/user_upload/pdf/Empfehlungen/Empfehlungen_fur_traumasensible_Begleitung_durch_Hebammen_11122012_web.pdf.

Doroszewska, A. (2018), *Raport z monitoringu oddziałów położniczych. Opieka okołoporodowa w Polsce w świetle doświadczeń kobiet*, Fundacja Rodzić po Ludzku, Warsaw, available at: https://www.rodzicpoludzku.pl/images/RAPORT_FRpL_2018.pdf.

Doyal L. (1995), *What makes women sick: Gender and the political economy of health*, Rutgers University Press, New Brunswick (NJ).

Drglin, Z. and Šimnovec, I. (forthcoming), 'Zero tolerance for violence during childbirth. Database on violence and inappropriate practices in perinatal care in Slovenia', *Natural Beginnings*.

ECDC (2020a), *Rapid Risk Assessment: Coronavirus disease 2019 (COVID-19) in the EU/EEA and the UK – Eleventh update: Resurgence of cases*, available at: <https://www.ecdc.europa.eu/en/publications-data/rapid-risk-assessment-coronavirus-disease-2019-Covid-19-eueea-and-uk-eleventh>.

ECDC (2020b), *Surveillance of COVID-19 at long-term care facilities in the EU/EEA*, available at: <https://www.ecdc.europa.eu/sites/default/files/documents/Covid-19-long-term-care-facilities-surveillance-guidance.pdf>.

EIGE (a), *Beijing Platform for Action*, available at: <https://eige.europa.eu/beijing-platform-for-action>.

EIGE (b), *COVID-19 and frontline workers*, available at: <https://eige.europa.eu/Covid-19-and-gender-equality/frontline-workers>.

EIGE (c), *Gender Equality Index 2019. Work-life Balance. Transport and public infrastructure*, available at: <https://eige.europa.eu/publications/gender-equality-index-2019-report/transport-and-public-infrastructure>.

EIGE (d), *Gender statistics database. Employment in human health activities by sex and age (from 2008 onwards) – 1,000*, available at: https://eige.europa.eu/gender-statistics/dgs/indicator/ta_wrklab_lab_employ_selected_healthcare_ifsa_eqa22d_hlth/bar/year:2008/geo:EU28,EU15,EA19,BE,BG,CZ,DK,DE,EE,IE,EL,ES,FR,HR,IT,CY,LV,LT,LU,HU,MT,NL,AT,PL,PT,RO,SI,SK,FI,SE,UK,IS,NO,CH,ME,MK,RS,TR/nace_r2:Q86/age:Y15-64/unit:THS/sex:M,W_.

EIGE (2018), *Estimation of girls at risk of female genital mutilation in the European Union. Belgium, Greece, France, Italy, Cyprus and Malta. Report*, Vilnius, available at: <https://eige.europa.eu/publications/estimation-girls-risk-female-genital-mutilation-european-union-report-0>.

EIGE (2019), *Intersecting inequalities Gender Equality Index*, Publications Office of the European Union, Luxembourg, available at: <https://eige.europa.eu/publications/intersecting-inequalities-gender-equality-index>.

EIGE (2020a), *Beijing +25: the fifth review of the implementation of the Beijing Platform for Action in the EU Member States*, Publications Office of the European Union, Luxembourg, available at: <https://eige.europa.eu/publications/beijing-25-fifth-review-implementation-beijing-platform-action-eu-member-states>.

EIGE (2020b), *Beijing + 25: the fifth review of the implementation of the Beijing Platform for Action in the EU Member States. Area C – Health of women: achieving gender equality in treatments, services and outcomes*, available at: <https://eige.europa.eu/publications/beijing-25-policy-brief-area-c-health-women>.

EIGE (2020c), *Gender equality and long-term care at home*, Publications Office of the European Union, Luxembourg, 2020, available at: <https://eige.europa.eu/publications/gender-equality-and-long-term-care-home>.

ETUI (2018), *HesaMag#17, All that glitters is not gold: The dark side of the beauty industry*, available at: <https://www.etui.org/Topics/Health-Safety-working-conditions/HesaMag/All-that-glitters-is-not-gold-the-dark-side-of-the-beauty-industry>.

Eurofound (2012), *Working conditions in the retail sector*, available at: <https://www.eurofound.europa.eu/publications/report/2012/working-conditions-in-the-retail-sector>.

Eurofound (2020), *Working conditions, Gender equality at work*, Publications Office of the European Union, Luxembourg, available at: https://www.eurofound.europa.eu/sites/default/files/ef_publication/field_ef_document/ef19003en.pdf.

European Commission (2009), *Access to healthcare and long-term care: Equal for women and men?*, Publications Office of the European Union, Luxembourg, available at: <https://ec.europa.eu/social/BlobServlet?docId=5590>.

European Commission (2014), *Roma health report. Health status of the Roma population. Data collection in the Member States of the European Union*, available at: https://ec.europa.eu/health/sites/health/files/social_determinants/docs/2014_roma_health_report_en.pdf.

European Commission (2017a), *Analysis and comparative review of equality data collection practices in the European Union. Equality data indicators: Methodological approach overview per EU Member State. Technical annex*, Publications Office of the European Union, Luxembourg, available at: <https://op.europa.eu/en/publication-detail/-/publication/1dcc2e44-4370-11ea-b81b-01aa75ed71a1/language-en>.

European Commission (2017b), *Project brochure GenCAD*, available at: https://ec.europa.eu/health/sites/health/files/social_determinants/docs/2017_gencad_brochure_en.pdf.

European Commission (2017c), *TASK 1: State-of-the-art study focusing on the health inequalities faced by LGBTI people. D1.1 State-of-the-Art Synthesis Report (SSR)*, available at: https://ec.europa.eu/health/sites/health/files/social_determinants/docs/stateofart_report_en.pdf.

European Commission (2018a), *2018 Report on equality between women and men in the EU*, Publications Office of the European Union, Luxembourg, available at: <https://op.europa.eu/en/publication-detail/-/publication/950dce57-6222-11e8-ab9c-01aa75ed71a1>.

European Commission (2018b), *A decomposition of the unadjusted gender pay gap using Structure of Earnings Survey data*, Publications Office of the European Union, Luxembourg, available at: <https://ec.europa.eu/eurostat/documents/3888793/8979317/KS-TC-18-003-EN-N.pdf/3a6c9295-5e66-4b79-b009-ea1604770676>.

European Commission (2018c), *Inequalities in access to healthcare. A study of national policies*, available at: <https://ec.europa.eu/social/main.jsp?catId=738&langId=en&pubId=8152&furtherPubs=yes>.

European Commission (2018d), *Reducing health inequalities experienced by LGBTI people: What is your role as a health professional? Trainers' manual*, revised in 2020, available at: https://ec.europa.eu/health/sites/health/files/social_determinants/docs/2018_lgbti_trainersmanual_en.pdf.

European Commission (2020), *European Commission report on the impact of demographic change*, available at: https://ec.europa.eu/info/files/report-impact-demographic-change-reader-friendly-version-0_en.

European Gender Medicine Network (EUGenMed) (2016), *Final Report Summary – EUGENMED (European Gender Medicine Network)*, available at: <https://cordis.europa.eu/project/id/602050/reporting>.

European Observatory of Health Systems and Policies (2017), *Implementation of the right to healthcare under the UN Convention on the Rights of the Child status report for the European Union*, available at: <https://www.euro.who.int/en/about-us/partners/observatory/publications/studies/implementation-of-the-right-to-health-care-under-the-un-convention-on-the-rights-of-the-child-2017>.

European Parliament (2018a), *Bullying and sexual harassment at the workplace, in public spaces, and in political life in the EU*, available at: [https://www.europarl.europa.eu/RegData/etudes/STUD/2018/604949/IPOL_STU\(2018\)604949_EN.pdf](https://www.europarl.europa.eu/RegData/etudes/STUD/2018/604949/IPOL_STU(2018)604949_EN.pdf).

European Parliament (2018b), *Sexual and reproductive health rights and the implication of conscientious objection*, available at: [https://www.europarl.europa.eu/RegData/etudes/STUD/2018/604969/IPOL_STU\(2018\)604969_EN.pdf](https://www.europarl.europa.eu/RegData/etudes/STUD/2018/604969/IPOL_STU(2018)604969_EN.pdf).

European Parliament (2019), *Access to maternal health and midwifery for vulnerable groups in the EU*, available at: [https://www.europarl.europa.eu/RegData/etudes/STUD/2019/608874/IPOL_STU\(2019\)608874_EN.pdf](https://www.europarl.europa.eu/RegData/etudes/STUD/2019/608874/IPOL_STU(2019)608874_EN.pdf).

Eurostat (2019), *How do women and men use their time – Statistics*, available at: https://ec.europa.eu/eurostat/statistics-explained/index.php?title=How_do_women_and_men_use_their_time_-_statistics#Women_are_more_involved_in_household_and_family_care_activities.

Eurostat (2020a), *Asylum Statistics*, available at: http://ec.europa.eu/eurostat/statistics-explained/index.php/Asylum_statistics.

Eurostat (2020b), *Migration and migrant population statistics*, https://ec.europa.eu/eurostat/statistics-explained/index.php/Migration_and_migrant_population_statistics.

Eurostat (2020c), *Health in the European Union – facts and figures*, available at: https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Health_in_the_European_Union_%E2%80%93_facts_and_figures.

Fjær, E.L., Stornes, P., Borisova, L.V., McNamara, C.L. and Eikemo, T.A. (2017), ‘Subjective perceptions of unmet need for healthcare in Europe among social groups: Findings from the European Social Survey (2014) special module on the social determinants of health’, *European Journal of Public Health*, Vol. 27, Suppl. 1, pp. 82–89.

FRA (2013a), *EU LGBT survey European Union lesbian, gay, bisexual and transgender survey. Results at a glance*, Publications Office of the European Union, Luxembourg, available at: https://fra.europa.eu/sites/default/files/eu-lgbt-survey-results-at-a-glance_en.pdf.

FRA (2013b), *Inequalities and multiple discrimination in access to and quality of healthcare*, Publications Office of the European Union, available at: https://fra.europa.eu/sites/default/files/inequalities-discrimination-healthcare_en.pdf.

FRA (2015), *Violence against women: An EU-wide survey. Main results report*, Publications Office of the European Union, Luxembourg, available at: <https://fra.europa.eu/en/publication/2014/violence-against-women-eu-wide-survey-main-results-report>.

FRA (2016), *Second European Union Minorities and Discrimination Survey Roma – Selected findings*, Publications Office of the European Union, Luxembourg, available at: https://fra.europa.eu/sites/default/files/fra_uploads/fra-2016-eu-minorities-survey-roma-selected-findings_en.pdf.

FRA (2017), *Accessing abortion services*, 2017, available at: <https://fra.europa.eu/en/publication/2017/mapping-minimum-age-requirements/access-abortion-services>.

FRA (2020), *EU-LGBTI II. A long way to go for LGBTI equality*, Publications Office of the European Union, Luxembourg, available at: https://fra.europa.eu/sites/default/files/fra_uploads/fra-2020-lgbti-equality-1_en.pdf.

FRA (undated), *The situation of Roma in 11 EU Member States – Survey results at a glance*, available at: https://fra.europa.eu/sites/default/files/fra_uploads/2109-FRA-Factsheet_ROMA_EN.pdf.

Freedman, L.P. and Kruk, M.E. (2014), 'Disrespect and abuse of women in child-birth: Challenging the global quality and accountability agendas', *The Lancet*, Volume 384, No 9948, pp. e42–e44, available at: [https://doi.org/10.1016/S0140-6736\(14\)60859-X](https://doi.org/10.1016/S0140-6736(14)60859-X).

Freire Barja, N., Luces Lago, A.M., Mosquera Pan, L. and Tizón Bouza, E. (2016), 'Prevention and detection of obstetric violence: A need in the Spanish delivery rooms?', *Revista de enfermería*, Vol. 39, No 7–8, pp. 40–44.

Gissler, M., Alexander, S., Macfarlane, A., Small, R., Stray-Pedersen, B., Zeitlin, J., Zimbeck, M. and Gagnon, A. (2009), 'Stillbirths and infant deaths among migrants in industrialized countries', *Acta Obstetricia et Gynecologica Scandinavica*, Vol. 88, No 2, pp. 134–148.

Global Health 50/50 (undated), 'The COVID-19 Sex-Disaggregated Data Tracker', available at: <https://globalhealth5050.org/covid19/healthcare-workers/>.

Grigoriev, P., Jasilionis, D. Klüsener, S., Timonin, S., Andreev, E., Meslé, F. and Vallin, J. (2020), 'Spatial patterns of male alcohol-related mortality in Belarus, Lithuania, Poland and Russia', *Drug and Alcohol Review*, Special Issue, available at: <https://onlinelibrary.wiley.com/doi/full/10.1111/dar.13037>.

Gunnell, D., Appleby, L., Arensman, E., Hawton, K., John, A., Kapur, N., Khan, M., C O'Connor, R., Pirkis, J. and the COVID-19 Suicide Prevention Research Collaboration (2020), 'Suicide risk and prevention during the COVID-19 pandemic', *The Lancet Psychiatry*, Vol. 7, No 6, pp. 468–471, available at: [https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366\(20\)30171-1/fulltext](https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(20)30171-1/fulltext).

Haw, C., Hawton, K., Gunnell, D. and Platt, S. (2014), 'Economic recession and suicidal behaviour: Possible mechanisms and ameliorating factors', *International Journal of Social Psychiatry*, Vol. 61, No 1, pp. 73–81.

Heslehurst, N., Brown, H., Pemu, A., Coleman, H. and Rankin, J. (2018), 'Perinatal health outcomes and care among asylum seekers and refugees: A systematic review of systematic reviews', *BMC Medicine*, Vol. 16, available at: <https://doi.org/10.1186/s12916-018-1064-0>.

Hill, S.E. (2015), 'Axes of health inequalities and intersectionality', Smith K.E. and Bambra, C. (eds.), *Health inequalities: Critical perspectives*, Oxford University Press, Oxford, pp. 95–108.

ICNARC (2020), *Report on COVID-19 in critical care*.

ILO (undated), 'Decent work and the Care Economy', available at: <https://www.ilo.org/global/topics/care-economy/dw-and-care-economy/lang--en/index.htm>.

Jewkes, R. and Penn-Kekana, L. (2015), 'Mistreatment of women in childbirth: Time for action on this important dimension of violence against women', *PLOS Medicine*, Vol. 12, No 6, available at: <https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001849>.

Kling, J.M., Rose, S.H., Kransdorf, L.N., Viggiano, T.R. and Miller, V.M. (2016), 'Evaluation of sex- and gender-based medicine training in post-graduate medical education: A cross-sectional survey study', *Biology of Sex Differences*, Vol. 7, Suppl 1, available at: <https://doi.org/10.1186/s13293-016-0097-3>.

Krieger, N., Chen, J.T. and Waterman, P.D. (2020), 'Excess mortality in men and women in Massachusetts during the COVID-19 pandemic', *The Lancet*, Vol. 395, No 10240, p. 1829, available at: [http://dx.doi.org/10.1016/S0140-6736\(20\)31234-4](http://dx.doi.org/10.1016/S0140-6736(20)31234-4).

Légaré, F., Lee-Gosselin, H., Borduas, F., Monette, C., Bilodeau, A., Tanguay, D., Stacey, D., Gagnon, M.-P., Roch, G., Dogba, M.J., Bussi res, A., Tremblay, M.C., B langer, A.-P., Jose, C., Desroches, S., Robitaille, H., Blair, L. and Rhugenda, S.-M. (2018), 'Approaches to considering sex and gender in continuous professional development for health and social care professionals: An emerging paradigm', *Medical Teacher*, Vol. 40, No 9, pp. 875–879.

Ludwig, S., Oertelt-Prigione, S., Kurmeyer, C., Gross, M., Gr ters-Kieslich, A., Reigitz-Zagrosek, V. and Peters, H. (2015), 'A successful strategy to integrate sex and gender medicine into a newly developed medical curriculum', *Journal of Women's Health*, Vol. 24, No 12, pp. 996–1005.

Macintyre S., Hunt, K. and Sweeting, H. (1996), 'Gender differences in health: Are things really as simple as they seem?', *Social Science & Medicine*, Vol. 42, No 4, pp. 617–624.

Maquibar, A., Hurtig, A.K., Vives-Cases, C., Estalella, I. and Goicolea, I. (2017), 'Mapping training about gender based violence in nurse education programmes in Spain', *European Journal of Public Health*, Volume 27, Suppl. 3, available at: <https://doi.org/10.1093/eurpub/ckx187.714>.

McGregor, A.J., N  ez, A., Barron, R., Casanova, R. and Lo Chin, E. (2016), 'Workshop summaries from the 2015 Sex and Gender Medical Education Summit: Utilization of sex and gender based medical education resources and creating student competencies', *Biology of Sex Differences*, Vol. 7, Suppl. 1, available at: <https://pubmed.ncbi.nlm.nih.gov/27785345/>.

Meeks, K.A., Freitas-Da-Silva, D., Adeyemo, A., Beune, E.J., Modesti, P.A., Stronks, K., Zafarmand, M.H. and Agyemang, C. (2016), 'Disparities in type 2 diabetes prevalence among ethnic minority groups resident in Europe: A systematic review and meta-analysis', *Internal and Emergency Medicine*, Vol. 11, No 3, pp. 327–340.

Mengeot, M.-A., Musu, T. and Vogel, L. (2014), *Preventing work cancers. A workplace health priority*, ETUI, 2014, available at: https://www.etui.org/sites/default/files/ez_import/2014-Guide_Cancers_EN.pdf.

Micheal, S. and Marjadi, B. (2018), 'Blended learning to teach gender in medical school', *The Clinical Teacher*, Vol. 15, No 3, pp. 208–213.

Miller, V.M., Kararigas, G., Seeland, U., Regitz-Zagrosek, V., Kublickiene, K., Einstein, G., Casanova, R. and Legato, M.J. (2016), 'Integrating topics of sex and gender into medical curricula – Lessons from the international community', *Biology of Sex Differences*, Vol. 7, Suppl. 1, available at: <https://dx.doi.org/10.1186 %2Fs13293-016-0093-7>.

Miller, V.M., Rice, M., Schiebinger, L., Jenkins, M.R., Werbinski, J., Núñez, A., Wood, S., Viggiano, T.R. and Shuster, L.T. (2013), 'Embedding concepts of sex and gender health differences into medical curricula', *Journal of Women's Health*, Vol. 22, No 3, pp. 194–202.

Modesti, P.A., Reboldi, G., Cappuccio, F.P., Agyemang, C., Remuzzi, G., Rapi, S., Per-ruolo, E. and Parati, G. and ESH Working Group on CV Risk in Low Resource Settings (2016), 'Panethnic differences in blood pressure in Europe: a systematic review and meta-analysis', *PLoS One*, Vol. 11, No 1, available at: <https://doi.org/10.1371/journal.pone.0147601>.

Morris, K., Beckfield, J. and Bambra, C. (2019), 'Who benefits from social investment? The gendered effects of employment and family policies on cardiovascular disease in Europe', *Journal of Epidemiology & Community Health*, Vol. 73, No 3, pp. 206–213.

Musu, T. and Vogel, L. (eds.) (2018), *Cancer and work: Understanding occupational cancers and taking action to eliminate them*, ETUI, Brussels, available at: https://www.etui.org/sites/default/files/ez_import/cancer-EN-WEB.pdf.

NWCI (2014), *Gender matters. Training handbook on gender mainstreaming in health*, available at: https://www.nwci.ie/images/uploads/NWCI_GM_Training_Manual_A4_WEB.pdf.

OECD (2007), *Babies and bosses: Reconciling work and family life: A synthesis of findings for OECD countries*, OECD Publishing, Paris, available at: <https://www.oecd.org/els/family/babiesandbosses-reconcilingworkandfamilylifeasynthesisoffindings-foroecdcountries.htm>.

OECD (2019a), *Putting people at the centre of health care. PaRIS survey of patients with chronic conditions*, available at: <https://www.oecd.org/health/health-systems/PaRIS-survey-Patients-with-Chronic-Conditions-June-2019.pdf>.

OECD (2019b), *Women are well-represented in health and long-term care professions, but often in jobs with poor working conditions*, available at: <https://www.oecd.org/gender/data/women-are-well-represented-in-health-and-long-term-care-professions-but-often-in-jobs-with-poor-working-conditions.htm>.

OECD and EU (2018), *Health at a Glance: Europe 2018: State of health in the EU cycle*, OECD Publishing, Paris/EU, Brussels, available at: https://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-europe-2018_health_glance_eur-2018-en.

Oertelt-Prigione, S. (2020), 'Putting gender into sex- and gender-sensitive medicine', *The Lancet*, Vol. 20, 2020, available at: [https://www.thelancet.com/action/showPdf?pii=S2589-5370\(202820\)2930049-3](https://www.thelancet.com/action/showPdf?pii=S2589-5370(202820)2930049-3).

Office for National Statistics [2020], *Deaths involving COVID-19 by local area and socioeconomic deprivation: Deaths occurring between 1 March and 17 April 2020*, available at: <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsinvolvingcovid19bylocalareasanddeprivation/deathsoccurringbetween1marchand17april>.

OSHA (2013), *New risks and trends in the safety and health of women at work. European Risk Observatory Literature review*, Publications Office of the European Union, Luxembourg, available at: <https://osha.europa.eu/en/publications/reports/new-risks-and-trends-in-the-safety-and-health-of-women-at-work>.

Pedersen, G.S., Grøntved, A., Mortensen, L.H., Andersen, A.-M.N. and Rich-Edwards, J. (2014), 'Maternal mortality among migrants in Western Europe: A meta-analysis', *Maternal and Child Health Journal*, Vol. 18, No 7, pp. 1628–1638.

Richardson, N. and Yordi Aguirre, I. (2018), *Improving men's health in Ireland: Building capacity among front-line health workers to engage men*, WHO Europe, available at: http://www.euro.who.int/data/assets/pdf_file/0007/377422/hss-ncd-policy-brief-ireland2-eng.pdf?ua=1.

Rieker, P. and Bird, C. (2005), 'Rethinking gender differences in health: Why we need to integrate social and biological perspectives', *The Journals of Gerontology. Series B, Psychological Sciences and Social Sciences*, Vol. 60, Spec. No 2, pp. 40–47.

Rodilnitsa (2013), *Nasilie nad razhdashti zheni (Насилие над рождащи жени)*, available at: <http://www.rodilnitza.com/blog/pregnancy/obstetric-violence/>.

Rojek, M.K. and Jenkins, M.R. (2016), 'Improving medical education using a sex- and gender-based medicine lens', *Journal of Women's Health*, Vol. 25, No 10, pp. 985–989.

Roxo, L., Bambra, C. and Perelman, J. (under review), *Gender equality and gender inequalities in self-reported health: A longitudinal study of 27 European countries 2004 to 2016*.

Rusby, J. S., Tasker, F. and Cherkas, L. (2016), 'Genetic and environmental components of female depression as a function of the severity of the disorder', *Brain and Behavior*, Vol. 6, No 10, pp. 2162–3279.

Sen, G., Reddy, B. and Iyer, A. (2018), 'Beyond measurement: The drivers of disrespect and abuse in obstetric care', *Reproductive Health Matters*, Vol. 26, No 53, pp. 6–18.

Song, M.M., Jones, B.G. and Casanova, R. (2016), 'Auditing sex- and gender-based medicine (SGBM) content in medical school curriculum: A student scholar model', *Biology of Sex Differences*, Vol. 7, Suppl. 1, available at: <https://doi.org/10.1186/s13293-016-0102-x>.

Stanistreet, D., Bambra, C. and Scott-Samuel, A. (2005), 'Is patriarchy the source of men's higher mortality?', *Journal of Epidemiology & Community Health*, Vol. 59, No 10, pp. 873–876.

Statista (2020), *Number of coronavirus (COVID-19) deaths in Germany in 2020, by gender and age*, available at: <https://www.statista.com/statistics/1105512/coronavirus-Covid-19-deaths-by-gender-germany/>.

Stuckler, D. and Basu, S. (2013), *The body economic. Why austerity kills*, Thomas Allen, London.

Taylor-Robinson, D., Lai, E.T.C., Wickham, S., Rose, T., Norman, P., Bambra, C., Whitehead, M. and Barr, B. (2019), 'Assessing the impact of rising child poverty on the unprecedented rise in infant mortality in England, 2000–2017: time trend analysis', *BMJ Open*, Vol. 9, No 10, available at: <https://bmjopen.bmj.com/content/9/10/e029424>.

The Economist (2020), *How to prevent a Covid-19 slump, and protect the recovery*, available at: <https://www.economist.com/leaders/2020/03/19/how-to-prevent-a-covid-19-slump-and-protect-the-recovery>.

The Guardian (2020a), *Domestic abuse killings 'more than double' amid Covid-19 lockdown*, available at: <https://www.theguardian.com/society/2020/apr/15/domestic-abuse-killings-more-than-double-amid-Covid-19-lockdown>.

The Guardian (2020b), *Lockdowns around the world bring rise in domestic violence*, available at: <https://www.theguardian.com/society/2020/mar/28/lockdowns-world-rise-domestic-violence>.

Thomas, P.A., Liu, H. and Umberson, D. (2017), 'Family Relationships and Well-Being', *Innovation in Aging*, Vol. 1, No 3, pp. 1–11.

United Nations (2017), *World family planning. Highlights*, United Nations, New York, available at: https://www.un.org/en/development/desa/population/publications/pdf/family/WFP2017_Highlights.pdf.

United Nations Economic and Social Council, Committee on Economic, Social and Cultural Rights (2000), *The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights)*, General Comment No. 14 (2000), E/C.12/2000/4, available at: http://docstore.ohchr.org/Self-Services/FilesHandler.ashx?enc=4slQ6QSmlBEDzFEovLCuW1AVC1NkPsgUedPIF1vfPMJ2c7ey6PAz2qaojTzDJmCOy_%2B9t_%2BsAtGDNzdEqA6SuP2rOw_%2F6sVBGT-pvTSCbiOr4XVFTqhQY65auTFbQRPWNDxL.

Vakrinaitė, L. (undated), *Žmogaus teisių pažeidimai ir smurtas akušerijoje*, Association Vilnius Women's House (VWH), available at: <https://www.vmotnam.lt/metodine-informacija/zmogaus-teisiu-pazeidimai-ir-smurtas-akuserijoje/>.

Valero, J. (2020), 'Coronavirus will trigger the deepest recession in EU history', *EURACTIVE.com*, 2020, available at: <https://www.euractiv.com/section/economic-governance/news/coronavirus-will-trigger-the-deepest-recession-in-eu-history/>.

van de Velde, S., Huijts, T., Bracke, P. and Bambra, C. (2013), 'Gender equity and the gender gap in depression in Europe', *Sociology of Health and Illness*, Vol. 35, No 5, pp. 682–698.

van der Meulen, F., Fluit, C. Albers, M. Laan, R. and Lagro-Janssen, A. (2017), 'Successfully sustaining sex and gender issues in undergraduate medical education: A case study', *Advances in Health Sciences Education*, Vol. 22, 2017, pp. 1057–1070, available at: <https://doi.org/10.1007/s10459-016-9742-1>.

van der Zanden, M. and Nap, AW. (2016), 'Knowledge of, and treatment strategies for, endometriosis among general practitioners', *Reproductive BioMedicine Online*, No 32, 2016, pp. 527–531, available at: [https://www.rbmojournal.com/article/S1472-6483\(16\)00053-5/pdf](https://www.rbmojournal.com/article/S1472-6483(16)00053-5/pdf).

Wang, Y, Hunt, K and Nazareth, I., Freemantle, N. and Petersen, I. (2013), 'Do men consult less than women? An analysis of routinely collected UK general practice data', *BMJ Open*, Vol. 3, No 8, available at: <https://bmjopen.bmj.com/content/bmjopen/3/8/e003320.full.pdf>.

Weber, C. and Henke, N. (2014), *Employment trends and their impact on women's OSH*, OSH WIKI, available at: https://oshwiki.eu/wiki/Employment_trends_and_their_impact_on_women%E2%80%99s_OSH#cite_ref-52.

Whiting, D.R., Guariguata, L., Weil, C. and Shaw, J. (2011), 'IDF diabetes atlas: Global estimates of the prevalence of diabetes for 2011 and 2030', *Diabetes Research and Clinical Practice*, Vol. 94, No 3, pp. 311–332.

WHO (2016a), *Prevention and elimination of disrespect and abuse during facility-based childbirth*, available at: https://www.who.int/reproductivehealth/topics/maternal_perinatal/statement-childbirth/en/.

WHO (2016b), *Women's health and well-being in Europe: Beyond the mortality advantage*, available at: http://www.euro.who.int/_data/assets/pdf_file/0006/318147/EWHR16_interactive2.pdf?ua=1.

WHO (2018), *The health and well-being of men in the WHO European Region: Better health through a gender approach*, available at: http://www.euro.who.int/_data/assets/pdf_file/0007/380716/mhr-report-eng.pdf?ua=1.

WHO (2019a), *Caring for women subjected to violence: A WHO curriculum for training health-care providers*, Geneva, available at: <https://www.who.int/reproductivehealth/publications/caring-for-women-subject-to-violence/en/>.

WHO (2019b), *European tobacco use. Trends report 2019*, available at: <https://www.euro.who.int/en/health-topics/disease-prevention/tobacco/publications/2019/european-tobacco-use-trends-report-2019-2019>.

WHO (2019c), *Healthy, prosperous lives for all: The European Health Equity Status Report*, available at: <http://www.euro.who.int/en/health-topics/health-determinants/social-determinants/health-equity-status-report-initiative/health-equity-status-report-2019>.

WHO (2019d), *New WHO evidence on mistreatment of women during childbirth*, available at: <https://www.who.int/reproductivehealth/mistreatment-of-women-during-childbirth/en/>.

WHO (2020a), *Report of the WHO-China Joint Mission on Coronavirus Disease 2019 (COVID-19)*, available at: <https://www.who.int/docs/default-source/coronaviruse/who-china-joint-mission-on-Covid-19-final-report.pdf>.

WHO (2020b), *State of the world's nursing 2020 report. Investing in education, jobs and leadership*.

WHO (undated), 'Migration and health: Key issues', available at: <http://www.euro.who.int/en/health-topics/health-determinants/migration-and-health/migrant-health-in-the-european-region/migration-and-health-key-issues>.

Wilkins, E., Wilson, L., Wickramasinghe, K., Bhatnagar, P., Leal, J., Luengo-Fernandez, R., Burns, R., Rayner, M. and Townsend, N. (2017), *European Cardiovascular Disease Statistics 2017*, European Heart Network, Brussels.

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