Gender Equality and Health in the EU

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Introduction

The Scientific Analysis and Advice on Gender Equality in the EU (SAAGE) network of the European Commission is completing a report for the European Commission on 'Gender Equality and Health in the EU'. This report, researched and written by Professor Clare Bambra and Dr. Paula Franklin, provided the starting point for the presentations and debate at this webinar.

The webinar sought to deepen knowledge and understanding of the relationship between gender and health, and to stimulate insights into effective policy and practice responses to gender specific health risks; mainstreaming gender within health policy; and gender sensitive health services.

European Commission: Gender Equality Policy Perspective

Karen Vandekerchove, Head of the Gender Equality Unit in DG Justice and Consumers, opened the webinar.

Gender inequality, discrimination, norms, and stereotypes are underlying factors impacting on the health of women and men over the life course. Women and men in all their diversity must be empowered to attain their full health potential. While health and social care is a national competence, action at the EU level is possible and this is a focus for the European Commission in its Gender Equality Strategy 2020-2025. We are working to better understand the links between gender equality and health, identify actions being taken to address these challenges, and establish the further opportunities that present for action.

There are specific EU initiatives being progressed that respond to issues of gender equality and health. The pay transparency initiative that is to be published this year will address the undervaluing of women's work, including in female dominated sectors such as the health services. The proposed legislative initiative on gender based violence will include measures to prevent violence and protect victims.

The European commission can support national action by identifying the links between gender equality and health, and enabling sharing of good practices and approaches between Members States. Sexual and reproductive health rights are at the core of gender equality. The UN 2030 Agenda and Sustainable Development Goals endorse global efforts to advance women's health. Women and men, girls

and boys, all need to be empowered to make free and informed choices about their sexuality and reproductive health to the same high health standards.

Gender Equality and Health in the EU

Presentation

Professor Clare Bambra, Population Health Sciences Institute, Newcastle University, UK, and Dr. Paula Franklin, Honorary Researcher, Population Health Sciences Institute, Newcastle University, UK and Senior Researcher, ETUI presented on their research report 'Gender Equality and Health in the EU'.

The overarching picture for gender equality and health is one of higher mortality rates and shorter life expectancy among men as opposed to higher morbidity rates amongst women. This varies across the Member States and gets more complex with certain indicators such as healthy life expectancy. Women and men differ too in terms of the diseases they are more likely to develop. There is a lack of women in decision-making positions, a particularly visible issue during the Covid-19 response.

The analysis developed on these inequalities points to biological, social, economic, and public policy explanations. Social factors emphasise behaviours, including health behaviours, and involve constructions of masculinity; work-family roles and the burden of work and care; and occupational choices and risks. Economic factors emphasise socio-economic issues, involving such as higher rates of poverty; lower employment rates and, historically, education rates; and discrimination experienced by women. Public policy factors play a role as macro-level determinants of gender inequalities in shaping these social and economic factors. Biological factors focus on sex rather than on gender and are not as convincing as these other factors.

Women more often use medication than men, especially when it comes to prescribed medicines. Women use health services more frequently than men. Barriers to using health services differ between women and men. Barriers identified for men include their perceptions of waiting room design; knowledge in relation to making appointments; fear of examination or intervention; lack of vocabulary in relation to health needs and issues; and gender stereotypes.

There are gendered differences in occupational safety and health risks due to vertical and horizontal labour market segregation. Care work is undervalued and the health and care sector, dominated by women, suffers from poor working and employment conditions. Work related accidents are more common among men. Women report work related ill-health more often than men. Women's exposure to dangerous substances, in sectors dominated by women, is under-assessed. The sectors dominated by women leave them particularly exposed to violence and harassment.

Access barriers to medical services include lack of availability of services, financial barriers, difficulty in reaching services, lack of information, poor quality of care, and discrimination. These barriers can affect men and women in different ways. Financial barriers can particularly affect women, with men more likely to have private health insurance. Difficulty in reaching services can be a particular issue for women as they rely more on public transport than men.

Sexual and reproductive health rights and services require strengthening. Unmet contraceptive needs particularly affect adolescents, people with a low income, people living in rural areas, people with HIV, and refugees and migrants. Access to maternal care for irregular migrants, refugees, asylum seekers and ethnic minorities needs to be improved. Violence in childbirth, obstetric violence, needs research and further response.

There is a lack of gender-sensitivity in healthcare and health research. Medical trials primarily test men, with the EU Clinical Trials Regulation still to be applied. Gender is not included in the training of healthcare professionals to any widespread extent. Guidelines are needed for health professionals in relation to recognising and managing the effects of sexual violence.

An intersectional perspective identifies a lack of attention, in research and data gathering, on minority ethnic and migrant women. These groups can experience specific language and cultural barriers. Particular issues of maternal mortality, post-natal depression, and risks of stillbirth, perinatal mortality, neonatal mortality, and infant mortality are evident for migrant women. Roma women evidence high levels of limitations to their health.

The Covid-19 pandemic has had a gendered impact. Men were slightly less likely to be infected, but were more likely to be admitted to hospital, and require

intensive care, with higher death rates. There were higher rates of intimate partner violence, mental ill heath, and reduced healthcare access due to lockdown strategies, particularly affecting women and children. Women are disproportionately represented in the health and social care workforce that was exposed to significant risk. The longer-term economic fallout from the pandemic may be worse for women given that they are more present in hard-hit sectors of the economy.

Recommendations to the EU include a focus on investigation and research, exchange and guidance, and monitoring, in relation to health inequalities, causal factors, and responses. More specifically, recommendations include that the post-2020 renewal of the EU Strategic Framework for Health and Safety at Work have a gender dimension; steps be taken to make the Clinical Trials Regulation applicable; and include ring-fenced resources in the EU4Health Programme, for materials that integrate sex and gender into the training curriculum for healthcare professionals.

Recommendations to the Member States include a focus on universal access to healthcare, gender equality assessment in policy making, gender budgeting in health policies, improved data collection, gender parity in health-related decision-making structures, and comprehensive, evidence-based gender and sex-education.

Themes from the Discussion & Debate

The following themes emerged from the discussion for future attention:

- Accessibility for some groups could be enhanced through telemedicine and such provision lags behind the development of the technology. However, the further use of this would require provision of supports to enable use of such services and provision of training for those delivering such services.
- Occupational health and safety issues can be inappropriately viewed as individual rather than structural issues. There are instances where these have been addressed through social partner frameworks. The targeting of campaigns to improve safety in female dominated, where there is less awareness, needs further consideration.

- Broader indicators of self-harm that look beyond suicide would assist a focus on the particular experience of women. Women might self-harm in different ways, in particular through eating disorders.
- Mental health care provision and access is limited for most groups. Minority ethnic groups and migrants face particular barriers where language and cultural differences are not catered for, and where there is a strong stigma associated with mental health issues within these groups.
- Obstetric violence can be a result of rigid training in management of labour that is connected to resources. This can lead to increased levels of forceps or caesarean delivery with little choice offered to the women involved.
- Women have experienced an increased burden of care with Covid-19. It can be difficult to maintain employment in such a context and women have dropped out of the labour market as a result. The response to Long Covid will need a gender sensitive response. Gendered aspects in higher case rates or higher susceptibility need to be monitored and appropriate supports developed for men and women
- Universal access to healthcare is an important step to addressing health inequalities. Universal access is particularly important in sexual and reproductive healthcare services and screening. There are significant socio-economic barriers to accessing contraception, abortion, menstrual products, and treatment for STDs.
- Pay transparency legislation is likely to assist women in a female-dominated sector such as the health and care sector. However, there are no short cuts to resolving the issues of the care economy. There is a need to invest in the care economy, including in terms of training and recognition.

European Commission: Health Policy Perspective

Isabel De La Mata Barranco, Principal Advisor for Health and Crisis Management, DG Health and Food Safety, opened the afternoon session.

Gender equality is on the agenda of DG Health and Food Safety and has been for many years, with significant reports produced and internal training conducted to ensure initiatives take gender differences into account and respond to different needs of women and men. A gender mainstreaming approach is taken, which has

been further strengthened by the current Commission and is now being driven through the Gender Equality Strategy 2020-2025.

There is important collaboration between DG Health and Food Safety and DG Justice and Consumers and with EIGE, which will continue. The focus on health inequalities will continue, including gender as a particular focus, but also as a focus within the range of other groups experiencing such inequalities. The EU4Health Programme is to be approved and will continue to include a consideration of gender issues in all its funding lines.

Gender Sensitivity in Healthcare in the Member States

Presentations

Ursula Barry, SAAGE expert from Ireland, presented on the Irish situation.

Gender mainstreaming in health policy has been a starting point for action on health inequalities and gender sensitive provision. Collaboration between different state agencies and engagement with civil society have been important in these initiatives. A gender mainstreaming framework was developed by the Health Service Executive and the NGO National Women's Council. This combined an acknowledgement of the different needs of men, women and trans people with the imperative of equal treatment. A training handbook on gender mainstreaming in health was developed, through a partnership between the state and civil society.

Initiatives flowing from this infrastructure included National Guidelines on Referral and Forensic Clinical Examination following Rape and Sexual Assault; a National Men's Health Policy; and guidelines for and training of health professionals on working with trans people and their families.

Policy implementation is at issue and there is a danger of policies being confined to the aspirational. Covid-19 highlighted this in the manner it interrupted gender mainstreaming in health services.

Anita Nyberg, SAAGE expert from Sweden, presented on the Swedish situation.

Gender mainstreaming in Sweden has the objective that women and men have the same power to shape society and their own lives. Gender equality in health is the newest sub goal in this strategy.

Research has demonstrated the influence of gender stereotypes in medical students' opinions on cases presented to them. It has evidenced differences in care between women and men without any obvious medical rationale in a range of settings. It has demonstrated the risk in phone-based healthcare advice of unmotivated medical differences in how women's and men's issues are perceived.

Three kinds of bias are evident in diagnosis and treatment: gender differences are exaggerated or created, with symptoms treated differently as a result; gender differences are ignored or not perceived, with one sex perceived as the norm; and making the individual gender specific, imposing a homogeneity on the group.

Support and systematic knowledge are needed to achieve gender equal health. A health centre in Sweden has developed a method for questioning, called the Gender Hand, to encourage staff to ask the same questions of both women and men, in order not to miss any area which might be relevant and for patients to receive equal treatment based on need.

Sexual and Reproductive Healthcare Services in the Member States

Presentation

Elvira Gonzalez Gago, SAAGE expert from Spain, presented on the Spanish situation.

A framework was put in place for the provision of sexual and reproductive healthcare services of legislation and strategy: the Spanish Organic Law 2/2010 for Sexual and Reproductive Health and the National Strategy for Sexual and Reproductive Health 2011. There have been issues with implementation with changes in government shortly after this framework was put in place.

There are two parts to this framework: public health provision and education; and voluntary interruption of pregnancy. This framework stands to be implemented by regions and municipalities. There is a variety of approaches taken among the regions, however, often depending on political leadership. Some elements are subject to a Common Service Portfolio which is compulsory in all regions.

The framework has recently been reactivated with a change in government and the introduction of an Operative Plan for Sexual and Reproductive Health 2019-2020. This included a definition of integral sexual health and the relaunching of the Observatory of Women's Health aimed at gender mainstreaming in health

policy. A new draft Education Law further provides for health education and sexual education, and foresees emotional and values education at all education levels.

Alexandra Scheele, SAAGE expert from Germany, presented on the German situation.

There are a wide range of services and actors involved in sexual and reproductive health services covering prevention and counselling. There is a divergence across the federal states on what is on offer and costs. There are particular access barriers for people with migrant background and lower socio-economic status.

In reproductive health:

- Pregnancy is self-determined with freedom of choice at birth, though this is somewhat undermined by a structural shortage of midwives.
- Artificial insemination includes a well-developed medical aspect, but there are tensions with the Embryo Protection Act.
- Contraceptives are privately financed, except for younger people up to age of 22 with statutory health insurance.
- Abortion remains an issue and is still illegal, but women are not prosecuted. While costs cannot be reclaimed under health insurance, abortion can be secured on foot of mandatory counselling, though not in all hospitals and doctors are not allowed provide information on abortion services.
- Sexual education and sex education for minors is recognised as part of the state's educational mandate at school, but there is tension as to whether this should include premarital sexual relationships, non-heterosexual orientations and non-binary gender identities.

In sexual health:

- The law on changing first names and determining sex in special cases offers two procedures with different legal effects for people within a voluntary framework. Public health insurance provides services for transsexual people under defined conditions. Intersex people can choose not only "male" and "female" sexes but also a "diverse" option, the so-called "third option".

Themes from the Discussion & Debate

The following themes emerged from the discussion for future attention:

- There are implementation issues to be considered when it comes to policy or legislation in relation to gender equality and health. Objectives are outlined but no budget is attached or resources allocated. There are instances of legislation being approved but not implemented in this field. Strategies to drive policy-making are well-developed at EU level, but strategies to drive policy implementation might need some prioritisation.
- There are particular challenges of implementation when different levels of governance are involved. Regions and municipalities have a level of autonomy and national policy does not necessarily reach the local level. How health services are organised and managed in different Member States needs consideration.
- Most health budgets do not involve budget analysis. A framework for this gender budgeting is needed. Implementation is a matter of resources.
- Training is important for a gender sensitive health service. Curricula for professional training need to be gender proofed. More comprehensive approaches to build a general awareness and understanding of gender issues is needed in training.

The next edition of the Gender Equality Index produced by EIGE will include a focus on gender equality and health, with a particular focus on sexual and reproductive health and mental health. There will be a link made to other domains in the index to capture social determinants of health issues. Intersecting inequalities will be a further feature.

The research report "Gender Equality and Health in the EU" will be finalised and published, and disseminated. Peer learning among relevant officials could be developed at EU level to include a focus on gender equality and health through the Mutual Learning Programme.