



World Health
Organization
REGIONAL OFFICE FOR Europe



POLICY BRIEF

HEALTH AND GENDER EQUALITY



Key messages

Taking action on one SDG gets results in others: health runs through every SDG.



ENSURE HEALTHY LIVES AND PROMOTE WELL-BEING FOR ALL AT ALL AGES.



ACHIEVE GENDER EQUALITY AND EMPOWER ALL WOMEN AND GIRLS.

WHO commits, at all levels of engagement, to the implementation of gender equality, equity and rights-based approaches to health that enhance participation, build resilience, and empower communities... to gender mainstreaming including not only sex-disaggregated data, but also bringing a gender lens to needs analysis and programme design (1).

- Member States of the WHO European Region have some of the highest levels of gender equality among WHO regions, but there are differences across the Region; according to existing gender equality indexes (2–4), no Member State has achieved full equality. Gender inequality is not simply a matter of human rights; evidence demonstrates that it has a significant negative impact on health and well-being.
- Gender power relations and gender norms and stereotypes affect women’s and men’s exposure and vulnerability to certain health risks, their health-seeking behaviour, their ability to access health services and the way that health systems respond to their needs. More equitable gender norms, roles and relations could profoundly improve health outcomes for both women and men.
- The framework provided by the Sustainable Development Goals (SDGs) offers a unique opportunity to achieve gender equality and simultaneously improve health and well-being for all. It presents a twin-track approach, highlighting gender equality as a stand-alone goal (SDG 5) but also recognizing its importance in contributing to progress across all the other goals and targets, including SDG 3 (achieving health and well-being for all). Conversely, achieving gender equality will be difficult without progress on health targets that address conditions which reproduce gender inequalities.



- /// In the WHO European Region, the Strategy on Women's Health and Well-being (5) and the Strategy on the Health and Well-being of Men (6) strengthen the links between SDG 3 and SDG 5 while providing a comprehensive working framework for improving health and well-being in Europe through gender-responsive approaches.

Health and gender equality: the connections



Gender is a social construct that intersects with, but differs from, biological sex. It refers to the socially constructed norms, roles, behaviours, attributes and relations that a given society considers appropriate for women and men. These affect responsibilities assigned, activities undertaken, access to and control over resources, as well as decision-making opportunities. When individuals or groups do not fit established gender norms, roles and relations, they often face stigma and discriminatory practices and social exclusion. However, gender norms, roles and relations change over time and vary in different cultures and populations; consequently, they can be transformed to become more equitable (7,8).

If there is gender equality, then men and women have the same opportunities to access and benefit from social and economic resources such as health assets, services, laws and policies (7,9). Unequal gender power relations and harmful gender norms and stereotypes affect the health and well-being of women and men in a number of different ways. The framework presented in the SDGs provides a unique opportunity to achieve gender equality and simultaneously improve health and well-being for all because of its twin-track approach. Gender equality is a stand-alone goal yet also has a crucial role in contributing to progress across all the other goals and targets (10). Reduction in gender inequalities will be an important accelerator for achieving SDG 3, and it will not be possible to achieve some SDG 3 targets without addressing related targets in SDG 5 (Box 1). Targets for SDG 5 highlight outcomes of structural gender inequalities that have serious health outcomes for women and call for empowerment of women and girls (11):

- /// discrimination and violence against women and harmful traditional practices (targets 5.1, 5.2 and 5.3);
- /// unequal access to economic resources and low value assigned to women's unpaid work (targets 5.4 and 5.a); and
- /// unequal access to decision-making (target 5.5) and sexual and reproductive health and reproductive rights (target 5.6).

Box 1. Relationships between SDG 3 and SDG 5

The following examples of synergies between the targets are not meant to be exhaustive but rather serve as an illustration.

Target 3.1 (maternal mortality) and target 5.1 (discrimination against women and girls). Maternal mortality has long been considered a human rights issue rooted in discriminatory practices that prevent women seeking, accessing and receiving appropriate care. Health policy and practice addressing maternal mortality will need to build on, reinforce and include strategies for eliminating discrimination against women and enabling women's empowerment.

Targets 3.3–3.5 (women's health and well-being) and target 5.2 (eliminate all forms of violence against women and girls). The elimination of violence in all its forms against women and girls has important implications for women's mental health and well-being (target 3.4), addressing alcohol use disorders (target 3.5) and, in certain contexts, reducing HIV incidence (target 3.3).

Targets 3.1, 3.2 and 3.7 (health care for women and children) and target 5.3 (eliminate harmful practices affecting women and children). Action on harmful practices, such as child, early and forced marriage and female genital mutilation, is crucial for reducing maternal mortality (target 3.1), reducing neonatal and child mortality (target 3.2) and ensuring girls' and women's access to sexual and reproductive health-care services (target 3.7).

Targets 3.4, 3.5 and 3.8 (health and universal health coverage) and targets 5.4 and 5.5 (women's unpaid care work and participation in leadership and decision-making). Recognizing and valuing women's unpaid care work (target 5.4), in particular chronic care and other long-term care work, is directly linked with achieving universal health coverage (target 3.8). In general, women carry out the greater share of unpaid care work, which is often not recognized or valued and has an impact on their health (targets 3.4, noncommunicable diseases (NCDs), and 3.5, substance abuse, in particular), their economic and political empowerment (target 5.5) and their quality of life, while it perpetuates the lower participation of men in care.

Target 3.4 (NCDs) and all SDG 5 targets (gender equality and empowerment of women and girls). NCDs are the main cause of ill health for both women and men in the WHO European Region but there are important differences between men and women across the life-course that cannot be explained simply by biology. Gender norms influence levels of exposure and vulnerability to NCD risk factors for men and women. Gender stereotypes and inequalities affect access to and use of health resources and health service responses, and these differences may be perpetuated by health promotion efforts.

Targets 3.7 and 5.6 both deal with universal access to sexual and reproductive health-care services. Universal access to sexual and reproductive health-care services (target 3.7) is essential for women's and girls' health and well-being, and for gender equality. It increases their decision-making power about their own sexual and reproductive health (target 5.6). Sexual and reproductive health is equally important for men, and improving the access of boys and men to sexual and reproductive health services supports more gender equal sharing of responsibilities for healthy sexuality, which is important for healthy relationships.

Target 3.8 (universal health coverage) and targets 5.2 and 5.4 (violence against women and girls and unpaid care and domestic work). Provision of universal health coverage is crucial for addressing women's and men's biological and gender-based needs and ensuring their access to health care. Women who have been trafficked or abused (target 5.2) need to have access to comprehensive woman-centred medical care to enable them to regain health and well-being and maintain an adequate standard of living. Ensuring provision of publicly funded care services (target 3.8) also has impact on the volume and distribution of unpaid care work (target 5.4).



Gender equality and empowerment of women and girls accelerate achievements within all the SDGs, with an impact on economic participation and opportunity, educational attainment, political empowerment and health. Gender intersects with other social determinants of health and forms of discrimination influencing exposure to health risks, health-seeking behaviours and the ability to access health services.



Gender norms and stereotypes put women and men at different levels of exposure and vulnerability to risk factors for disease and injury. Levels of physical activity, diet, tobacco and alcohol consumption, sexual behaviour, engagement in violence and exposure to injuries are all heavily influenced by norms and stereotypes on what constitutes masculine and feminine behaviours (9,12).

Gender affects health-seeking behaviours and shapes how women's and men's health needs are perceived by themselves and by others. Women's health needs are often reduced to those related to reproductive and maternal health, while in fact NCDs are the main cause of ill health for both women and men in the WHO European Region (13). Traditional masculinities may act as a barrier for men to access primary health care and to manage self-care for NCDs and for sexual and reproductive health, including testing for HIV and sexually transmitted diseases and contraceptive use.

The inherent right to the highest attainable standard of health is enshrined in the WHO constitution and international human rights law (14). Yet the selection, design and organization of services often do not consider gender norms, roles and power relations to respond to the health needs of women and men. Gender impacts the design of health systems and their responses to people's health needs. The health workforce often fails to understand the influence of gender norms and roles and to address the barriers for women and men to access and use services. Women make up the majority of the health workforce in the WHO European Region, yet gender inequalities within the health system persist (12). Female health workers still face significant barriers in terms of achieving leadership positions, income equality and overcoming gender stereotypes about the types of health-care role that women generally fill. Unequal distribution of unpaid caregiving affects women's health, economic empowerment and quality of life, particularly in older age, while it perpetuates the lower participation of men in care (12). Gender bias in research and the underrepresentation of women in clinical trials has been highlighted in recent years, with calls to ensure equal inclusion of male and females in order to ensure that biological and gender-based differences are taken into account and that safe and effective diagnosis and treatment of disease occurs for both women and men (12,15). Design of primary health care, for example, may not take into consideration the needs of men most at risk of high blood pressure.

Gender intersects with other social determinants of health and other grounds of discrimination, such as education, income, ethnicity, sexual orientation, gender identity or place of residence, and it influences exposure to health risks, health-seeking behaviours and the ability to access health services. Unequal power relations in the household may affect a woman's access to health care (5,6,15–17) and gender stereotypes and unequal power relations may hamper women negotiating contraceptive use (12). In societies where normative models of hegemonic masculinities prevail, there can be increased exposure to risk factors, vulnerability and stigma among boys and men with migrant or ethnic minority status, with different sexual orientation/gender identity (gay, bisexual, transgender, intersex) or living in specific contexts, such as being homeless or incarcerated (9).

Facts and figures



Gender equality and the empowerment of all women and girls



- According to gender equality measurements, no Member State of the WHO European Region has achieved gender equality. Gender inequalities are particularly evident with regard to economic empowerment and political opportunity. The best performer in the 2018 WEF Global Gender Gap Report, Iceland, still exhibited a gap of over 33% between men and women (18). By contrast, the poorest performing country in the Region, Hungary, exhibited a gap of 95.5%, with no women in ministerial positions. Four of 14 countries worldwide that had closed at least 80% of the economic gap between men and women are from the WHO European Region (Belarus, Latvia, Norway and Sweden) (18).
- Child marriage affects girls and boys in different ways and is more prevalent among girls. Estimates suggest that child marriage has increased in central Asia and south Caucasus and current data indicate that 10% of girls in eastern Europe and central Asia are married before the age of 18. Rates vary significantly among countries and among social groups within countries (12).
- The vast majority of victims of gender-based violence perpetrated by men are women and girls – a clear example of unequal gender power relations (12).
- Women victims of violence who also belong to a minority group may experience further barriers in health-seeking behaviour (12).
- Girls forced into early marriage give birth earlier, are more likely to suffer complications during childbirth and have less decision-making power over their sexuality and health care compared with girls who marry at a later age (12). Because of early marriage, girls often drop out from education, and children under 5 years with mothers who lack education are almost three times as likely to die as children of mothers who have secondary education or higher (19).
- Although data on sex ratio at birth are fairly limited (20), skewed ratios have been found in Albania, Armenia, Azerbaijan, Georgia, Montenegro and Tajikistan (21). Sex ratio at birth is one of the variables used to generate the WEF Gender Gap Index health and survival score, and 12 out of 20 lowest-ranking countries globally on this indicator in 2015 were from the WHO European Region (22).
- In nearly all countries in the European Union (EU), women face a higher risk of poverty than men. In 2015, on average, one third of older female single households were at risk of poverty, compared with one fifth for males (12).



Gender-based violence



- Around 25% of women in the WHO European Region will experience violence on the basis of gender at one point in their lives. This estimate covers the lifetime prevalence of physical and/or sexual intimate partner violence for ever-partnered women from the age of 15 (range in the Region, 23.2–25.4%) (23).
- Violence has serious effects on women's physical and mental health. In addition to physical injury, disability or death, other results are poor maternal and perinatal health outcomes and physiological trauma, stress and depression (12). Women who have experienced intimate partner violence are 1.5 times as likely to contract HIV and are twice as likely to experience depression and alcohol use disorders (15).

- Women aged 18–29 years reported the highest prevalence of intimate partner (6%) and non-partner violence (9%) over the previous 12 months in 2014 (24).
- Large differences were found in reported prevalence of non-partner violence in the EU Member States among women of different occupations in 2014. The highest level (28–30%) was for professionals, managers, directors and supervisors; rates were lower among those doing skilled manual work (17%) or who had never had paid work (13%) (24).
- When women are killed, it is often their partner who is responsible (25). As many as 38% of female homicides globally in 2013 were committed by male partners, while the corresponding figure for men was 6% (23).
- There is growing evidence on the role of alcohol misuse in intimate partner violence and sexual violence perpetrated by men against women (26,27).
- Although there are not comparable data at European level, national reports indicate the presence of specific forms of violence against women, such as female genital mutilation, so-called honour killings, bride kidnapping and trafficking (12).
- Men are disproportionately represented among victims of death through violence and are also the main perpetrators of interpersonal violence (28). Boys are more likely to be victims and perpetrators of bullying and physical violence at schools and, in some countries, are more likely to report being victims of cyberbullying (29).

Sexual and reproductive health and rights



- The average estimated maternal mortality ratio in the WHO European Region decreased by more than half from 2000 to 2015 (from 33 to 17 deaths per 100 000 live births) (12). Despite this overall decrease, discrepancies within the Region are evident, with estimated maternal mortality 25 times greater in some Member States than in others (e.g. in 2015, there were approximately 76 maternal deaths per 100 000 live births in Kyrgyzstan compared with 3 per 100 000 live births in Finland, Greece, Iceland and Poland) (30).
- Across the Region, the adolescent birth rate (annual number of live births per 1000 adolescent women aged 15–19) varied in 2015 from approximately 3.2 in the Netherlands to 47.9 in Tajikistan, with an average of 16.6 for the Region (data from 36 Member States) (31). A high adolescent birth rate can reflect limited access to, or use of, contraception; limited comprehensive sexuality education; and/or the practice of child marriage. Adolescent births have been linked to poorer education and employment opportunities for women and girls (12).
- Throughout the Region, access to safe abortion is legal in most countries. Except for circumstances where it would save a woman's life, it is illegal in Andorra and San Marino, while it is illegal in all circumstances in Malta. Abortion is only permitted under some restricted circumstances in Monaco and Poland. These circumstances include pregnancy in the case of rape or incest, or fetal impairment. In several Member States where abortion is legal, women continue to face many barriers in accessing abortion services (32).

- There is great variation across the WHO European Region with respect to women's access to modern contraceptive choice. In a study of 16 EU countries across eight policy measures (policy-making and strategy; general awareness of sexual and reproductive health and rights and modern contraceptive choice; education on sexual and reproductive health and modern contraceptive choice for young people and young adults; education and training of health-care professionals and service providers; provision of individualized counselling and quality services; existence of reimbursement schemes; prevention of discrimination; and empowering women through access to modern contraceptive choice), Germany was ranked the highest performing country and Lithuania the lowest (33).
- Use of male condoms varies across Member States of the Region but, in general, is low compared with other modern and traditional contraceptive methods (international comparable data are limited to a survey of married or partnered women of reproductive age) (34). Among adolescents, however, condom use is much higher, with an average of 68% of 15-year-old boys who claimed to have sex reporting using a condom at last intercourse (29).
- An assessment of the status of sexual education in 25 Member States of the WHO European Region identified the need to include gender equality, sexuality and social media, violence and sexual abuse, human rights and sexuality of others in sexual education programmes and curricula (35).
- Direct exposure to discrimination based on sexual orientation and gender identity has been shown to be inversely linked to self-rated health and well-being among same-sex couples in Europe (9). They may also experience discrimination and abuse in medical settings, including unethical and harmful so-called therapies to change sexual orientation, forced or coercive sterilization, forced genital and anal examinations, and unnecessary surgery and treatment of intersex children without their consent (9).

Noncommunicable diseases



- NCDs are the main cause of ill health for both women and men in the WHO European Region, but indicators reveal important differences between men and women across the life-course in all Member States. While biology is important in shaping these differences, it does not explain them all. Gender norms influence level of exposure and vulnerability to NCD risk factors for men and women and impact the way they use services and the responses they receive.
- It is estimated that 18% of NCD deaths in the Region can be linked to use of tobacco. The estimated percentage for men is four times that for women (28% and 7%, respectively). While the prevalence of smoking is declining among men in the Region, the situation for women is mixed and in some countries prevalence is increasing (36–38).
- Prevalence of diabetes mellitus for men exceeds that for women until age 70, after which the prevalence for women is greater. Prevalence is greatest for both women and men in those aged 70–79 years, at approximately 20% (36).
- Among adolescents aged 15 years, 43% of girls were unsatisfied with their bodies compared with 22% of boys. Among the girls, 26% reported being on a diet, even though only 13% were overweight (compared with 11% of boys being on a diet and 22% being overweight) (29).

- /// Anorexia nervosa has a prevalence of 0.3% among young women and a high mortality, but only 30% of young women with anorexia are treated by the health system (39).
- /// Social norms of traditional masculinity can impact men's help-seeking behaviour for mental health and can result in delayed diagnosis or symptoms of mental health conditions, including depression, remaining undiagnosed (40).
- /// The prevalence of alcohol use disorders differs substantially among men and women in the WHO European Region: 14.8% for men and 3.5% for women (27).
- /// Socioeconomic factors have a greater impact on overweight and obesity in women than in men, with women in low socioeconomic circumstances being more vulnerable than men to developing obesity (12,41). Across the Region in 2014, obesity in young women aged 15–29 was lowest among those with higher incomes (12,41).
- /// The suicide rate is over four times higher in men than in women in the Region (17.4% and 4.2%, respectively) (31); self-harm ranks second among causes of death of young women aged 15–19 in the Region (38).

Gender imbalance of paid and unpaid care



- /// Health systems can perpetuate many existing gender biases and social inequalities across and within health occupations (12). Notable differences between male and female medical professionals are seen in relation to specialty choice (horizontal segregation), with women underrepresented in high-prestige leadership roles and highly remunerated specialties such as surgery (42).
- /// Evidence suggests that family commitments restrict women more than men. Women in medicine tend to be overrepresented in family-friendly working situations with flexible hours (such as general practice and paediatrics), which are characterized by lower remuneration and less prestige among peers (43).
- /// Gender segregation is also evident within the medical hierarchy (vertical segregation): women are often overrepresented in nursing and midwifery services and care professions, while men are overrepresented in generally higher-wage professions such as medicine and dentistry (12).
- /// A review of health workforce wage data in 16 Member States of the Organisation for Economic Co-operation and Development (OECD) in 2016 found that women not only received lower wages than men in general but also received lower wages for doing the same or similar jobs as men within the same occupational group (44).
- /// A more gender equal distribution for unpaid care has a positive impact on both women's and men's health. For example, men involved in childcare are less likely to consume alcohol and drugs, have fewer accidents, have less physical and mental health problems overall and live longer (9).
- /// The global financial crisis in 2008 led to major cuts in public expenditure and social protection measures in many countries, which have had a profound impact through increases in the burden of unpaid work for women, especially in poor households (45).
- /// Unequal distribution of unpaid caregiving affects women's health, economic empowerment and quality of life, particularly in older age, while it perpetuates the lower participation of men in care (38).

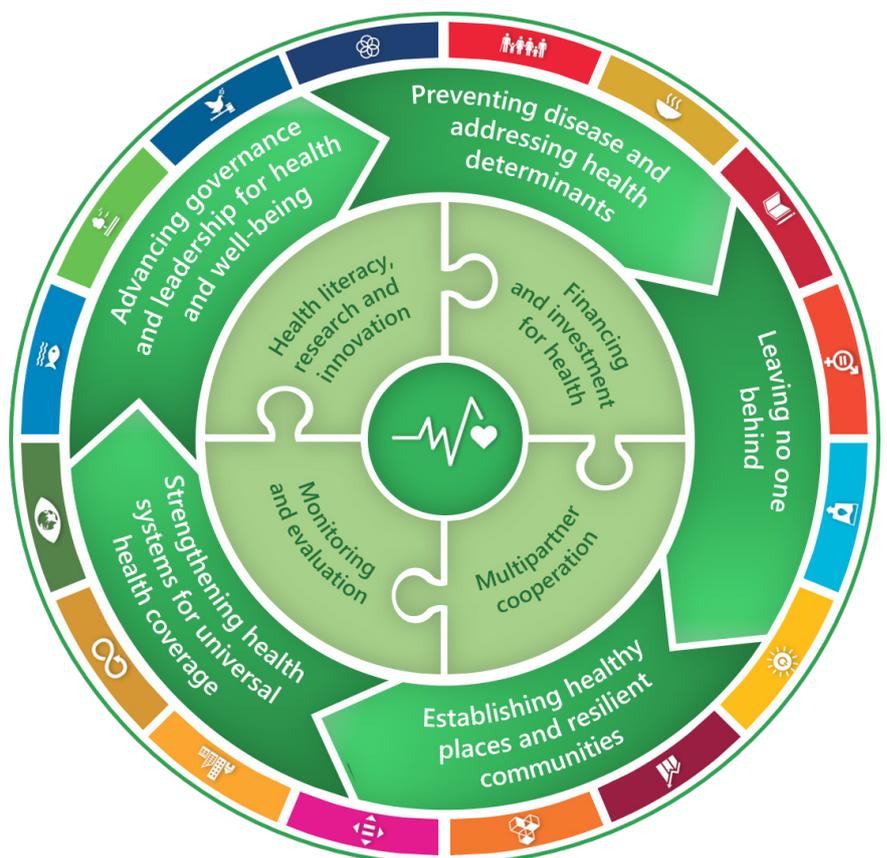
- Women assume most informal care responsibilities for older age groups in nearly all countries, but the proportion of male carers increases with age. In most Member States of the WHO European Region, men are more likely to adopt informal caring roles for individuals over the age of 75, while women form the majority of informal carers for individuals aged between 50 and 74 years (12,46).
- An unbalanced gender composition is also evident in formal long-term care, with women making up over 80% of the formal long-term care workforce in OECD countries in the Region surveyed in 2016 (47).
- The majority of health professionals in the Region are women but this is not reflected in health-care leadership roles: only 30% of health ministers are women (48).

Priorities for action: what now?

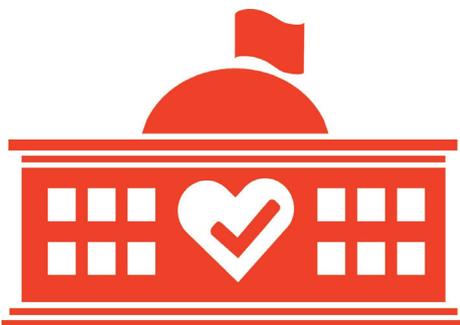
Member States of the WHO European Region have committed to the 2030 Agenda for Sustainable Development (49) and to their Roadmap for its implementation (50). Through the adoption of strategies for health and well-being for women and men in the Region (5,6), Member States have a comprehensive working framework for improving health and well-being through gender-responsive approaches that strengthen the links between SDG 3 and SDG 5.

Some of the key recommendations from these strategies are outlined within the five strategic directions of the SDG Roadmap (Fig. 1). Cross-cutting across all strategic directions is the need to improve the collection and analysis of sex- and age-disaggregated data across the SDGs.

Fig. 1. The strategic directions and enablers of the WHO SDG Roadmap



Advancing governance and leadership for health and well-



Improving the health and well-being of women and men and contributing to gender equality are complementary objectives that will require changes in how we govern for better health. This will include new and appropriate governance mechanisms that are sensitive to the relations that unite men and women as social groups in a particular community. Policies and action should build on the gains achieved by addressing gender and social determinants to obtain greater health equity. They should focus on the promotion and protection of women's and men's health, breaking down barriers between different programmes instead of reinforcing them.

Currently, few gender equality policies include health in their main priorities. Likewise, gender equality initiatives are less developed in existing health reports and policies. Engaging men in gender equality and empowering women would lead not only to greater gender equality but also to better health for all.

Examples of such changes that can be and already are implemented by some of the WHO European Region Member States include:

- /// integrating gender equality and health equity goals into national development plans, national health policies and multisectoral action plans;
- /// ensuring that gender equality policies address the impact of gender as a determinant of health and the empowerment of women and men as active agents of change;
- /// integrating gender budgeting across health policies and programmes for more efficient financing of the health priorities for both men and women and for promoting gender equality;
- /// improving collection of sex- and age-disaggregated data for health-related SDG-targets;
- /// building policy-makers' expertise on gender equality and health through collaboration with research institutions specializing on the subject; and
- /// strengthening collaboration and partnerships between the health sector and civil society, in particular organizations active in the field of women empowerment, fatherhood, engaging men in care, reproductive health and the prevention of violence (Box 2).

Box 2. Multipartner cooperation: the Issue-based Coalition on Gender Equality (IBC-Gender)

Issue-based coalitions act as regional interagency taskforces to strengthen cooperation between United Nations agencies and other partners. Within the European and Central Asia Region, there are six such coalitions, clustered around cross-cutting policy issues such as health, social protection, or youth and adolescents (51). The main goal of the Issue-based Coalition on Gender Equality in the European and Central Asia Region (IBC-Gender) is to ensure a coordinated approach to promoting gender equality and women's empowerment in the Region. Membership of IBC-Gender includes United Nations agencies and related entities at the regional level (52). The Coalition is chaired jointly by a representative from UN Women and one from another United Nations agency (determined on a rotational basis) (52,53).

IBC-Gender actions include:

- ▀ promoting gender equality through regional and international initiatives such as the Commission on the Status of Women and the Beijing Platform for Action review and follow-up;
- ▀ contributing to mainstreaming, acceleration and policy support (MAPS) missions by providing gender-related expertise and support;
- ▀ supporting joint advocacy and coordination with regional partners engaged in gender equality policies and programming, such as the EU and the World Bank;
- ▀ contributing to the yearly Regional Forum on Sustainable Development led by the United Nations Economic Commission for Europe to ensure that gender is a main part of the agenda;
- ▀ sharing key resources and materials on gender and SDGs with United Nations country teams;
- ▀ providing programming and policy/normative guidance and technical support on gender-related issues at regional and country levels;
- ▀ increasing effective and efficient use of human and financial resources within and between member agencies on gender-related initiatives and interventions;
- ▀ improving coordination, communication and information sharing on key lessons and good/promising practices from all regions among member agencies at the regional and country level in order to help to meet gender equality goals established by countries in the Region; and
- ▀ identifying gaps in gender equality programming and developing innovative regional mechanisms to address those gaps, including through advancing strategies for joint programming.

Publications from IBC-Gender include guidance on integrating gender equality and the empowerment of all women and girls in the nationalization and localization of the SDGs (11), a desk review of 18 United Nations development assistance framework and common country analysis documents from a gender perspective in order to assess the gender-responsiveness of United Nations common country programming at the country level in the Region (54), and a case study from the Republic of Moldova examining gender equality as an accelerator for the SDGs using data from a MAPS mission (55).

Preventing disease and addressing health determinants



The determinants of health are not to be found just in clinics but also in the home, workplace, school, street and environment and in how society treats its citizens. Many factors influence health and health-related behaviour across the life-course, at both societal and individual levels, with gender being one of the most important. The SDGs present a major opportunity to embed activity on the determinants of health across all sectors of policy-making, and through engagement with a wide range of stakeholders. The following measures have significant cobenefits for health and gender equality:

- /// working with the social and the education sectors to promote positive and healthy gender norms and roles and to challenge gender inequalities and harmful stereotypes from early childhood using life skills training, parenting and community-based programmes;
- /// monitoring the impact of education and employment policies on women's and men's health and well-being across the life-course to identify critical actions;
- /// strengthening intersectoral mechanisms between the health and the social welfare and labour sectors to reduce the negative impact on health and well-being of precarious employment and working conditions;
- /// providing paid family leave for mothers and fathers to protect women's health and well-being before and after childbirth, enhance child health and well-being and support men's roles as fathers and carers, while recognizing and valuing unpaid care work; and
- /// strengthening the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children.

Leaving no one behind



The commitment to leave no one behind underlies all the SDGs. Specifically for SDG 3, this involves making policy decisions that reduce health inequities, thus equalizing opportunities and contributing to improved health and well-being for all at all ages. Acting on gender inequality in health is one of the most direct and powerful ways to reduce health inequities (Box 3) (15). Gender-responsive approaches to leaving no one behind in health policy and practice include:

- /// developing and implementing multisectoral policies that value girls and eliminate harmful practices, including strengthening policies and measures to reduce violence against women;
- /// addressing sexual and reproductive health needs of men and women across their life-course and without discrimination;



- /// specifically targeting adolescents with interventions that address the impact of discriminatory gender norms and roles in health and in harmful practices, and that provide options for transformative change;
- /// ensuring that measures for health equity specifically consider the impact that gender norms and roles may have in creating exclusions, for example through existing health issues (e.g. mental illness or disability), being a migrant or part of an ethnic minority, living in specific contexts (e.g. unemployed, homeless or incarcerated) or having different sexual orientation/gender identity (lesbian, gay, bisexual, transgender, intersex); and
- /// giving visibility to and working with women facing multiple vulnerabilities and severe exclusion, such as migrant women, those belonging to minority groups, those with low levels of education, individuals living in rural and remote areas, trafficked women, sex workers, older women, women discriminated against because of their sexual orientation/gender identities or those living in humanitarian crises and fragile settings.

Box 3. Measuring gender equality

All current measures of gender equality, including the WEF Global Gender Gap Index (2), the United Nations Development Programme's Gender Inequality Index (3) and the European Institute for Gender Equality's Gender Equality Index (4), show that women in the WHO European Region continue to experience discrimination on the basis of their sex, with some being subject to multiple discrimination through additional factors such as their age, ethnicity, disability, socioeconomic status, sexual orientation or gender identity. The WEF Global Gender Gap Index assesses national gender gaps in four areas of overall inequality:

- /// economic participation and opportunity, which covers the concepts of the participation gap, the remuneration gap and the advancement gap;
- /// educational attainment, which captures the gap between women's and men's current access to education through male:female ratios in primary, secondary and tertiary education;
- /// political empowerment, which measures the gap between men and women at the highest level of political decision-making through the ratio of women to men in ministerial positions and in parliamentary positions; and
- /// health and survival, which provides an overview of the differences between women's and men's health through the sex at birth ratio and men's and women's healthy life expectancy.

While gender equality, inequality, parity and gap indexes are important to track progress, they should be interpreted within context. For example, in many European countries gender parity scores for education are high, while educational choices still tend to reflect gender stereotypes in society, which are then reproduced as segregation in employment. Similarly, for health indicators, similar levels between women and men in terms of life expectancy (especially when low), smoking and alcohol consumption are not necessarily reflecting higher levels of gender equality. These highlight the need for qualitative analysis (beyond indicators) when using measures of gender equality for designing policy priorities.

The WHO Health Equity Status Report and accompanying tools will be published in 2019 and provide evidence on how to remove the barriers that prevent people from achieving optimal health and to create conditions that allow all people to prosper in life (56). The tools will allow countries to monitor and evaluate their progress towards health equity (56).



Establishing healthy places, settings and resilient communities



Achieving the SDGs depends on the engagement of local communities, including schools, local enterprises and groups of individuals. This also involves dialogue with public agencies, spatial planners, voluntary bodies, business, industry and all other actors in taking action to implement common priorities in tackling both gender inequality and health. The measures could include:

- // strengthening policy action and community capacity at the national, subnational and city levels to improve the health and well-being of the most at-risk women and men in both urban and rural settings;
- // strengthening gender-responsive school programmes that foster healthy lifestyles and well-being, promote the appropriate use of social media and the Internet, and tackle bullying (including cyberbullying) and the use of violence in conflict situations;
- // targeting the workplace as a key setting in which to develop a range of health initiatives, based on consultations with men and women;
- // improving specific settings that influence health (e.g. housing, health-care facilities, education facilities and the workplace), including sanitation and hygiene facilities (particularly for women and girls) in those settings;
- // ensuring that health promotion initiatives also occur within recreational and sports facilities (often a particularly good area to access men and boys) to promote and facilitate participation in transformative actions to improve personal health and the health of communities;
- // supporting age-friendly environments and spaces at local level that promote well-being and reduce the increased risk of loneliness and social isolation that people from various socioeconomic groups and at various ages may experience; and
- // building on lessons learned from digital health initiatives, such as online counselling, that address women's and men's specific needs using life-course, gender and social determinants of health approaches, particularly in respect of mental health, substance abuse, parenting, sexual and reproductive health, emotional well-being and caring roles.



Strengthening health systems for universal health coverage



Member States of the WHO European Region have committed to progress towards universal health coverage. The aim is to ensure that all people obtain the high-quality health promotion, disease prevention, curative, rehabilitative and palliative services they need without experiencing financial hardship. Through gender-responsive health promotion and health service delivery, health systems can take important steps towards eliminating discrimination and promoting gender equality (9,12), including:

- ensuring a model of care that recognizes that women's and men's health needs, their health-seeking behaviour and the responses of the health system are influenced by gender norms and roles and the intersections with other determinants of health;
- ensuring a model of care that meets women's and men's health needs across their life-course through gender-responsive policies, services and programmes;
- taking positive measures for a more gender-balanced health workforce within all professional categories to ensure gender equitable and sustainable models of care and combat job segregation that perpetuates stereotypes and unequal pay;
- supporting gender-transformative policies that guarantee support for carers and ensure models of care that do not increase the pressure on women and put them at risk of social exclusion (e.g. policies that increase men's participation in caring for their families through paternity leave and other measures);
- strengthening the role of the health sector and the capacity of health professionals to identify and care for women experiencing intimate partner violence, building on WHO guidelines and protocols;
- guaranteeing universal access to sexual and reproductive health services;
- designing specific measures within universal policies and programmes to enable marginalized groups to access them (e.g. specific primary health services for minority groups addressing geographical barriers, cultural barriers and racism in health services delivery);
- promoting research and innovation on sex and gender differences in health service delivery, use of medicines and health promotion; and
- utilizing digital health to improve the quality and outreach of health and social services to women and men through new and innovative applications of technology that also address social and practical barriers experienced by some groups.

Commitments to act



There are a number of formal commitments that support achievement of SDG 5.

Convention on the Elimination of All Forms of Discrimination Against Women, 1979 (57)

Health 2020: a European Policy Framework and Strategy for the 21st Century, 2013 (58)

Action Plan for Sexual and Reproductive Health: Towards Achieving the 2030 Agenda for Sustainable Development in Europe, 2016 (10)

Global Plan of Action to Strengthen the Role of the Health System within a National Multisectoral Response to address Interpersonal Violence, in particular against Women and Girls, and against Children, 2016 (59)

Strategy on Women's Health and Well-being in the WHO European Region, 2016 (5)

Roadmap to Implement the 2030 Agenda for Sustainable Development, Building on Health 2020, the European Policy for Health and Well-being, 2017 (50)

Strategy on the Health and Well-being of Men in the WHO European Region, 2018 (6)

Resources

Women's Health and Well-being in Europe: Beyond the Mortality Advantage, 2016

http://www.euro.who.int/__data/assets/pdf_file/0006/318147/EWHR16_interactive2.pdf?ua=1

The Health and Well-being of Men in the WHO European Region: Better Health through a Gender Approach, 2018

http://www.euro.who.int/__data/assets/pdf_file/0007/380716/mhr-report-eng.pdf

Key definitions

Gender

A social construct that interacts with, but is different from, biological sex. It refers to the socially constructed norms, roles, behaviours and attributes that a given society considers appropriate for women and men. Individuals or groups that do not fit established gender norms often face stigma, discriminatory practices or social exclusion (7).

Equal chances or opportunities for groups of women and men to access and control social, economic and political resources, including protection under the law (such as health services, education and voting rights) (7).

Gender equality

Gender equality in health

Equal conditions for women and men to realize their full rights and potential to be healthy, contribute to health development and benefit from the results. Achieving gender equality requires specific measures designed to support groups of people with limited access to such goods and resources (9,12).

Beliefs about women and men, boys and girls that are passed from generation to generation through the process of socialization (7). Gender norms differ in different cultures and populations and change over time. Gender norms can lead to inequality if they reinforce mistreatment of one group or sex over the other or lead to differences in power and opportunities.

Gender norms

Gender parity

Relative equality (in terms of numbers and proportions) of men and women, girls and boys. It is often calculated as a ratio between men and women for a given indicator such as income, education or political power (7).

Social relations between and among women and men that are based on gender norms and roles, which often create hierarchies that can lead to unequal power relations, disadvantaging one group over another (7).

Gender relations

Gender responsive

A policy or programme that considers gender norms, roles and inequality with measures taken to actively reduce their harmful effects.

Social and behavioural norms that, within a specific culture, are widely considered to be socially appropriate for individuals of a specific sex (e.g. in the household, community or workplace) (7).

Gender roles

Gender stereotyping

A generalized view or preconception about attributes, characteristics or the roles that are, or ought to be, possessed by or performed by women and men (7). Gender stereotyping is harmful when it limits women's and men's capacity to develop their personal abilities, pursue their professional careers and make choices about their lives.

Any behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours. It includes violence by both current and former spouses and partners (59).

Intimate partner violence

Sex ratio at birth

The ratio of male to female births in a population, multiplied by 100. The ratio can vary somewhat because of biological factors, but the normal range is usually 104–106, with a few populations ranging between 102 and 107. Imbalanced, or skewed, ratios are those that lie outside this normal range (60).

“Any sexual act, attempt to obtain any sexual act, or other act directed against a person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting. It includes rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part or object” (59).

Sexual violence

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