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Strategy on women's health and well-being in the WHO European Region

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Strategy on women's health and well-being in the WHO European Region

The draft Strategy on women's health and well-being in the WHO European Region is based on a review of the evidence, guidance from the Twenty-third Standing Committee of the WHO Regional Committee for Europe, feedback from technical experts, results of an online consultation with Member States, face-to-face consultations in countries and feedback from WHO regions for health and healthy cities networks.

WORLD HEALTH ORGANIZATION REGIONAL OFFICE FOR EUROPE
UN City, Marmorvej 51, DK-2100 Copenhagen Ø, Denmark Telephone: +45 45 33 70 00 Fax: +45 45 33 70 01
Email: eugovernance@who.int Web: http://www.euro.who.int/en/who-we-are/governance

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Introduction

1. Although women's health and well-being in the WHO European Region is generally better than elsewhere in the world, this is not necessarily true for all women. Health inequities among women remain large and unjustifiable, both within and between countries in the European Region. This is recognized in the report *Beyond the mortality advantage (1)*, which was discussed at the technical briefing on women's health held during the 65th session of the WHO Regional Committee for Europe in September 2015.

2. The Strategy on women's health and well-being in the WHO European Region is underpinned by the values of the European policy framework for health and well-being, Health 2020 *(2)*, which acknowledges that gender is a determinant of health, alongside social and environmental determinants, and which identifies gender mainstreaming as a mechanism to achieve gender equity. Gender refers to the socially constructed roles, behaviours and attributes that a given society considers appropriate for women and men. A gender-based approach means supporting the need to strengthen the understanding of the determinants of men's as well as women's health with a view to making policies and strategies more responsive to both men's and women's needs across the life-course, and therefore an analysis of the determinants of men's health will be taken forward in the future. This Strategy focuses on the determinants of women's health, without necessarily making comparisons between women and men.

3. The Strategy sets priority areas for action in line with Health 2020, and provides guidance to optimize investment in girls' and women's health, including by refining existing national policies and strategies to make them more consistent with current evidence and more responsive to women's health and well-being across the life-course. This will require action by ministries of health, both alone and in collaboration with other sectors, including departments for women's issues, social protection, social affairs, education, labour and employment. It also calls for a whole-of-society approach that acknowledges the extraordinary contributions of women to society, family and work, and empowers women by strengthening their participation in key decision-making on their health and well-being throughout the life-course.

4. Global efforts to advance women's health have been endorsed by Member States through the adoption of the 2030 Agenda for Sustainable Development and its accompanying Sustainable Development Goals (SDGs), in particular SDG3, SDG5 and SDG10, on health and well-being, achieving gender equality, and reducing inequalities, respectively. These are further strengthened by the WHO Global Strategy for Women's, Children's and Adolescents' Health (2016–2030) *(3)* and the plan *(4)* to take it forward that was endorsed by Member States at the Sixty-ninth World Health Assembly in May 2016.

5. The Strategy will strengthen these efforts at regional and country levels by identifying key areas for action to reduce health inequities for women throughout the life-course. For important priorities relating to women's sexual and reproductive health, including family planning, sexuality education, sexual and reproductive rights, and cervical cancer prevention and control, this Strategy refers to the Action plan for sexual and reproductive health: towards achieving the 2030 Agenda for Sustainable Development in Europe – leaving no one behind (EUR/RC66/13).

Evidence

6. Women and men alike have the right to the highest attainable standard of physical and mental health. Despite great progress in that regard, there is still no country in the WHO European Region in which women and men have equal access to resources *(5)*. Gender inequalities and inequalities in the social and economic determinants of health are at the core of health inequities for girls and women in the Region, and must be addressed if the Health 2020 strategic objective of reducing health inequalities is to be achieved.

7. Since the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action were adopted in the mid-1990s, governments have taken steps to implement the commitments undertaken *(6)*. Despite the progress made, much remains to be done. This was underlined by the United Nations Commission on the Status of Women at the anniversary of the Beijing Conference in 2015 *(7)*. The Action plan for sexual and reproductive health addresses this, looking at the overall sexual and reproductive health needs of women and men from a rights' perspective.

8. From 2000 to 2012, life expectancy improved for women in all but one country in the European Region, and remained higher than for men in all 53 Member States. This is referred to as women's "mortality advantage", but it may be offset by fewer years lived without disability or activity restriction. Women see themselves as less healthy than men, report more illness and more frequently forego care for financial reasons. Equal access to health services has not been achieved for rural, minority, migrant, refugee or asylum seeking women, or for women in detention *(6)*.

9. Data on mortality, disease burden and well-being for women in the European Region throughout the life-course have been reviewed *(1)*. Physical health conditions dominate in early life, depressive and anxiety disorders develop among young women moving into adult life, and lower back pain, ischaemic heart disease and cancers are more prevalent in older age *(1)*. The findings of the Health Behaviour in School-aged Children 2013/2014 survey *(8)* show a marked decline in subjective well-being among girls during adolescent years.

10. The data were reviewed to identify the effects of gender inequalities and the principal social determinants of health, such as income, access to financial resources, access to education, employment, working conditions, social protection and environment, at key stages to allow prioritization of interventions that improve girls' and women's health throughout the life-course.

11. Despite significant progress in areas such as education and participation, gender inequalities in employment, quality of work and job segregation continue to exert a negative influence. Data analysis has its challenges, however: while efforts to improve the collection of data disaggregated by age and sex have increased, collection and analysis of such data combined with other variables, such as income, place of residence and education, are still lacking *(1)*.

12. Gender stereotypes[1] have consequences for women's health in terms of self-confidence and well-being; in particular, concerns about physical appearance may cause girls and young women to develop eating disorders and other mental illnesses, such as depression and anxiety. Moreover, stereotypes and sexism pave the way for certain forms of oppression, such as sexual harassment and gender-based violence *(10)*. Gender stereotypes affect health systems responses, such as in under- and overdiagnosis of certain conditions *(11)*.

13. The fact that violence against women persists in all countries and among all population groups shows the need to continue to address violence as a public health issue. WHO estimates that one in every four women in the European Region has been subjected to intimate partner violence during her lifetime. Girls and women need protection from gender-based violence, including intimate partner violence, sexual violence, female genital mutilation, early marriage, exploitation, abuse, and involuntary or unwanted sterilization. Recent studies show that social media has been associated with serious health effects among young women as a result of activities such as cyberbullying *(1)*. Health care providers are often ill equipped to understand and address the causes and manifestations of practices such as gender-biased sex selection and female genital mutilation; it is therefore crucial to increase their knowledge, competences and skills in detecting and preventing these practices without further discriminating against or stigmatizing women.

14. Women's increasing exposure to risk factors for noncommunicable diseases (NCDs) increases the risk of developing diseases and disabilities earlier in life. More than 50% of women in the European Region are overweight, with higher prevalence of obesity among women with lower levels of education than is the case for men. In addition, adolescent girls have reduced physical activity and, in many countries, are catching up with males in their use of tobacco and alcohol, abetted by the tobacco and alcohol industries through marketing that specifically targets young people *(1)*.

15. Women's risk of contracting NCDs may be increased by health system biases: while cardiovascular disease is the major cause of death for women in the European Region, it is still perceived as a men's health issue. The risk to women is often underestimated owing to the perception that they are physiologically protected against it. While women are indeed at lower risk during their fertile years, protection fades after menopause, when risk increases. Assessment and management of cardiovascular risk in women often ignores factors that are particularly important, such as diabetes, obesity, physical inactivity and smoking.

16. Major depressive disorders are the main cause of disease among adolescent girls and women across the Region, and dementia and Alzheimer's disease are main causes of ill health among older women in western European countries *(1)*. The impact of socioeconomic inequalities has a huge influence on women's mental health both as patients and informal providers of care. Treatment gaps experienced by young women affected by depression and anxiety disorders upon reaching maturity need particular attention given the high prevalence of these conditions.

[1] Gender stereotyping is the practice of ascribing to an individual woman or man specific attributes, characteristics or roles by reason only of her or his membership in the social group of women or men *(9)*.

17. Differences between men and women in sensitivity to toxic substances, combined with gender division of labour, may increase the exposure and vulnerability of girls and women to chemicals and pollution. The division of labour prevalent in households and the unavailability of running water inside homes in some parts of the European Region, especially in rural areas, means that women and young girls may spend much of their time collecting drinking water. This may lead to missed learning opportunities for girls. Lack of access to adequate water, sanitation and hygiene conditions in health facilities may discourage or delay women seeking care *(12)*.

18. In areas where domestic heating and cooking needs are met by burning solid fuels (wood, charcoal, coal, dung and crop waste) on open fires or traditional stoves, women and young children who spend a significant amount of time indoors at home are disproportionally exposed to high levels of household air pollution, which includes a range of health-damaging pollutants such as fine particles and carbon monoxide *(13)*. It is estimated that 117 200 deaths per year in the European Region are attributable to household air pollution.

19. Despite increased inclusion of women in clinical trials, participation is especially low in studies in which safety, safe dosage range and side effects are determined. This results in a lack of awareness among health care professionals about the importance of sex-specific differences in disease manifestation and response to treatment throughout the life-course, which can cause problems in diagnosis and treatment, including delays in diagnosing women in the early stages of coronary disease because the symptoms seem atypical. Women are also 1.5 times more likely than men to develop adverse reactions to prescription drugs *(1)*.

20. Women are overrepresented not only as care providers in the formal and informal sectors but also as care recipients among those aged 65 and over in institutions and at home. The internationalization of long-term care has brought growing staff migration, mostly involving women. Formal care alternatives in many countries are few and may be inaccessible, unaffordable and/or of low quality. This puts pressure on women of all ages, for whom the expectation of providing intergenerational support is high *(1)*.

21. The links between migration, female-headed households, feminization of poverty in rural areas and access to health services need to be better explored. The specific health needs of migrant women and women left behind by migrant partners should be addressed in coordination with the Strategy and action plan for refugee and migrant health in the WHO European Region (EUR/RC66/8), also submitted for consideration by the Regional Committee at its 66th session in September 2016.

Vision

22. The Strategy on women’s health and well-being is based on the vision of a WHO European Region in which all girls and women are enabled, supported and empowered in achieving their full health potential and well-being, with their human rights respected, protected and fulfilled, and in which countries, both individually and together, work towards reducing gender and socioeconomic inequities in health within the Region and beyond.

Mission

23. The Strategy seeks to inspire governments and stakeholders to work towards improving the health and well-being of women and girls beyond maternal and child health, ensuring that policies and health systems are gender-responsive and based on a life-course approach.

Guiding principles

24. The Strategy's guiding principles align with the agreed principles informing Health 2020, the 2030 Agenda on Sustainable Development and the WHO Global Strategy for Women's, Children's And Adolescents' Health (2016–2030).

25. Adopting a **human rights-based approach** means that women's rights and the right to health are integral to all priorities and actions. This includes ending discrimination against women and girls in all forms by ensuring women's equal access to, and equal opportunities in, political and public life, education, health and economic resources. Countries can build on existing actions and commitments to promote the systematic application of human rights standards, including the United Nations Convention on the Elimination of All Forms of Discrimination against Women and the Convention on the Rights of the Child. On the basis of the human rights treaties and commitments to which all Member States are party as the foundation for the Strategy, country action will facilitate the aim of progressively realizing the right to health for every girl and woman in the European Region. This will contribute to meeting the specific targets under SDG5 on gender equality to end all forms of discrimination, eliminate all forms of violence and eliminate all harmful practices.

26. By being **equity-driven**, the Strategy recognizes that women are not a homogeneous group. Their health opportunities and risks vary according to social, economic, environmental and cultural influences throughout their lifetime. Consideration must be given to how gender intersects with other axes of social inequalities, such as ethnicity and place of residence, and the unequal distribution of social determinants of health such as income, education and employment. The effects on women's vulnerability to ill health from specific processes, such as social exclusion and discrimination, climate change, conflict situations, humanitarian crises, economic crises and responses, migration and human trafficking, should also be assessed.

27. A **gender-responsive** focus reflects the need to adopt whole-of-government policies promoting gender equality and health policies that consider gender norms, values and inequalities, along with measures taken to actively reduce their harmful effects. Countries can build on existing actions under the SDGs, the Beijing Declaration and Platform for Action, and the Programme of Action of the International Conference on Population and Development, specifically increasing women's access throughout the life-course to equal opportunities to education, employment and power; appropriate, affordable and quality health care, information and related services; strengthening preventive programmes that promote women's health; undertaking gender-responsive initiatives that address sexually transmitted infections, HIV/AIDS, and sexual and reproductive health issues; promoting research and disseminating information on

women's health; and increasing resources and monitoring follow-up for women's health.

28. Promoting a **life-course approach** to women's health acknowledges that sex and gender combine with social and environmental determinants of health to influence how health risks and benefits accumulate through life. A life-course approach to women's health not only recognizes that women's health is important for ensuring a better start in life for their children and providing care for their families, but also aims to achieve better health for girls and women in their own right, regardless of their status as mothers or as future mothers and carers. The Strategy adopts a life-course approach, consistent with the Minsk Declaration *(14)*, endorsed at the WHO European Ministerial Conference on the Life-course Approach in the Context of Health 2020, which states that: "The adoption of the life-course approach across the whole of government would improve health and well-being, promote social justice, and contribute to sustainable development and inclusive growth and wealth in all our countries."

29. **Intersectoral action** is central to the Strategy. As well as strengthening the role of the health sector in improving women's health, the Strategy identifies key areas for collaboration with other sectors, such as education, social protection, the labour market, the environment and civil society. The education, employment, agriculture and social sectors, in particular, have a key role to play in eliminating gender stereotypes and in improving women's socioeconomic status through gender-responsive social policies. An intersectoral approach is necessary to ensure equal access to economic resources and to value unpaid care through the provision of public services, infrastructure and social protection policies: principles that are clearly anchored in SDG Target 5.4. Action across governments and society is also required to meet Health 2020 targets.

30. Ensuring **effective participation of women** is crucial. Women are powerful actors for change and the Strategy supports their leadership of, and participation in, decision-making. Experience has shown that the participation of girls, women and communities is crucial to the successful development, implementation and accountability of strategies, policies and services. To be consistent with the guiding principle of a human rights-based approach, participation must be genuine, transparent and representative, and should employ mechanisms for securing the involvement of all girls and women, including those who are socially disadvantaged, socially excluded and/or belong to minority groups.

Priorities and key areas for action

31. The priorities set out below have been identified through a review of existing evidence, a consultative process with experts, and ongoing engagement with Member States and civil society. An adapted version of the conceptual framework developed by the Women and Gender Equity Knowledge Network of the WHO Global Commission on Social Determinants of Health *(15)* was used to support priority setting. The conceptual framework identifies multiple and complex pathways that explain how gender influences the impact of socioeconomic determinants on inequitable health outcomes, mainly through discriminatory values, norms, practices and behaviours; differential exposure and vulnerability to disease, disability and injuries; biases in health

systems; and biases in health research. This is complemented by recognition of the ongoing need to strengthen governance for women's health and health equity.

32. Based on this framework, life-course priorities on neglected issues and emerging priorities have been identified. They require actions to strengthen health systems and increase cooperation with other sectors. These priorities are also guided by the recommendations in the final report of the review of social determinants and the health divide in the WHO European Region *(16)*.

Strengthening governance for women's health and well-being, with women at the centre

33. Improving women's health requires changes in governance for health that integrate women's lifelong needs into health policies, health-in-all-policies approaches and intersectoral action. Engagement of women to ensure that they are at the centre of these changes is a defining factor for success. Applying a rights-based approach requires urgent political commitment and investment in proven interventions and programmes and the removal of structural, political and social barriers that prevent the realization of women's full health and well-being potential.

34. Member States and partners can ensure that policy-makers improve governance for women's health and well-being by putting in place the following incentives and enabling mechanisms:

(a) collecting and using disaggregated data to inform policies and programmes – disaggregation by age and sex needs to be complemented by disaggregation on grounds of disability, ethnic origin, level of education, place of residence, sexual orientation and gender identity so that policies can address gender inequities and inequities among women;

(b) improving transparency and accountability on how priorities are set, data are collected and research funding is allocated;

(c) improving financing to address women's health priorities and integrating gender budgeting across health policies and programmes;

(d) assessing the impact on women's health of national strategies and action plans within and outside the health sector to identify critical actions;

(e) including gender perspectives in initiatives addressing the social, economic, environmental and cultural determinants of health and health equity;

(f) strengthening opportunities and building capacities for women's participation as citizens, carers, users and patients in leading and managing health policy and health system actions;

(g) strengthening intersectoral mechanisms between the health and the education sectors to eliminate gender stereotypes in primary, secondary and tertiary education, and to integrate gender into health workforce education;

(h) strengthening collaboration and partnership between the health sector and civil society, in particular with organizations active in the field of women's rights and health;

(i) building on existing policy frameworks and intersectoral commitments, such as those taken by Members States under the European Environment and Health Process;

(j) adapting at the national level the WHO 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 (*17)*, endorsed by the Sixty-ninth World Health Assembly in resolution WHA69.5; and

(k) strengthening monitoring frameworks for women's health at the national, subnational and local levels that are in line with the targets and indicators of regional and global mechanisms.

Eliminating discriminatory values, norms and practices that affect the health and well-being of girls and women

35. Gender-based values and social and cultural norms and stereotypes that are discriminatory and/or harmful translate into practices that affect the health and well-being of girls and women *(1)*. These include boys being valued over girls, beliefs that men have the right to control women and girls, harmful traditional practices,[2] limits placed on women's education and occupational choices and opportunities, gender-based stereotypes, and institutional biases[3] that may perpetuate discriminatory values, norms and practices.

36. In implementing the Strategy, Member States and partners are advised to consider addressing the following priorities in their national strategies and action plans relevant to women's health:

(a) developing and implementing gender equality, multisectoral policies that value girls and eliminate harmful practices, including strengthening actions such as collecting data on the prevalence of early marriage or bride-kidnapping and researching the drivers of those phenomena, providing girls and their families with the knowledge and opportunities to make informed decisions, and promoting the value of girls in affected communities;

(b) increasing the capacity of health service providers to eliminate practices that damage the health of girls and women and violate their human rights, taking account of the relationship between age and gender inequalities and other determinants of social inequalities, such as poverty, migration and ethnicity; these increase social vulnerability and stigmatization of girls and women and hamper access to and responses from services;

[2] Harmful traditional practices include female genital mutilation; forced feeding of women; early marriage; the various taboos or practices that prevent women from controlling their own fertility; nutritional taboos and traditional birth practices; son preference and its implications for the status of the girl child; female infanticide; early pregnancy; and dowry price *(18)*.

[3] Institutional bias means a tendency for the procedures and practices of particular institutions to operate in ways that result in certain social groups being advantaged or favoured and others being disadvantaged or devalued. This may result not from any conscious prejudice or discrimination but rather from the majority simply following existing rules or norms. Institutional racism and institutional sexism are the most common examples *(19)*.

(c) ensuring health promotion interventions that project a positive and strong self-image for all girls and women, regardless of age, sexual orientation, gender identity, ethnicity, culture and religion – it is important to eliminate gender stereotypes in education at all levels, health curricula and the media, in particular acknowledging and challenging gender stereotypes that start early in life and which are reinforced throughout the life-course, driving women towards health-damaging behaviours and outcomes such as eating disorders, depression, low physical activity and suicide, and into educational and occupational choices that limit their quality of life, financial security and independence;

(d) developing innovative programmes and strengthening comprehensive sexuality education aimed at transforming gender norms and values that drive boys and men into high-risk behaviours and violent practices and perpetuate discrimination and harmful practices against women and girls; and

(e) identifying and addressing institutional biases that may perpetuate intended or unintended gender-based discrimination in areas such as education, employment, social protection mechanisms, pension schemes and health insurance policies.

Tackling the impact of gender and social, economic, cultural and environmental determinants on women's health and well-being

37. The risk of poverty and social exclusion for women varies both within and between countries across the European Region, but women who are more likely to have higher exposure and vulnerability to ill health and lower well-being scores are those who have fewer years in formal education, do not have access to or participate in lifelong learning programmes, are unemployed or in low-quality and part-time jobs, were married at an early age, are sole breadwinners, are migrants, are lesbian, gay, bisexual, trans and/or intersex, belong to a minority group such as Roma, have a disability, are older, reside in rural areas, and/or are living in emergency settings and experiencing a humanitarian crisis.

38. Gender wage and pension gaps, which exist in all Member States in the European Region, directly affect women's experience of health and well-being and their opportunities to access services throughout their life, with the greatest impact on older women. Despite efforts in some countries to encourage policy innovation for the promotion of women's economic empowerment, there has been an overall increase in part-time jobs, precarious employment and unpaid care work.

39. The following actions should be prioritized to tackle differential exposure and vulnerability to ill health and the experience of well-being caused by the interaction between gender and other social and environmental determinants of health:

(a) giving visibility in political agendas to women facing multiple vulnerabilities and severe exclusion, such as migrant women, those whose education is below secondary level, women living in rural and remote areas, those belonging to minority groups, trafficked women and sex workers, older women, women discriminated by their sexual orientation and gender identities and/or those living in humanitarian crises and fragile settings;

(b) improving the circumstances, environments and specific settings that influence girls' and women's health, with particular attention to housing, health care facilities, education facilities and the workplace, including access to safe water, sanitation and hygiene facilities, indoor air pollution and exposure to chemical and physical hazards: this will protect women's own health and will minimize intrauterine and early childhood exposure to environmental hazards, as highlighted by the Minsk Declaration *(14)*;

(c) analysing and addressing intersections between biology, gender and social determinants of the mental health and well-being of girls and women from childhood to older age;

(d) ensuring that national plans addressing NCDs are gender mainstreamed in order to counteract the rise of risk factors (such as tobacco and alcohol use and low physical activity) among adolescent girls and adult women in the European Region and taking joint action with other sectors and stakeholders to tackle the links between these risk behaviours and their social and economic determinants;

(e) 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 experienced by many women in the Region; and

(f) ensuring that women's work is not only valued but valued equally to that of men and that women's paid and unpaid contributions as care providers are recognized, valued and compensated, including through specific actions such as recognizing time out of work for care responsibilities as equivalent to individual contributions to the pension system and transformative actions aimed at involving men in care work.

Improving health system responses to women's health and well-being

40. Gender-responsive health systems ensure that the links between biology, gender and social determinants are addressed across their functions. Although they are beneficial for women and men alike, existing biases may have negative effects on the whole population or on one group. For example, health services often view girls and women within their reproductive role and are blind to wider gender differences in health. Ensuring that health systems are responsive to women's health needs requires taking into account governance mechanisms, policies, collection and use of data, design of services, composition of the workforce, financing arrangements, coverage and funding exemptions, essential packages of services, use of medicines and technologies, and research priorities and criteria.

41. Health systems may also fail to achieve gender equity from the perspective of women as service users, patients and carers. It is often assumed that women experience conditions such as cardiovascular diseases, cancers, chronic respiratory diseases and diabetes in the same way as men, an assumption that can result in misdiagnosis and ineffective and unequal treatment, as demonstrated by the evidence on cardiovascular disease *(20)*.

42. Health and care services depend on women contributing as unpaid, informal educators and carers, particularly for children, sick family members and older people. Women are overrepresented in the health and social sectors but rarely hold executive or management-level positions. Instead, they tend to be concentrated in lower-paid jobs where they are exposed to greater occupational health risks. The health sector can lead by example in improving opportunities for women's paid employment and increased job and financial security by addressing gender inequalities in the health workforce and within informal health care services. This includes looking at the effects of health sector workforce and employment policies in relation to how they promote gender inequality and/or exacerbate it for women. Key areas for attention include gender balance in management in academic medicine, public health and nursing, parental leave provision for women and men, and child care arrangements.

43. Biases in the health system tend to be mirrored in health research, although this is changing due to improved knowledge of the social determinants of health and new approaches to assessing how social and family policies affect women's health and well-being. However, other biases persist, with drugs and treatments continuing to be designed around men's physiology rather than that of women. Limiting the participation of women in research restricts the potential value of research findings and may be detrimental to women's health.

44. Health systems should ensure that women's differential health needs are mainstreamed in all national health policies and strategies by:

(a) ensuring the collection, analysis and use of data disaggregated by sex and age and cross-sectioned with other variables, such as income, education, and urban or rural residence;

(b) promoting people-centred health services that respond to all women's needs regarding prevention and care throughout the life-course and not only when (and if) they become mothers: people-centred health systems are at the core of Health 2020, as articulated in the framework for action adopted by the Regional Committee in resolution EUR/RC62/R4;

(c) supporting gender-transformative policies[4] that guarantee care for carers and ensure sustainable models of care that do not increase the pressure on women and put them at risk of social exclusion, examples of which include policies that increase men's participation in caring for their families through paternity leave and other measures;

(d) adopting gender-transformative policies in working conditions for the health sector workforce that demonstrate health systems leadership in promoting gender equity in the workplace;

[4] In the WHO Gender Responsive Assessment Scale, gender transformative actions and policies address the causes of gender-based health inequities by including ways to transform harmful gender norms, roles and relations. The objective of such programmes is often to promote gender equality and foster progressive changes in power relationships between women and men *(21)*.

(e) strengthening the knowledge, skills and competences of the health workforce in addressing interactions between biology, gender and other social determinants of health and their impact on women's health and well-being, and in addressing gender stereotypes that may result in direct or indirect discrimination against women in access to health and health care services;

(f) promoting research and innovation that eliminates sex and gender bias in the use of medicines, service delivery and health promotion, and identifies and disseminates good practices;

(g) supporting gender-based medicine to improve detection, diagnosis and treatment of the most common NCDs and their risk factors, with an emphasis on diseases specific to women (such as endometriosis), cardiovascular diseases, mental health disorders, cancers and chronic obstructive pulmonary disease;

(h) increasing women's participation in clinical trials, performing a gender analysis of data, increasing women's awareness of cardiovascular disease and building professionals' capacity;

(i) ensuring policy and service responses that end the acceptance and tolerance of all forms of violence against women and girls, 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; and

(j) improving health literacy among women to ensure that they have the opportunity to make informed, evidence-based, health-conscious and self-determined decisions on health issues.

Time frame, implementation and support from the Regional Office

45. The Strategy will guide action to improve women's health and well-being in the WHO European Region with the support of the Regional Office for Europe through biennial region-wide activities and country cooperation strategies. These could include:

(a) advocating for women's health at the subnational, national and international levels;

(b) providing guidance and building capacity for mainstreaming gender-responsive actions in national and subnational policies and strategies;

(c) reviewing, developing and implementing sectoral policies and strategies with a focus on women's health;

(d) facilitating the development of intersectoral collaboration and structures;

(e) supporting country and local leadership;

(f) promoting participation of women in decision-making as agents of change;

(g) providing technical support in data collection and analysis;

(h) improving surveillance, monitoring and evaluation systems;

(i) strengthening accountability; and

(j) committing the Regional Office to be a role model of this approach.

Monitoring and accountability

46. Monitoring and reporting will be carried out in connection with the Health 2020 monitoring framework, the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030) and the SDGs to avoid duplication and facilitate accountability. Alignment through a common platform is critical to minimize the reporting burden on countries and to maximize the impact of reviews on subsequent action.

47. The Regional Office will regularly monitor progress on policy development and implementation and will provide a revision and midterm review of the Strategy to the 69th session of the Regional Committee in 2019, based on the latest available evidence.

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