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European Women's Lobby Position Paper: **Women's Health in the European Union**

Introduction

'Women have the right to the enjoyment of the highest attainable standard of physical and mental health. The enjoyment of this right is vital to their life and well-being and their ability to participate in all areas of public and private life.'

Beijing Platform for Action, Women and health, 1995

Health and wellbeing, both physical and mental, are crucial conditions for the full development of every human being. Health is more than a biological issue, representing according to the World Health Organisation, 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.'¹ Both the biological concept of sex and the social construct of gender matter in health at all levels and impact differently on women and men's health, access to health and health-care.² Unequal access to resources coupled with other social factors produce unequal health risks and access to health information, care, and services for women and men. In addition to this, biological differences imply that women have particular health concerns and needs, especially related to their sexual and reproductive health.

Public policies in the health sector theoretically sometimes acknowledge that gender is a significant health determinant across the life cycle.³ However, women's health needs are not fully and consistently integrated into European and national health policies.⁴ The lack of a consistent and integrated approach to women's rights and gender issues within health policy needs to be urgently addressed, including in a context of a financial and social crisis marked by cuts in public spending in services that are crucial for the attainment of a 'high level of human health protection' for all, as guaranteed by the European Union (EU) Treaties.⁵ To be effective, all aspects of health policies, currently to a large extent gender-blind in practice, must include a women-specific approach and make full use of gender mainstreaming as a tool.

The present paper presents first the analysis of the European Women's Lobby (EWL) regarding these issues and then recommendations for national and European decision-makers in order for public policies in the health sector to fully address women's health needs.

1. The gender dimension of women's health

Biology plays a crucial role in health status. Differences related to reproductive functions have long been recognised as of primary importance, while women's health needs must not be reduced to these functions, as

¹ Preamble to the Constitution of the WHO, adopted 1946.

² Sen, G. & P. Östlin, *Unequal, Unfair, Ineffective and Inefficient. Gender Inequity in Health*, 2007.

³ Council of the European Union, *Conclusions on Women and Health, 2005; Conclusions on Health and Migration in the EU, 2007; Conclusions on Roma Inclusion, 2008; Resolution on the health and well-being of young people, 2008.*

⁴ See Section 4 below.

⁵ Art. 168 TFEU (ex Art. 152 TEC).



is currently the case in many EU Member States.⁶ Biological differences between women and men also include, for example, the better infant survival rates of females, sex-specific diseases, distinctions in symptoms of diseases, or women's longer life expectancy. Some of these biological differences seem to advantage women over men. However, they are mostly cancelled out by the gender inequalities embodied in the social disadvantages women face in comparison to men, such as lesser access to resources (including unequal pay and unequal pensions), heavier workload as women combine a greater share of paid and unpaid work, male violence against women, services and treatments which are not adapted to women's need, and sex-based or multiple discrimination. Gender stereotypes also affect all areas of health care.

Biological sex must not be used as an isolated factor to analyse and tackle health issues. Beyond sex, the social construct of *gender* influences the extent to which women are able to have control over the circumstances affecting their health and quality of life. Existing research indicates gender inequalities in health status, health-related behaviour, access to health and treatment.⁷ Policy makers and medical research must question and investigate the causes of these inequalities and offer effective answers.

For example, biomedical research continues to be based on the unstated assumption that women and men are physiologically similar in all respects apart from their reproductive systems, and it ignores other biological, social and gender differences which have a considerable impact on health.⁸ It is the case for pain: women have pain more often, more intense pain and pain killers are less effective with women than with men.⁹ Another relevant example is the identification of differences in symptoms and application of targeted treatment of coronary heart diseases for women and men. Only recent research on women's heart conditions and symptoms has proved that women suffer from cardiovascular heart diseases (CHD) in much higher numbers than men, but these diseases come later in life, manifest themselves through different symptoms as compared with men, and should be treated differently in terms of medication allocation.¹⁰ In many cases, preventive and curative strategies are applied to women while they have been tested only on men and might therefore have little or even counterproductive effect.

Some research centres acknowledge the fact that men and women are not biologically equal and take a broader perspective on the biological aspects of a woman's life, i.e. childhood, adolescence, childbearing age, pregnancy, and menopause. Nevertheless, the fact remains that, there are still major gaps in expertise and general knowledge about the differences between disease processes in women and men, and a blatant lack of sufficient gender-sensitive studies, analyses, investigations and sex-disaggregated data that can provide an answer to these differences.

⁶ Crepaldi, Ch. Et al., Access to Healthcare and Long-Term Care: Equal for women and men, 2009, p. 61.

⁷ World Health Organisation, *Women and Health. Today's Evidence, Tomorrow's Agenda*, 2009; **Thummler**, K. et al., *Data and Information on Women's Health in the European Union*, 2010; **European Institute of Women's Health**, *Women's Health in Europe. Facts and Figures Across the European Union*, 2006.

⁶ Crepaldi, Ch. Et al., Access to Healthcare and Long-Term Care: Equal for women and men, 2009, p. 61.

⁷ World Health Organisation, *Women and Health. Today's Evidence, Tomorrow's Agenda*, 2009; **Thummler**, K. et al., *Data and Information on Women's Health in the European Union*, 2010; **European Institute of Women's Health**, *Women's Health in Europe. Facts and Figures Across the European Union*, 2006.

⁸ Lin, V. & al., 'Gender-sensitive indicators: Uses and relevance', *International Journal of Public Health*, vol.52, 2007, pp. 527-534.

⁹ Conseil National des Femmes francophones de Belgique, *Les femmes...négligées par la médecine?*, 2009.

¹⁰ Schenck-Gustafsson, K., Centre of Gender Medicine, public presentation sponsored by 1.6 Million Club for Women's Health, Brussels, 26 January 2010; See also *Red Alert on Women's Hearts. Women and Cardiovascular Research in Europe*, 2009.



2. Women's health risks and needs

The sex and gender dimensions of health entail that women face a number of specific health risks over their lifetimes. In addition to this, age, ethnicity, disability, sexual orientation or identity, resources, education, social and marital status, position in the labour market, place of residence, the level of gender equality in society and other attributes influence women's health needs and access to health. Taking into consideration women's diversity and incorporating it in the health policies addressed to women would strengthen the efficiency of these policies.

2.1 Women's specific health concerns

a. Cancer of the breast, cervix or uterus

Cancer represents one of the biggest health threats in Europe today, fatal in 2006 for 140 women out of every hundred thousand.¹¹ Women suffer predominantly from different forms of cancer than their male counterparts, most notably breast, uterus and cervical cancers. Breast cancer affects almost exclusively women and remains the main causes of cancer mortality among women in the EU, with 25.14 victims per hundred thousand women under 65 years of age.¹² Cervical cancer affects women exclusively and is potentially lethal, especially for women living in new EU Member States.¹³

Screening procedures are considered to be one of the most efficient cancer prevention measures.¹⁴ Breast and cervical cancer can be treated in their early stages if access to effective screening is ensured to all women and is coupled with scientifically validated treatments. All EU Member States have provisions for breast and cervical cancer screening, but conditions of access and quality of treatment differ from country to country. Only ten EU Member States have set the very much-needed target screening 100% of the female population for breast cancer and only 8 countries have such a target for cervical cancer screening.¹⁵

Two vaccines have recently been made available to prevent two types of Human Papilloma Viruses (HPV) that are said to cause 70% of cervical cancers.¹⁶ In order to be effective, the vaccine must be given prior to the beginning of sexual life.¹⁷ It is available in 13 EU Member States, targeting girls between 9 and 13 years of age, and in most cases is free of charge and available on demand. In several other Member States, like Cyprus, the Czech Republic, Estonia and Malta, plans to make the vaccine available to the public have been discussed but

¹¹ EUROSTAT, *Key Figures on Europe*, 2009, Figure 2.8: Causes of death, EU-27 by 2006, p. 58.

¹² Mladovsky, P. et al., *Health in European Union*, 2007, p. 27. There is a need for more research to prove the impact of environment, specifically endocrine disruptors, on the increased incidence of breast cancer among women in Europe.

¹³ World Health Organisation, Regional Office in Europe, *Atlas of health in Europe*, 2008, p. 49.

¹⁴ Spadea, T. et al., 'Inequalities in female cancer screening rates', in EUROTHINE, *Tackling Health Inequalities in Europe: An Integrated Approach*, 2007, pp. 500-521.

¹⁵ Spadea, T. et al., 'Inequalities in female cancer screening rates', in EUROTHINE: *Tackling Health Inequalities in Europe: An Integrated Approach*, 2007, pp. 500-521.

¹⁶ HPVs are a group of over 100 related viruses among which 9 are considered high-risk HPV that might lead to cervical or anal cancer. The vaccination is only for HPV 16 and 18, which according to statistics represent 70% of the HPV found in cervical cancer (to take with caution as it might be pharmaceutical companies who provide these figures). Source: <http://www.who.int/immunization/topics/hpv/en/>

¹⁷ European Cervical Cancer Association, *Guidelines for Cancer Prevention, HPV Vaccination Across Europe*, 2010.



as yet either not adopted or not implemented.¹⁸ Availability of the HPV vaccination, however, should not lead to a decrease in cervical cancer screening, which remains the main tool for cervical cancer prevention given the absence of full coverage of the vaccination.

Other forms of cancer that affect both women and men have gendered dimensions. Lung cancer, for example, was for a long time considered a male disease and measures to prevention and treatment measures were developed accordingly. Existing data shows that lung cancer continues to be more predominant among men in Europe as compared to women,¹⁹ but women's mortality rates have increased rapidly over the last decades.²⁰ Indeed, while men's rates are decreasing, women's continue increasing almost everywhere, except in the UK and, to some extent, in Ireland and Denmark.²¹ According to a French study, while the lung cancer rate for men of 40 years of age has halved over the last ten years, the rate for women has multiplied by four over 15 years.²² For women, lung cancer has only recently been recognized as a health problem and treated as such. European comparative data has highlighted a geographical pattern of lung cancer incidence linked with smoking habits over the last two to three decades. Thus, the highest rates of lung cancer are among women in Denmark, Hungary and the United Kingdom, while the lowest are in Spain, Malta and Portugal.²³ On the other hand, today smoking is more prevalent among women in Southern European countries compared to those from further North.²⁴ Accordingly, prevention and treatment approaches need to change and adapt to these gendered and geographical patterns.

b. Reproductive health and care, maternal mortality, infertility and Artificial Reproductive Technologies (ART)

• Women's reproductive health and care and maternal mortality

Each year more than five million women give birth in the EU. Another two million women have failed pregnancies – spontaneous and induced abortions as well as ectopic pregnancies.²⁵ Because of different factors ranging from longer studies, growing involvement in paid employment, difficulties in conciliating private and work life, costs, etc, women in Europe are increasingly having children later in life, which creates different types of health risks and needs.²⁶

¹⁸ Ibid.

¹⁹ Mladovsky, P. et al., *Health in European Union*, 2007, Fig. 3.6 Standardised lung cancer incidence rates per 100 000, in selected European countries, 2000, p. 33. World Health Organization, *Atlas of health in Europe*, 2008, Deaths from lung cancer, 25 – 64 years, p. 47.

²⁰ 'Unfortunately, mortality for lung cancer among women is increasing almost everywhere, except in the UK and, to some extent, in Ireland and Denmark. The leading contribution to lung cancer are the number of cigarettes smoked per day, the degree of inhalation and the initial age at which individuals start smoking.' In Mladovsky, P. et al., *Health in European Union*, 2007, p.34.

²¹ Ibid.

²² L'Institut de veille sanitaire, Bulletin Épidémiologique No. 19-20 (BEH), *Special Issue – World No Tobacco Day, 31 May 2010*, <http://www.invs.sante.fr/beh/>

²³ Thummler, K. et al., *Data and Information on Women's Health in the European Union*, 2010, p. 37.

²⁴ Boyle, P. and Fery, F., Cancer incidence and mortality in Europe 2004, in *Annals of Oncology* No. 16, pp. 481- 488. Elmadfa I (ed.) : *European Nutrition and Health Report 2009*, Forum Nutrition Basel, Karger, vol. 62, pp. 180-184.

²⁵ An ectopic pregnancy happens when the pregnancy implant is located outside of the uterine cavity. It is treated as an emergency and if not properly dealt with can be a cause of death.

²⁶ World Health Organisation, Regional Office in Europe, *Atlas of health in Europe*, 2008, p. 16.



Health-care for pregnant women must begin as soon as possible in the first trimester of pregnancy in order to make it possible to identify specific conditions that may require surveillance, recognise social problems for which women may need help from social or mental health services, and inform women about pregnancy-related issues. Focus on the expectant mother's health and the provision of extra attention to women at risk of preeclampsia, diabetes, and high blood pressure can significantly lower mother and child mortality and morbidity.²⁷ Pre-conceptual examination of both partners needs to be promoted, as there are several health risks that can be avoided: genetic diseases that lead to haemophilia, infections (HIV-AIDS, Hepatitis C, Syphilis, Tuberculosis, diabetes and the prevention of Spina Bifida.)

Data from a number of EU Member States²⁸ shows that more than 90% of women undertake a medical check-up during their first trimester of pregnancy, which means that still one in ten women in Europe doesn't access care in the first months of pregnancy.²⁹ In addition, access to antenatal care and even childbirth services is sometimes problematic. Women living in rural areas, for example, often need to travel long distances in order to give birth, which may put their lives in danger.

In most EU countries, childbirth services are provided for free, even if a woman is not insured.³⁰ Nevertheless, in many EU Member States, women are not given a free choice between different ways of giving birth. There is an overmedication of birth documented by caesarean section rates of over 30% that can lead to different types of obstetrical complications and health problems. The psychological trauma and negative experiences of childbirth must be paid more attention, as they are part of the quality of maternity care.

Maternal mortality is considered a major marker of health system performance.³¹ The maternal mortality ratio in Europe is low compared to other regions, due both to a very low fertility level (1.5 children per woman)³² and to high levels of care. Data from the latest global report on maternal mortality (April 2010) shows that 13 EU Member States are among the 20 countries in the world where the maternal mortality ratio is the lowest, around 7/100 000 live births.³³ Still, even one maternal death can be considered a warning signal of some dysfunction in the provision of care, and five new EU Member States have maternal mortality ratios higher than 18/100 000.³⁴

²⁷ Preeclampsia, Pregnancy Induced Hypertension and toxemia are closely related conditions. HELLP syndrome and eclampsia are the manifestations of the same syndrome. Globally preeclampsia and other hypertensive disorders of the pregnancy are a leading cause of maternal and infant illness and death.

²⁸ Czech Republic, Germany, France, Italy, Portugal, Slovenia, Finland and Sweden.

²⁹ Table 5.1 Percentage of pregnant women by timing of first antenatal visit, in *European Perinatal Health Report*, 2008, p. 73

³⁰ EURO-PERISTAT Project, *European Perinatal Health Report*, 2008, p. 94.

³¹ Maternal mortality ratio is the number of maternal deaths per 100 000 live births.

³² See http://epp.eurostat.ec.europa.eu/portal/page/portal/population/data/main_tables

³³ The Lancet, *Maternal mortality for 181 countries, 1990-2008: a systematic analysis of progress towards Millennium Development Goal 5* April 2010.

³⁴ Ibid. Latvia (18), Slovenia (19), Estonia (22), Romania (26), Bulgaria (28) and Cyprus (41).



- **Women's infertility and access to Assisted Reproductive Technologies (ART)³⁵**

The majority of EU Member States have deemed infertility a medical condition, but there are significant differences between the Member States in regulating the access and provision of ART services to treat infertility in both women and men or in other cases. In most cases, all or some portion of infertility treatments are funded through national health policies. For example, in Portugal and Spain, ART procedures are fully reimbursed if provided in a public clinic or hospital. Germany and Austria reimburse 70% of the cost of treatment.³⁶ Lack of public funding restricts access in e.g. Ireland, Romania, and UK; in Portugal and Italy, for example, national legislation prohibits certain ART treatments. In such cases, women or couples take advantage of European freedom of movement provisions to travel to other countries in order to receive treatment. For instance, half of the women receiving fertility treatment in Spain come from other EU Member States.³⁷

Women also widely face restrictions when accessing ART treatment on the basis of age, sexual orientation and marital status. Belgium and France are the only two European countries to provide access to ART to women over the age of 40.³⁸ The majority of EU Member States exclude single and/or lesbian women from access to such services. Slovakia is such an example where assisted reproduction intervention is conditioned by intimate physical relationship between a man and a woman. Where treatment is legally possible for single women or those in same-sex relationships, e.g. in Belgium, it is provided only subject to certain conditions.

- **HIV-AIDS**

In 2008, 850 000 adults and children were expected to live with HIV-AIDS in Western and Central Europe, a third of whom are women. While the dominant way of transmission of HIV-AIDS is sex between men, heterosexual intercourse amounts to 29% of new HIV diagnosis in Western Europe and 51% in Central Europe. The rate of mother-to-child HIV transmission for Europe as a whole approaches zero, but has not totally been eradicated in all countries.³⁹ Due to a combination of biological factors and gender inequalities women and girls are particularly vulnerable to HIV infections: They are twice more likely to acquire HIV from unprotected heterosexual intercourse with a partner than men. Additionally, economic and social dependence sometimes increases the vulnerability of women who might not have the power to refuse sex or to negotiate the use of condoms.⁴⁰

³⁵ Assisted Reproductive Technologies cover: *in vitro* fertilization (IVF), intra cytoplasmic sperm injection (ICSI), frozen embryo replacement (FER), egg donation (ED), pre-implantation genetic diagnosis/screening (PGD/PGS) and *in vitro* maturation (IVM). See Sorensen, C., 'ART in the European Union', *Euro Observer*, 2006, Vol. 8, No. 4.

³⁶ Table 1: Funding and reimbursement status of ART in EU-15, *Euro Observer*, 2006, Vol. 8, No. 4, p. 7.

³⁷ *Euro Observer*, 2006, Vol. 8, No. 4.

³⁸ 'Due to declining fertility and greater risk of miscarriage with increased age, the costs of IVF per successful pregnancy are more than three to five times higher for women age 40 years or older, compared to those 30 years and younger.' Data available at Table 1: Funding and reimbursement status of 'ART in EU-15', *Euro Observer*, 2006, Vol. 8, No. 4, p. 7.

³⁹ UNAIDS/WHO: AIDS epidemic update 2009, Geneva, p. 65-67, 82.

http://data.unaids.org/pub/Report/2009/jc1700_epi_update_2009_en.pdf

⁴⁰ <http://www.unaids.org/en/PolicyAndPractice/KeyPopulations/WomenGirls/default.asp>



- **Sexually Transmitted Diseases (STDs)**

The risk of infection by a sexually transmitted disease or HIV-AIDS is significantly higher for women than for men. But women mostly depend on the goodwill of their partner in relation to prevention.⁴¹ Women's organizations involved in the Beijing and Cairo Conferences have highlighted the need to develop new methods of prevention like new models of female condoms or virucides to give women the power to protect themselves; however, the financial resources to develop new female condoms have not been awarded, or even planned.

- **Women's sexual and reproductive rights**

Sexual and reproductive rights include open access to legal and safe abortion, reliable, safe, and affordable contraception, coupled with sexual education and information in relation to sexual and reproductive health, free choice and consent. It is vital that all women living in the European Union Member States must enjoy freely these rights and have full access to the related health services.

Some EU Member States perform well in terms of guaranteeing women these rights. Denmark, Sweden, Finland, and the Netherlands have the lowest abortion rates in Europe and in the world. Women living in these countries gained the right to free abortion in the 1970's or 1980's, and are provided with access to information and to all methods of contraception.

On the other hand, these rights are severely limited and/or conditioned in several EU Member States. In Malta and Ireland, abortion is a criminal offence. Poland and Cyprus have very restrictive laws on abortion. The legislation in Hungary, Latvia, Lithuania, Luxembourg and Slovakia is also highly restrictive as it imposes a complicated procedure of authorisation. Furthermore, in these countries, the price for such a medical intervention is extremely high and mostly not covered by health insurance. Access to contraceptive methods is equally limited by price. The lack of access to sexual and reproductive rights leads to dangerous and costly illegal abortions, as well as inequalities between women.

Even in countries where abortion is legal, access is often restricted by lengthy procedures, costs and geographical disparities in the availability of such services. The increasing number of medical professionals who refuse to perform abortions, especially in Spain, Italy, Poland and Hungary, represents another threat to the health and rights of women. In many Member States, women under 18 years of age are requested to have the consent of a parent or legal guardian.⁴² Not all countries provide counselling pre- and after abortion as well as information about contraception and its availability.⁴³ Restrictions and budgetary cuts made by national governments in the area of public health also make access to services and health more onerous. Finally, the rising influence of 'anti-choice' and religious movements plays a very important role in the limitation of sexual and reproductive health services and in breaching the right to self-determination for

⁴¹ WHO, UNAIDS, *The Female Condom. A guide for planning and programming*, Geneva, 2001.

⁴² IPPF European Network, *Abortion Legislation in Europe*, 2009.

⁴³ The latest data of using contraception show that in only 6 EU Member States more than 70% of women between 15 and 49 use modern contraception; in 8 EU Member States like Poland, Lithuania, Romania, Bulgaria, less than 40% of women use modern contraception. Save the Children, 'The Complete Mothers' Index 2010', in *Women on the Front Lines of Health Care. State of the World's Mothers 2010*.



women. In this respect, the restrictive Protocols and Unilateral Declarations annexed to Accession Treaties to the European Union for Ireland, Malta and Poland need to be denounced.

c. Eating disorders

Women report eating disorders more often than men.⁴⁴ Women's self-perception of health is generally worse than that of men.⁴⁵ More particularly, women, especially those under 30, have a more negative self-perception of body image as compared to young men.⁴⁶ The eating disorders associated with this reported low sense of self-worth are rooted in pressure emanating from pervasive stereotyping of women's bodies in media and advertising.⁴⁷ The long-term physical and mental health effects of eating disorders such as anorexia and bulimia have been well documented, as has the gender-dimension of their causes.⁴⁸ Nevertheless, a gender-sensitive approach needs to be mainstreamed within the health discourse and in information addressed to the general public.

d. Osteoporosis, musculoskeletal problems and central nervous system illnesses

Illnesses such as osteoporosis,⁴⁹ musculoskeletal problems and central nervous system illnesses like Alzheimer and/or dementia⁵⁰ are linked to hormonal changes women experience at the time of menopause.⁵¹ While it is therefore known that women are affected by these illnesses with higher frequency than men, the gender dimension of research on such topics has been weak and there is a general lack of programmes that address the specific needs of women, inform them about prevention methods, offer training to medical staff, etc.⁵²

One of the most consistent findings in the social epidemiology of mental health is the gender gap in depression. Because of a variety of factors including mainly different gender roles and gender inequalities, depression is approximately twice as prevalent among women as it is among men. However, the absence of comparable data hampers cross-national comparisons of the prevalence of depression in general populations. A study examining the situation indicates that women report higher levels of depression than men do in all countries, but there is significant cross-national variation in this gender gap. Gender differences in depression are largest in some of the Eastern and Southern European countries and smallest in Ireland, Slovakia and some Nordic countries. Socioeconomic as well as family-related factors moderate the relationship between gender

⁴⁴ Elmadfa, I. et al., 'Health and Lifestyle Indicators in the European Union', in Elmadfa I (ed.): *European Nutrition and Health Report 2009*, Forum Nutrision Basel, Karger, vol. 62, pp. 157-171.

⁴⁵ European Commission, Special Eurobarometer No. 283, 'Health and long-term care in the European Union', 2007.

⁴⁶ World Health Organisation, Regional Office in Europe, *A Snapshot of the Health of Young People in Europe*, 2009, p. 56 and Figure 3.3.4

⁴⁷ Orbach, S., *Bodies*, 2009, Profile Books LTD, London, UK.

⁴⁸ Orbach, S., *Fat is a Feminist Issue*, 1978, Arrow, UK.

⁴⁹ Data from International Osteoporosis Foundation, facts and Statistics about osteoporosis and its impact: <http://www.iofbonehealth.org/facts-and-statistics.html> The same data offer information on the estimated number of women and men suffering from osteoporosis in several EU Member States (BE, DK, FIN, FR, GER, GR, SP, SE, UK) and the availability and the costs of treatment for this disease.

⁵⁰ Alzheimer Europe, *Dementia in Europe. Yearbook 2008*, p. 133.

⁵¹ World Health Organisation, *Gender and Health*, Gender, Health and Ageing, 2003.

⁵² Two publications are cited as evidence for this conclusion: Freedman KB, Kaplan FS, Bilker WB, et al. (2000) Treatment of osteoporosis: are physicians missing an opportunity? *J Bone Joint Surg Am* 82-A:1063 et Siris ES, Miller PD, Barrett-Connor E, et al. (2001) Identification and fracture outcomes of undiagnosed low bone mineral density in postmenopausal women: results from the National Osteoporosis Risk Assessment. *JAMA* 286:2815 sur <http://www.iofbonehealth.org/facts-and-statistics.html>



and depression. Lower risk of depression is associated in both genders with marriage and cohabiting with a partner as well as with having a generally good socioeconomic position. In a majority of countries, socioeconomic factors have the strongest association with depression in both men and women⁵³.

e. Women's consumption of alcohol and drugs

The consumption of alcohol and drugs increases drastically among women and girls, which poses serious threats to their physical and psychological health. Research and statistics in Sweden as well as in Europe shows growing alcohol-related health problems among women. The traditional treatment of abusive problems has had men's needs and symptoms as norm and starting point. Women, thereby, are seen as a subgroup and programmes for prevention, access to help etc are done based on men's experiences. This has to change in order to make sure women get adequate treatment and care.

2.2 Structural determinants of women's health risks

a. Male violence against women

Male violence against women and its impacts on women's health constitute a fundamental barrier to the achievement of gender equality and women's full enjoyment of their human rights. Male violence against women is 'violence directed against a woman because she is a woman or that affects women disproportionately. It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty'.⁵⁴ Male violence can happen to anyone. It is a structural phenomena not primarily related to social status, education, poverty or any other issue.

According to the Council of Europe, one-fifth to a quarter of women are subjected to male violence, which can take many forms.⁵⁵ For example, more than one in ten women in Europe is a victim of sexual violence involving the use of force.⁵⁶ In the UK, two women die each week at the hands of a partner or an ex-partner. 80,000 women experience rape or attempted rape.⁵⁷ In France, one woman is killed every three days by her partner.⁵⁸ Between 40 and 50% of women in the EU report experiencing sexual harassment at work.⁵⁹ Out of an estimated 250,000 people trafficked in Europe each year, 79% are trafficked for sexual exploitation and

⁵³ Gender differences in depression in 23 European countries. Cross-national variation in the gender gap in depression, Van de Velde S, Bracke P, Levecque K., Soc Sci Med. 2010 Jul;71(2):305-13. Epub 2010 Apr 24.

⁵⁴ CEDAW Committee, *General Recommendation No. 19*. Male violence against women includes, though is not limited to: sexual assault; rape; sexual harassment; physical violence; verbal violence; mental and psychological violence; male domestic violence (in intimate partnership and/or in the family); stalking; forced marriage; female genital mutilation; crimes committed in the name of 'honour' including murder, stoning, acid attacks and forced suicide; violations of women's sexual and reproductive health and rights including forced sterilization; pornography and sexist advertising; violence in institutional settings like hospitals and care institutions, prisons or reception centres for asylum seekers; prostitution; trafficking in women; and male violence against women in conflict.

⁵⁵ Council of Europe, *Combating violence against women – stocktaking study on the measures and actions taken in Council of Europe member states*, 2006.

⁵⁶ Council of Europe, 2008.

⁵⁷ Phillips, T., *Chair Equality and Human Rights Commission in UK*, intervention on 26 November 2007.

⁵⁸ *Mission Égalité des Femmes et des Hommes*, 2009.

⁵⁹ United Nations Factsheet, 2006.



more than 80% of these victims are female.⁶⁰ Currently, it is estimated that 500,000 women and girls living in the European Union are affected by – or threatened with – female genital mutilation.⁶¹

Most existing studies evaluate the costs of male violence against women in economic terms. For the 27 EU Member States, it has been estimated that the total annual cost of domestic violence could reach the sum of 16 billion Euros, amounting to 1 million Euros every half hour.⁶² The annual budgets for programmes designed to prevent male violence against women, in the 27 EU Member States, are 1 000 times less. Still, it is very difficult to measure the incidence of male violence against women, whatever the form. Current social 'norms' make it very difficult for women to report such violence and ignore its prevalence; indeed, women are often blamed for 'inciting' violence rather than being considered victims.

Male violence against women can have serious health consequences, which are often either not recognised or minimised in the same manner as the existence of the violence itself. These health consequences are costly, but the full nature of the impact cannot be measured in economic terms. In addition to physical trauma, including many types of sexual suffering, becoming a victim of any form of male violence – in the professional, private or public sphere – can have serious mental health consequences for women. Experience of violence can lead to post-traumatic stress disorder, depression, anxiety, panic attacks and high-risk health behaviour (including substance addiction, unsafe sexual behaviours and abusive relationships).⁶³ Male domestic violence has severe and persistent effects on women's physical and mental health and carries an enormous cost in terms of premature death and disability.⁶⁴ Sexually transmitted diseases and unplanned pregnancy are other consequences that women victims can experience in cases of rape (including in marriage), incest, prostitution, pornography, etc.⁶⁵ Women and girls who are subjected to female genital mutilation are exposed to short and long-term effects on their physical, psychological, sexual and reproductive health.⁶⁶

A variety of factors contribute to the way different forms of male violence impact on women's health, including poverty, economic dependence, lack of social support, different forms of discrimination based on age, migrant status, sexual orientation, disability, etc. The current economic recession impacts strongly on the protection of women from male violence, as funding and support for NGOs, the public and/or specialist services have decreased or are subject to significant cuts. The increase of extreme poverty gives also rise to prostitution, exploitation of all kinds, trafficking in women, and to general male violence.⁶⁷ The prevalence of male violence against women, couple with the economic crisis, has a great impact on women's health as it leads to the increase in use of health-care services and the challenges such services face in preventing and also reporting violence.⁶⁸

⁶⁰ UN Office on Drugs & Crime, *Trafficking in Persons – Analysis on Europe*, 2009.

⁶¹ *Association of European Parliamentarians with Africa*, 2009.

⁶² Daphne Project on the cost of domestic violence in Europe, 2006.

⁶³ Thummler, K. et al., *Data and Information on Women's Health in the European Union*, 2010.

⁶⁴ *Ibid.*

⁶⁵ Martin, S. and Macy, R., *Sexual Violence Against Women: Impact on High-Risk Health Behaviors and Reproductive Health*, National Online Research Center on Violence Against Women, 2009.

⁶⁶ Amnesty International Campaign Strategy against Female Genital Mutilation.

⁶⁷ European Women's Lobby and Oxfam International, *An Invisible Crisis? Women's poverty and social exclusion in the European Union at a time of recession*, 2010.

⁶⁸ *Ibid.*



b. Discrimination against women in relation to health

Apart from the lack of gender mainstreaming in health policies and the inadequacy of health services catering to women's needs, there are also instances of discrimination against women in relation to health, in particular for some groups of women who face multiple discrimination.

Council Directive 2000/43/EC forbids discrimination based on ethnic or racial origin as 'regards both the public and private sectors, including public bodies' that offer 'social protection, including social security and healthcare' and 'access to and supply of goods and services [...]'.⁶⁹ Still, this Directive is not fully applied in EU Member States in relation to access to health-care for women from different ethnic and racial background. For example, women from the Roma community face such (double) discrimination. Roma women use health care services less than the rest of the population, partly due to the discrimination and harassment they often face from medical professionals. Language and other cultural barriers also restrict Roma women's access to health-care.⁷⁰ This discrimination can even lead to violence, with the forced sterilisation of Roma women – a serious violation to bodily integrity, freedom of choice and the entitlement to self-determination of reproductive life – receiving increasing attention.⁷¹

Forced sterilisation is an issue with regard to women with disabilities,⁷² who also face a variety of barriers in accessing health-care. There is very limited adaptability of health services towards the specific needs and rights of women with disabilities, especially in the field of sexual and reproductive health. They are often stigmatised as asexual unable to make decisions concerning their sex lives independently. Guaranteeing safe, informed, and adaptable access to sexual and reproductive health and rights to women with disabilities represents one of the greatest challenges to health services in the majority of EU Member States. Disabled women are entitled to freedom of choice, including as regards bodily integrity and informed consent. Women with disabilities also have the right to family life and privacy and thus their right to informed family planning and assisted reproduction must be guaranteed.⁷³

Very little research has been carried out on the specific health situations of lesbian women, including their vulnerability to particular diseases and needs in terms of health services.⁷⁴ Sexual orientation *per se* does not directly influence the prevalence of cancer or any other disease. Nonetheless, reports show that double discrimination based on gender and on sexual orientation can have a significant impact on mental and physical wellbeing, and can prevent some women from seeking assistance from health-care providers. Lesbian and bisexual women visit gynaecologists less regularly than heterosexual women. The little investigation carried out evidences widespread mistreatment and discrimination of lesbian women at the hands of medical

⁶⁹ Council Directive 2000/43/EC of 29 June 2000 implementing the principle of equal treatment between persons irrespective of racial or ethnic origin, in the O.J. L 180 from 19/07/2000, Art. 3 (e) and (h).

⁷⁰ Corsi, M. et al., *Ethnic minority and Roma women in Europe: A case for gender equality?*, European Commission, 2010, pp. 111-115

⁷¹ For more information, see the work of European Roma Rights: <http://www.errc.org>

⁷² European Disability Forum, *Statement Against The Forced Sterilization of Girls and Women with Disability on 25th November 2009*, accessible at www.edf-feph.org. These cases have not been documented in a comprehensive Report at the European level, but cases are known and signalised by NGOs working in the area.

⁷³ See the work of European Disability Forum and several public interventions on this topic: www.edf-feph.org

⁷⁴ Genon, C. et al., 'Pour une promotion de la santé lesbienne : état des lieux des recherches, enjeux et propositions', in *Genre, sexualité & société*, No. 1, pp. 1-24. The majority of research cited as reference for the study was carried out in Canada and USA.



professionals and personnel.⁷⁵ The fear of a lesbophobic reaction from health-care providers and a stronger reluctance to share 'private matters' with a stranger play a significant role, causing lesbian women to often seek medical assistance only in cases of strict necessity and forego preventive visits.⁷⁶

c. Poverty

Poverty in Europe is multidimensional and is linked not only to material deprivation but also to different issues including poor health. Women lag behind men on virtually every indicator of social and economic status and are more likely to experience poverty than their male counterparts. Women are the majority of part-time workers and those on temporary contracts with poor medical insurance coverage or none at all.⁷⁷ There are more women than men active in informal work, including in the home, and are not covered by health-care provisions.

Poverty is frequently associated with many of the factors contributing to poor health as it deprives individuals of the possibility to satisfy basic needs and rights, namely to achieve sufficient nutrition, to obtain remedies for treatable illnesses, and to have access to clean water and sanitary facilities.⁷⁸ In some EU Member States, these fundamental health services are not necessarily covered by basic public health insurances, the quality of the services is poor, and most of the time their costs are excessively high.⁷⁹

3. Women's access to health and existing barriers

Existent gender inequalities are reflected in the way women and men can access health and in the types of health services provided specifically for women or for men. Several EU comparative reports and other documents on health issues support the conclusion that health care systems have a crucial role to play in improving the health status of the population, in diminishing health inequalities and in preventing diseases.⁸⁰

Access to quality health services is an important health determinant and the range of barriers women can face in accessing these services prevent them from fully enjoying their fundamental right to health. These barriers to access may stem from factors within the health system itself, including gaps in population coverage of health insurance; limited scope of public health benefits; high costs; geographical factors such as distance or lack of infrastructure; organisational factors, e.g. waiting lists and limited opening hours; or insufficient or inappropriate information. They may alternatively relate to the characteristics of the potential service user, such as income, education, age, language, disability, sexual identity, cultural background and/or civil status.⁸¹ In all these categories, gender plays a significant role.

⁷⁵ Fundamental Rights Agency, *Homophobia and Discrimination on Grounds of Sexual Orientation and Gender Identity in the EU Member States: Part II – The Social Situation*, 2009, pp. 76–82.

⁷⁶ ILGA, *Lesbian and Bisexual Health Women's Report*, 2006.

⁷⁷ Huber, M. et al., *Quality in and Equality of Access to Healthcare Services*, 2008, European Commission, p. 66.

⁷⁸ Hogstedt, C. et al., *Health for all? A critical analysis of public health policies in eight European countries*, 2008, Stockholm, Sweden.

⁷⁹ It is the case of new EU Member States from Central and Eastern Europe, like Hungary, Romania, Bulgaria, and Czech Republic. See Ziglio, E. et al., *Health Systems Confront Poverty*, World Health Organization, Regional Office in Europe, 2002.

⁸⁰ Huber, M. et al., *Quality in and Equality of Access to Healthcare Services*, 2008, European Commission. Health Systems, *Euro Observer - The Health Policy Bulletin of the European Observatory on Health Systems and Policies*, Vol. 8, No.2, 2006.

⁸¹ Huber, M. et al., *Quality in and Equality of Access to Healthcare Services*, 2008, European Commission.



a. Inequalities between women and men in access to health

Women use health-care – especially primary-care – services more often than men. This is mainly related to women's reproductive health and child-bearing functions, but also to their persistent social role as the primary caretakers of dependents, whether children or other family members. In spite of this higher level of use by women, health-care systems and services are not particularly women-friendly or considerate towards women's health needs. Furthermore, there are practices and barriers that discriminate against women. Studies show inequalities between women and men in access to specialist doctors and treatments. For example, women with angina are less likely to be referred to a specialist or to undergo a revascularisation, a process that prolongs life.⁸² Also, it is not widely accepted or understood by medical professionals that differential approaches and treatments, including counselling, indirectly discriminate against women service users.

At the same time, women are the majority of employees within the health sector, especially as caregivers, nurses and general practitioners. Nonetheless, they dominate in lower-paid and lower-status positions rather than for example as specialised doctors.

b. Financial barriers

Financial barriers in particular restrict women's access to health and health-care. Recent reforms of health systems in European countries have led to a weakening of universal health-care coverage and a change in the balance between public and private contributions to health-care costs. This has a detrimental impact on women as they generally have less access to resources and/or private health coverage. According to the European Commission, 'in several EU countries, some of the typical gaps in health baskets include limited coverage for dental and ophthalmic services, and limited access to specialised services, which frequently require going through a GP [general practitioner] gatekeeper.'⁸³

c. Migrant and refugee women's access to health

Linguistic and cultural barriers as well as restrictive legislation limit migrant and refugee women's access to health and health-care. Health insurance, for example, is generally strongly connected to employment status, which makes it out of bounds in particular for migrant refugee women. It can also be conditioned on marital status.⁸⁴ The lack of an independent residence status for migrant women, especially those benefiting from family reunification procedures or having immigrated to work for a specific employer, creates a dependency factor, which puts migrant women in a vulnerable position and can have a severe impact on their access to health-care.

Access to women's shelters for victims of violence is in some cases denied to third country nationals. Even when available, many women victims of violence – at the hands of either their husband or employer – fear

⁸² 'Gender equity in use of treatment for cardiac heart disease' in Fernandes A. et al., *Health and Health Care in Portugal: Does gender Matter?*, 2009, pp. 57-71. *The Gender and Access to Health Services Study. Final Report*, Department of Health, UK, 2008, pp. 15-26.

⁸³ Huber, M. et al., *Quality in and Equality of Access to Healthcare Services, 2008*, European Commission, p. 66.

⁸⁴ Xuseyn, A., *Access to Health Services. Migrant Women's Experience*, presentation given during the EWL Thematic Seminar on Women's Health in Europe, January 2010, Dublin, Ireland. Alwiye Xuseyn is a Women's Health Officer with AkiDWA, African women's organisation in Ireland.



leaving an abusive relationship because it would mean losing their legal status and becoming undocumented. Without documentation, women victims are often denied access to shelters and in some countries access to health-care more generally. Even when this is not strictly the case, undocumented migrant women are often hesitant to access health services, fearing expulsion.⁸⁵

d. Women in rural areas

The majority of the rural population in several new EU Member States such as Romania, Hungary or Bulgaria, are women, older women in particular. Their access to health-care services – and even health information - is greatly affected by a lack of infrastructure and transport facilities. Pregnant women living in remote areas have difficulty accessing medical assistance during pregnancy or child-birth. In Lithuania, a recent report emphasised that women and girls living in rural areas do not have access to contraception and family planning services, that sexual and health education is not taught in schools, that there is limited access to information and that the accessible contraceptive methods are very expensive.⁸⁶

4. The need for a dual approach of specific measures for women *and* gender mainstreaming in health policies

In the majority of EU Member States, the universality of the right to health and access to health-care according to needs is enshrined in the constitution or equivalent legislation. At European Union level, the Council has endorsed universality, access to quality care, equity, and solidarity as common values and principles underpinning the health systems of the EU Member States.

The concept of 'universality' requires that no person be barred access to health-care. 'Solidarity' is related to the financial structuring of national health systems so as to ensure this universal access. 'Equity' implies equal access according to need, regardless of ethnicity, gender, age, social status or ability to pay.⁸⁷ In addition, the European Charter of Fundamental Rights guarantees that 'everyone has the right of access to preventive health-care and the right to benefit from medical treatment under the conditions established by national laws and practices.'⁸⁸ These principles are complemented by a general gender-mainstreaming obligation enshrined in the European Treaty which applies also to the work of all European and national decision-makers in the field of health policy.⁸⁹

Health systems should aim to reduce health inequalities, among which gender is recognised as a determinant.⁹⁰ It is therefore both a legal and a social responsibility for relevant decision-makers at the

⁸⁵ Women Against Violence Europe (WAVE), *Fempower Magazine* No. 4, 5, 6, 2002.
<http://www.wave-network.org/start.asp?ID=16>

⁸⁶ *Supplementary Information on Lithuania Scheduled for Review during the 41st Session of the CEDAW Committee*, 2008, pp.7-8

⁸⁷ Council of the European Union, 'Annex: Common Values and Principles', *Council Conclusions on Common values and principles in European Union Health Systems* (2006/C 146/01). The application of these principles across the EU Member States is evaluated through the Open Method of Coordination.

⁸⁸ EU Charter of Fundamental Rights, Art. 35, OJEU, 2000.

⁸⁹ Art 3(3) in TEU (ex. Art. 2 TEC). Art. 8 TFEU (ex. Art. 3(3) TEC).

⁹⁰ Council of the European Union, *Council Conclusions on Common values and principles in European Union Health Systems* (2006/C 146/01) and *Council Conclusions on Women's Health*, (2006/C 146/02).



European and national level to fully integrate women's experiences and needs when defining public policies in the health sector. Unfortunately, the panorama of the current situation shows that this is at present not the case.

a. Specific health policies and measures to address women's health needs

Putting people first is supposed to be one of the objectives of health services. However, although women are the majority of health-care users, insufficient attention is given to their diverse needs throughout the life-cycle, and to the constraints they face in protecting their health and that of persons dependent on them or in fully accessing available services.

Key concerns for women seeking health-care include respect, trust, privacy, confidentiality and non-discrimination. This means eliminating gender biases and discrimination in health services, ensuring services are fully available and inclusive of all women's needs and situations. Health policies need to take into account the needs of different groups of women and the social role of women, who remain the primary carers for children and other dependants while increasingly also working outside the home.

As shown above, public health policies at all levels need to better address women's specific needs in terms of prevention, medication testing, treatment, service provision, etc. Research focused on women's health status, needs, illness development and prevention must to be developed, funded and supported as a matter of emergency. Health systems must build capacity to address the broader range of health issues that affect women, including, but not limited to sexual and reproductive health. In Europe, medical services dealing with women's health issues including sexual and reproductive health, and specifically abortion are too often understaffed. Finally, both public and private health-care providers need to be adequately trained to take action against practices that violate rights and harm the health and/or integrity of women and girls, such as for example female genital mutilation.

b. Health policy at European Union level and its lack of a gender equality perspective

The primary responsibility for health-related policies in the EU lies with the Member States. The EU nevertheless has a competence in health promotion and disease prevention and a role to play in coordinating and providing support to Member States in order to attain 'a high level of human health protection.'⁹¹

Women's health has been addressed as a policy issue at the EU level in the context of the social and economic determinants of health and specific age groups. In theory, the EU recognises that gender – alongside age, education, economic and civil status – is a significant determinant for health and health-care. The European Commission Directorate General for Public Health has published several reports including data on the situation of women's health and access to health-care.⁹² However, these documents were not followed-up with concrete policy actions and programmes to address women's health needs and European public health policies broadly remain gender blind.

⁹¹ Art. 168 TFEU.

⁹² Thummler, K. et al., *Data and Information on Women's Health in the European Union*, 2010; European Institute of Women's Health, *Women's Health in Europe. Facts and Figures Across the European Union*, 2006.



Neither gender and sex differences in health nor a broad gender equality perspective are systematically taken into account in EU health-related policies and activities. Rather, they are addressed sporadically and in very general terms. Despite the existing Treaty obligation to integrate a gender equality perspective in all the activities of the EU (gender mainstreaming), this is rarely done in European Commission policy papers and even less so in actions and programmes. In particular, insufficient resources and attention are given to gender equality issues and women's needs in EU-sponsored research in relation to health. The European Women's Lobby five year review of EU public health policies in 2010, *From Beijing to Brussels – An Unfinished Journey*, emphasised the lack of gender sensitivity of several key EU public health documents and policies.⁹³

c. Gender mainstreaming within health policies

Gender mainstreaming is a tool for reaching equality between women and men through challenging and transforming institutions and policies so that they fully reflect the particular needs and situation of women. It is also a Treaty obligation for the European Union and its member countries. The goal of gender mainstreaming within public health policies should be to ensure that women and men have equal access to the resources they need to realise their health potential.⁹⁴ These resources must include high quality and appropriate medical care and other social, economic and cultural goods that are necessary for the sustainability of their wellbeing. Public health policies need to be gender sensitive in design, delivery and evaluation; this should be accompanied by objectives that need to be transposed into indicators and further developed.

In recent years, evidence of gender health status differences – both general and in comparative terms across the EU Member States – have increasingly been collected and made available at European level for decision-makers.⁹⁵ Nonetheless, this knowledge and the recommendations that have flown from it have rarely been translated into efficient public health policies or well-funded projects and programmes to address the existing gender inequalities, discrimination and barriers that women constantly face. There are few countries where gender as a determinant of health has been adequately integrated into public health policies (Denmark, Germany, Sweden and the United Kingdom being the exceptions) or where specialised research institutes are funded and supported to collect, produce and distribute information in relation to women's health and gender as a determinant of health, as is the case in Sweden and Spain.⁹⁶

In terms of funding, all 27 EU governments allocate a percentage of their GDP – varying from around 5% in Poland, the Czech Republic, Hungary and Slovakia to over 8% in Denmark, Germany, France – to public spending of health-care.⁹⁷ Age and gender play a significant role when looking at the distribution of public health-care spending. The health-care spending for both women and men over 54 or 60 years is much higher compared to the spending allocated to younger age groups. Women between 25 and 40 or 45 (the key period of fertility) are allocated more spending compared to men in the same age groups. However, on the whole,

⁹³ European Women's Lobby, 'Women and Health', in *From Beijing to Brussels – An Unfinished Journey*, 2010.

⁹⁴ Doyal, L., *Gender Equity in Health: debates and dilemmas*, 2000.

⁹⁵ Thummler, K. et al., 2010; European Institute of Women's Health, 2006; Mladovsky, P. et al., 2009; Zatoński, W. et al., *Closing the health gap in European Union*, 2008.

⁹⁶ The centre for the Gender Medicine at Karolinska Institute in Stockholm, Sweden; and the Women and Health Observatory in Madrid, Spain.

⁹⁷ European Community Health Indicators, DG SANCO, based on *OSCE Health Data 2009*.



women are allocated a lesser proportion of health-care as compared to men.⁹⁸ This demonstrates clearly and unequivocally how funding is spent in Member States to address gender-specific and gender-influenced health conditions. This needs to be addressed through the implementation of gender budgeting methods across the spectrum of health-related policies.

EWL RECOMMENDATIONS

In order to ensure the integration of women's perspectives and needs within health policies, a multi-pronged strategy is needed in different sectors and at different levels, including: medical research, data collection, medical testing, training of the care and medical professionals at all levels and in all sectors, budgetary provisions and allocations in the health sector, reform of health systems, gender-sensitive service delivery and implementation of a gender budgeting approach to financing policies in the health sector.

The European Union and Member States must:

- Ensure the integration of a gender perspective in all aspects of health policies, programmes and research from their development and design to impact assessment and budgeting.
- Introduce and use gender budgeting in public health policies at all levels.
- Conduct gender impact assessments of the recent changes brought about by health sector reforms, especially when addressing health-care financing and delivery.
- Maximise the participation of all women in health policy development, programme planning and service delivery, through positive action programmes that recognize women's role as paid and unpaid providers of health care and as services users.
- Support health research focused on women's health and women's health needs, including through the creation of specific programmes, bodies or institutes. Ensure a wide distribution of the research outcomes, especially amongst health policy-makers, practitioners and personnel.
- Promote a greater participation of women in medical research, including at the highest levels and through positive action measures.
- Take stock of the specific health needs of women; and develop public health policies in accordance with these needs and demands.
- Promote and make mandatory the collection of comparable sex-disaggregated data at EU and national level.
- Recognise male violence against women as a public health issue, whatever form it takes.
- Support civil society and women's organisations that promote women's human rights, including women's sexual and reproductive rights, and work to ensure that women have a voice in European and national health policy issues.
- Grant migrant women an independent legal status within maximum one year of arrival.
- Take measures to ensure the access to health-care services – including women's shelters – to all women independent of their legal status, disability, sexual orientation, race or ethnic origin, age or religion.

⁹⁸ Graph 65: 'Age-related expenditure profiles of health care provisions', in European Commission and Economic Policy Committee, *The 2009 Ageing Report*, pp. 111-112.



The European Union must:

- Support health research focused on women's health and health needs, especially in the framework of EU Research Framework Programmes; and include gender as a criterion for funding in all EU research.
- Ensure that all EU-funded research projects include a balance between women and men among researchers and fully integrates a gender mainstreaming approach.
- Promote multidisciplinary research into the socio-economic determinants of health across the lifespan of women.
- Promote sexual and reproductive health and rights, adequate gender-sensitive information and reliable, safe and affordable contraception, and provide the opportunity of safe abortion within and beyond the European Union.
- Take a strong position in favour of women's human rights, including by denouncing the forced sterilisation of women, especially in cases of women with disabilities or Roma women, and female genital mutilation.

The European Union Member States must:

- Halt and reverse current cuts in public spending for services crucial to the attainment of a high level of health protection for women and men.
- Investigate, ban and prosecute direct and indirect discrimination against women in access to health and health-care services. The public authorities specialised in combating discrimination and protection of human rights must take the necessary measures in order to prevent any further discrimination against women in access to health-care and health services. Women need to be informed in order to be able to denounce such acts of discrimination and help to overcome such experiences.
- Prevent, ban and prosecute forced sterilisation of women, notably in cases of women with disabilities or Roma women.
- Prevent, ban and prosecute female genital mutilation and provide health services specialised for women victims of FGM.
- Eliminate discrimination against women in relation to access to Artificial Reproductive Technologies based on marital status, age and sexual orientation.
- Ensure that health services addressed to women or developed particularly for women are covered under public health services and are accessible by/through public health insurances.
- Ensure a stronger focus on prevention, including prevention of women specific diseases, in public health policy.
- Make widely accessible and improve pre- and post-natal medical care to all women and pay more attention to psychological trauma and other issues related to childbirth.
- Identify and evaluate the outcome of good models of mental health care that both integrate maternity care and mental health services for women.
- Initiate research into women's birth experience and the relationship between the development of mental health difficulties



EUROPEAN WOMEN'S
LOBBY
EUROPEEN DES FEMMES

POSITION PAPER

- Fully implement the European Parliament target of screening coverage of 100% of the female population for breast and cervical cancer.⁹⁹
- Recognise and guarantee sexual and reproductive health and rights, including safe abortion, and ensure access to free-of-charge, safe and reliable methods of contraception for all women.
- Develop new methods to prevent sexually transmitted diseases including free access to HIV-AIDS testing and early medical treatment and dramatically increasing funding for the research, access to, purchase and distribution of effective female condoms.
- Develop and financially support educational programmes on sexual and reproductive rights and health including information on contraceptives in schools; provide universal free access to sexual and reproductive health education and information, targeted to the different needs of women and men and also to various age categories.
- Devote more attention and research to discrimination against lesbians and trans-women and their specific health needs.

⁹⁹ European Parliament, *Opinion of the Committee on Women's Rights and Gender Equality on the Commission communication on Action against Cancer: European Partnership*, 2009/2103(INI), Feb 2010, 1&9.