

### Introduction

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. However, in the EU, health is a significant area of inequality between women and men. Gender differences in health are not only biological but also strongly shaped by the interaction of economic, political and cultural factors. Increased recognition of the impact of social factors on health and well-being is reflected in the Directive on Work-life Balance for Parents and Carers (2019), which highlights the positive health impacts of an improved work-life balance. Furthermore, the Third EU Health Programme, 2014-2020, has funded projects that recognise the impact of gender on health, even if it does not explicitly incorporate a gender perspective.

Gender stereotypes and socioeconomic inequalities continue to impact on access use of preventative and curative health

services. For example, 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. To date, important unmet mental health needs of women and men persist, and access to sexual and reproductive health services varies greatly between the Member States.

Looking broadly at medical research, this area has historically shown limited gender sensitivity. An important step forward in this respect is the Clinical Trials Regulation of the European Commission (2014), which requires the consideration of gender in clinical trials, even though this has yet to be implemented. It should help address concerns about drugs being mainly tested on men, and thus possibly ignoring adverse side effects that are more common among or exclusive to women.



## Consideration of gender in treatment and care is lacking

Broadly speaking, women enjoy longer lives than men, but spend less of them in (self-reported) good health (Figures 1 and 2). This broad comparison rests on a number of health-related differences among men and women, which result from particular combinations of certain biological and social factors.

For example, the mental health needs of women and men differ: there is a greater prevalence of depression and anxiety disorders among women and of externalising mental health disorders (such as drug and alcohol abuse) among men. This is partly explained by social factors: higher prevalence of depression among women is linked to low socio-economic status as a predictor of depression. The burden of combining employment and family demands appears especially harmful for women's mental health. Intimate partner violence also significantly affects the mental health of women. Men are less likely to seek out help related to mental health because of gendered behavioural norms, which has been linked to higher suicide rates among them.

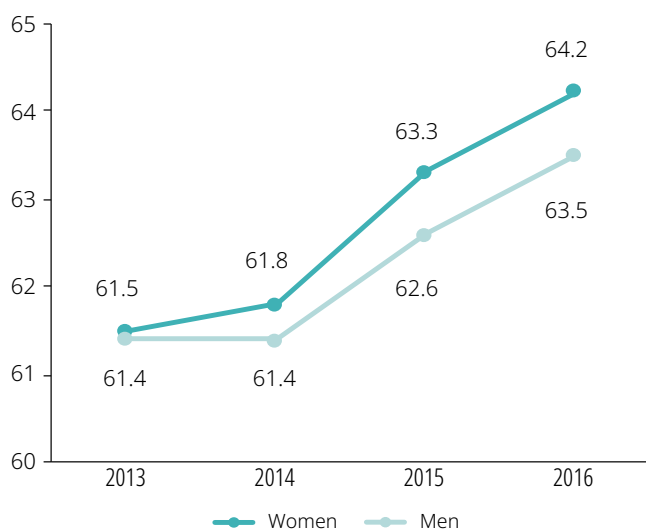
As women and men are not homogeneous groups, their health opportunities and risks vary according to social, economic, environmental and cultural influences throughout their lifetime. This is likely to add to health vulnerabilities and problems with healthcare access for certain groups, including women with lower income and/or educational attain-

ment; those from certain migrant and ethnic backgrounds; older women and women with disabilities; and LGBTQI\* people. For example, both women and men with low education levels are more likely to develop diabetes, but women with low education levels have higher death rates from diabetes than men from similar backgrounds, partly due to lower levels of care.

This is linked to challenges related to the low representation of women subjects in clinical research, gender-blind or biased medical research and healthcare services, and gendered use of healthcare services. For example, women's health needs are overlooked in cases of non-communicable diseases (NCDs) such as cardiovascular disease, despite this being the main cause of death for women in the WHO European Region. Conversely, men's health needs are often presented in terms of NCDs, with little attention paid to their sexual, reproductive, family and mental health needs.

Insufficient gender sensitivity in medical research and healthcare is perhaps not very surprising, given the under-representation of women in health governance, decision-making and certain occupations. Although women are now well represented among medical students and doctors, they are less well represented among senior doctors and professors, or in executive health sector positions overall.

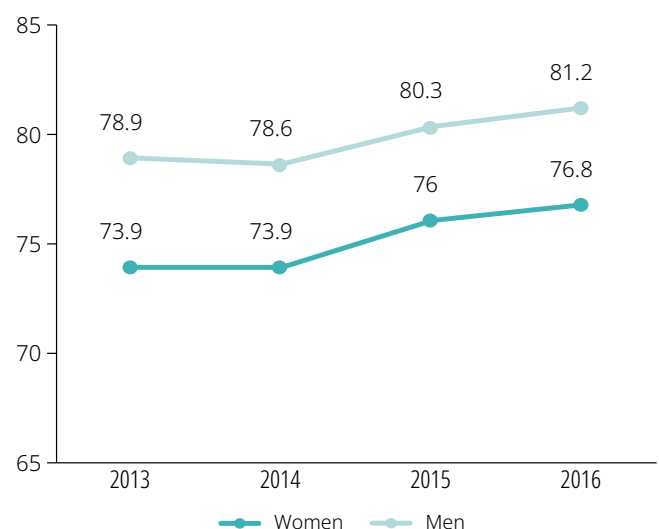
Figure 1. Healthy life years at birth by gender, EU-28



Source: EU-SILC hlth\_hlye

NB: 2013, estimated; 2015, break in the series; 2017, data not available.

Figure 2. Healthy life years at birth as a percentage of total life expectancy by gender, EU-28



Source: EU-SILC hlth\_hlye

NB: 2013, estimated; 2015, break in the series; 2017, data not available.

## Threats to sexual and reproductive health services

Under international law, Member States in the EU are required to provide access to safe and high-quality sexual and reproductive healthcare. This is not only a legal obligation, but also a crucial element of safeguarding the wider health and well-being of women.

In practice, however, access to sexual and reproductive health services varies significantly by Member State. This is due to differences in service availability and affordability, legislation, and cultural and religious factors. Since 2013, a worrying trend of retrogressive policy and legislative proposals has been seen in several Member States, threatening the sexual and reproductive rights of women. Although these proposals have mostly been rejected, in some cases they have led to tangible restrictions, such as introducing new preconditions for women to access legal abortion services or allowing conscientious objections by gynaecologists to perform abortions. The sexual and reproductive health needs of certain groups of women, such as women with disabilities, often remain unmet, while in some countries the rights of

women with disabilities and Roma women have been violated through forced sterilisation.

Many women lack, or have limited access to, necessary prenatal and maternal healthcare. Currently, some 500 000 women in the EU lack access to health services during pregnancy. For instance, nearly half of pregnant refugees and migrants in Europe may not have access to antenatal care, which helps explain higher risks of maternal mortality among migrant women in Europe; the increased risk is 25 times greater in some countries. Roma women experience greater risks of maternal mortality than non-Roma women in the EU, and face access issues.

Around 10 % of married women in Europe continue to report unmet need for contraception — given the focus on only married women, this figure may well be a (significant) underestimate. Unmet contraceptive needs particularly affect vulnerable groups, including adolescents, those with a low income, those living in rural areas, people with HIV, refugees and migrants.

## Recommendations for action

To make EU health policy more gender sensitive, it is important to systematically mainstream gender into key EU health strategies. It would also be good to highlight the importance of mental and physical health (and its gendered aspects) in key EU employment and social policy strategies.

Robust implementation of gender sensitive measures at EU level, such as effective monitoring and enforcement of the EU Clinical Trial Regulation, would strengthen the gender sensitivity of medical research and healthcare. These measures would be well complemented by efforts to strengthen the representation of women in health governance, decision-making and certain occupations (e.g. senior doctors or professors).

Member States are recommended to develop gender-sensitive health policies, and to design medical research and health services that address the impact of both sex (biological factors) and gender (social factors) on the health differ-

ences of women and men. Desirable measures include appropriate training for healthcare professionals on gender and health, ensuring access to medicines and services that reflect gendered health needs (e.g. prenatal and maternity services, hormonal contraception and abortion) and providing sex and relationship education to young people. Targeted initiatives to increase the access of vulnerable groups to healthcare services would be welcome, including provision of multilingual information on the availability of healthcare services (e.g. through asylum reception centres) and ensuring that interpreters accompany migrants to healthcare appointments where they may face language barriers. Finally, Member States are recommended to strengthen the collaboration between health and other ministries, including employment, social affairs and finance, to address work, care and fiscal conditions that have a negative impact on women's health over the life course.

## Further information

Beyond the developments presented here, a number of other challenges persist. Biological and social differences see women and men experiencing different responses from health systems and exhibiting different health-seeking behaviours and outcomes. Women with fewer years in education, those who have had unpaid caring roles in the family, and those who have had part-time and temporary contracts during their working years are more likely to have inadequate or no

pensions and are at higher risk of social isolation, poverty, and poor mental and physical health in later life.

Further information on EU policy developments and trends in the area of women and health can be found in EIGE's Beijing + 25 report. Some other policy briefs based on this report also present challenges closely related to women and health (such as Area A, Women and poverty, Area D, Violence against women, and Area I, Human rights of women).

EIGE regularly produces reports reviewing different areas of the Beijing Platform for Action (BPfA) or other EU policy priorities, as requested by the presidencies of the Council of the European Union. This factsheet is based on the report *Beijing + 25: The fifth review of the implementation of the Beijing Platform for Action in the EU Member States*, prepared at the request of Finland's Presidency of the Council of the EU.

Other publications include:

- [Tackling the Gender Pay Gap: Not without a better work-life balance](#) (2019)
- [Gender Equality and Youth: Opportunities and risks of digitalisation](#) (2019)
- [Women and Men in ICT: A chance for better work-life balance](#) (2018)
- [Study and Work in the EU: Set apart by gender](#) (2018)

You can explore all of EIGE's previous BPfA reports and publications at <https://eige.europa.eu/beijing-platform-for-action>

### European Institute for Gender Equality

The European Institute for Gender Equality (EIGE) is the EU knowledge centre on gender equality. EIGE supports policymakers and all relevant institutions in their efforts to make equality between women and men a reality for all Europeans by providing them with specific expertise and comparable and reliable data on gender equality in Europe.  
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