European Institute for Gender Equality

Gender Equality Index 2021
Health

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European Institute for Gender Equality

The European Institute for Gender Equality (EIGE) is an autonomous body of the European Union established to strengthen gender equality across the EU. Equality between women and men is a fundamental value of the EU and EIGE's task is to make this a reality in Europe and beyond. This includes becoming a European knowledge centre on gender equality issues, supporting gender mainstreaming in all EU and Member State policies, and fighting discrimination based on sex.

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"Europe has made fragile gains in gender equality. But big losses are emerging as a result of the COVID-19 pandemic. The economic fallout is lasting longer for women, while life expectancy for men has dropped. Our Index findings can help Europe's leaders tackle the different effects of the pandemic on women and men and alleviate the unequal short and long-term impacts."

Carlien Scheele,
EIGE's Director

Abbreviations

EU Member State codes

BE	Belgium
BG	Bulgaria
CZ	Czechia
DK	Denmark
DE	Germany
EE	Estonia
IE	Ireland
EL	Greece
ES	Spain
FR	France
HR	Croatia
IT	Italy
CY	Cyprus
LV	Latvia
LT	Lithuania
LU	Luxembourg
HU	Hungary
MT	Malta
NL	Netherlands
AT	Austria
PL	Poland
PT	Portugal
RO	Romania
SI	Slovenia
SK	Slovakia
FI	Finland
SE	Sweden
EU	27 EU Member States (2020)

Other country codes

NO	Norway
UK	United Kingdom

Frequently used abbreviations

ADHD	attention-deficit hyperactivity disorder
CEO	chief executive officer
COVID-19	coronavirus disease 2019
ECDC	European Centre for Disease Prevention and Control
EHIS	European Health Interview Survey
EIGE	European Institute for Gender Equality
EQLS	European Quality of Life Survey
ETUI	European Trade Union Institute
EU	European Union
EU-LFS	European Union Labour Force Survey
EU-OSHA	European Agency for Safety and Health at Work
Eurofound	European Foundation for the Improvement of Living and Working Conditions
EU-SILC	European Union Statistics on Income and Living Conditions
EWCS	European Working Conditions Survey
FGM	female genital mutilation
FRA	European Union Agency for Fundamental Rights
FTE	full-time equivalent
GBD	Global Burden of Disease
HBSC	Health Behaviour in School-aged Children
HIV	human immunodeficiency virus
HPV	human papillomavirus
ICN	International Council of Nurses
ICT	information and communications technology
ICPD	International Conference on Population and Development
ILO	International Labour Organization

LGBTQI* ([1])	lesbian, gay, bisexual, transgender, queer, intersex and other non-dominant sexual orientations and gender identities in society
NCD	non-communicable disease
OECD	Organisation for Economic Co-operation and Development
p.p.	percentage point(s)
PPE	personal protective equipment
PPS	purchasing power standard
PTSD	post-traumatic stress disorder
SDG	Sustainable Development Goal
SDH	social determinants of health
SES	Structure of Earnings Survey
SRH	sexual and reproductive health
SRHR ([2])	sexual and reproductive health and rights
STD	sexually transmitted disease
STEM	science, technology, engineering and mathematics
STI	sexually transmitted infection
SUD	substance use disorder
UN	United Nations
UNFPA	United Nations Population Fund
WHO	World Health Organization
WHO-5	World Health Organization Five Well-Being Index
WMID	Women and Men in Decision-Making

([1]) This report uses the acronym LGBTQI*, as it represents the most inclusive umbrella term for people whose sexual orientation differs from heteronormativity and whose gender identity falls outside binary categories. The language used to represent this very heterogeneous group continuously evolves towards greater inclusion, and different researchers and institutions have adopted different versions of the acronym (LGBT, LGBTIQ and LGBTI). This report uses those researchers' and institutions' chosen acronyms when describing the results of their work.

([2]) The report uses the acronym SRHR when the nexus of sexual and reproductive health and rights is the focus, for example concerning legal access to health services. The acronym SRH is used when outcomes and behaviours relating to sexual and reproductive health are discussed. The report uses institutions' and authors' chosen acronyms when describing the results of their work.

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Gender Equality Index 2021 highlights

- The Gender Equality Index score for the EU is 68.0 points out of 100 ([3]). This is an improvement of just 0.6 points since the 2020 edition and of only 4.9 points in total since 2010. Even that minimal progress on gender equality is threatened by the impact of the COVID-19 pandemic.

- Overall progress in gender equality between 2010 and 2019 was largely driven by advances in the domain of power, in particular improved gender balance on company boards and in politics. However, progress in other domains is much slower, and their impact on the overall progress in Index is lower. The contribution to the Index score of the domain of time is negative in the long term. An enormous increase in unpaid care during the COVID-19 crisis – particularly by women – has put a spotlight on long-standing gender inequalities in the home.

- Achievements in gender equality vary considerably by country. Although EU Index score generally rose from 2010 to 2019, Index scores in some Member States fluctuated and disparities among Member States differed from one year to the next one. This was largely due to varying national responses to gender inequalities in economic and political decision-making. With COVID-19 impacting Member States to different degrees, both overall and in the extent to which women and men are relatively affected, greater divergence on gender equality progress or even regression is probable.

Domain of work

- With a score of 71.6 points – an increase of only 0.2 points since 2018 – this domain signals a setback in annual progress and indicates major ongoing gender equality challenges in the EU labour market. Progress in the subdomain of participation has slowed, and strong gender segregation in the labour market continues. This is demonstrated by the particularly low and almost static score of 61.3 points for the subdomain of segregation and quality in 2019.

- Gender gaps in full-time equivalent (FTE) employment rates remain extremely large in some groups. The biggest gap, of 27 percentage points (p.p.), is between women and men taking unpaid care of children, followed by a 21 p.p. gap between foreign-born women and foreign-born men. Both reflect the negative influence of gender roles and stereotypes on women's participation in the labour market, and thus on their economic independence and empowerment.

- Not only has COVID-19 revealed gender divisions in the labour market, but its adverse effects on employment prospects have been greater, and are likely to be more prolonged, for women than for men as a result of labour market gender segregation and the highly unequal distribution of unpaid care duties. The pandemic could stall or even erase gender equality gains among groups, including foreign-born women and men, with the risk of further widening divisions in our societies.

Domain of money

- With a score of 82.4 points, the domain of money has slightly improved since the previous edition, and has risen by 3.3 points since 2010. Although access to financial resources is driving overall growth in this domain, a fall of 0.2 points in the economic situation subdomain since 2018 has slowed the overall pace of growth.

([3]) The Gender Equality Index 2021 is calculated for the 27 EU Member States (EU-27).

- The gender gap in mean equivalised net income has stagnated in the EU since 2014. The gender gap among people aged 16 years or older was 925 purchasing power standard (PPS) ([4]) in 2019, although gaps in data hamper assessment of income inequalities among Roma people and undocumented migrants.

- The COVID-19 pandemic is likely to exacerbate the income gap between women and men because of the gender imbalance in paid and unpaid work. More women than men in the EU have lost income because they have had to assume care duties, including home schooling. Without appropriate income support, the feminisation of poverty will accelerate post pandemic.

Domain of knowledge

- With an EU score of 62.7 points, the score for the domain of knowledge has remained static since the 2020 edition of the Gender Equality Index, improving by only 2.9 points overall since 2010. Although educational attainment is increasing among young women and men, more significant progress in this domain is being curbed by persistent gender segregation in higher education and by low participation in lifelong learning.

- The proportions of women and men aged 15 years or older in formal or non-formal education and training remained low in the EU in 2019 – 17 % and 16 %, respectively – despite a small increase since 2010. Participation in adult learning gradually decreases with age, and engaging hard-to-reach groups remains a challenge.

- The closure of schools and childcare services during the pandemic has increased the childcare burden for parents and created new unpaid roles, such as home schooling. Women in the EU have been generally more engaged in supporting their children with online schooling during the pandemic and are more dissatisfied with this type of schooling than their partners.

Domain of time

- Owing to the lack of updated data on time use, the score for the domain of time has not been revised for this edition and relies on information from 2016. With the most recent progress unable to be assessed, this domain's overall contribution to the Index score in the long term is negative. The score of 64.9 points reveals entrenched gender inequalities in the time women and men spend on paid and unpaid work and in recreation.

- Housework is the most unequally shared of the three most common forms of unpaid care, the other two being childcare and long-term care for older people and people with disabilities and chronic conditions. About 78 % of women in the EU dedicate at least 1 hour per day to housework, compared with 32 % of men. This gender gap of 46 p.p. increases to 62 p.p. among women and men with children.

- The COVID-19 pandemic has had a huge impact on people with care responsibilities, especially women with children. Restrictions have made external care services from professional providers and social networks such as grandparents, friends and neighbours either unavailable or harder to access. Consequently, care has been provided largely from within the family. As Chapter 4, on the domain of knowledge, shows, online schooling has seen parents adopt new forms of unpaid work in their daily routine. Across the EU, increased time spent on unpaid care activities has led to acute work–life tensions, particularly for women.

Domain of power

- The domain of power is progressing the most. Since 2010, its score has increased by

([4]) See the Domain of money chapter.

13.1 points; between 2018 and 2019 alone, it increased by 1.9 points. This improvement accounts for almost two thirds of all progress in the Gender Equality Index since 2010.

- Nevertheless, the score of 55.0 points for the power domain is still the lowest of all the domains. Women account for only one in three national parliamentarians. In economic decision-making, women continue to be substantially under-represented in corporate boardrooms – accounting for 30 % of boardroom members in 2021. In large companies, less than 1 in 10 board presidents or chief executive officers (CEOs) are women. Progress in corporate boardrooms has been largely driven by legislative action in seven Member States (BE, DE, EL, FR, IT, AT and PT). In countries without specific gender equality action on decision-making, it will take more than 125 years to reach gender parity.

- The glaring lack of women in decision-making has become far more obvious during the COVID-19 pandemic. This is particularly evident among entities responding to the crisis or designing economic stimulus and recovery measures. Although an overwhelming majority of EU healthcare workers are women, men dominate leadership positions in the sector. By March 2021, only one in four EU health ministers and 4 out of 10 junior/vice ministers were women.

Domain of health

- The domain of health, although having the highest score of all six domains, at 87.8 points, has made minimal progress since 2010, increasing by just 1.1 points. No progress has been recorded since the 2020 Index. The subdomains of health status and access to health services have made marginal headway since 2010, increasing by 1.7 and 2.0 points, respectively. Despite a lack of updated data, the greatest gender inequalities are found in health behaviour, with an EU score of 74.8 points.

- Access to health services in the EU is still not universal. More than 3 % of women and nearly 3 % of men report unmet needs for medical examinations. The groups most likely to report unmet medical examination need are women and men with disabilities (7 % and 6 % respectively), lone parents (5 %) and specific groups of women, such as those with a low level of education and those older than 65 years (4 % each).

- While the full effects of the pandemic on people's health remain unclear, they are likely to be far-reaching. As of July 2021, COVID-19 has claimed the lives of more than 730 000 people in the EU, with another 33 million infections registered ([5]), which combined account for 7 % of the EU population ([6]). However, the burden of infection and death has been unevenly distributed across countries and population groups. Life expectancy fell in most EU countries in 2020 compared with 2019. Preliminary data shows that it decreased slightly more for men than for women in all EU Member States except Spain. The largest life expectancy falls were among men in Poland, Lithuania (both – 1.5 years) and Romania (– 1.4 years) and among women and men in Spain (– 1.6 years and – 1.4 years, respectively) ([7]). The greater decline in life expectancy among men can be attributed to the fact that, in most EU countries, COVID-19 fatality rates are higher among men , resulting in excess mortality rates being higher among men than among women (see Section 9.2.2).

- The pandemic is also linked to a fall in the number of registered births in late 2020 and

([5]) European Centre for Disease Prevention and Control (ECDC) COVID-19 surveillance update, https://www.ecdc.europa.eu/en/cases-2019-ncov-eueea, accessed 7 July 2021.

([6]) Authors' elaboration based on ECDC daily data, https://www.ecdc.europa.eu/en/cases-2019-ncov-eueea, as of 19 May 2021, based on 2020 data for population.

([7]) Authors' elaboration based on Eurostat data 'Life expectancy by age and sex', https://ec.europa.eu/eurostat/databrowser/view/demo_mlexpec/default/table?lang=en, accessed 8 April 2021.

early 2021, especially in countries most affected by COVID-19 ([8]). This fall is expected to exacerbate demographic challenges posed by declining birth rates in ageing societies across the EU, with Member States in southern and central Europe particularly affected.

Domain of violence

- Regular updates to the domain of violence are a challenge because of the dearth of prevalence data. Although not comparable to the European Union Agency for Fundamental Rights' (FRA's) survey on violence against women (2014), the *Fundamental Rights Survey* (2021) data provides more recent insights. It shows that 8 % of women in the EU experienced physical violence (excluding sexual violence) in the 5 years before the survey, and 5 % of women experienced physical violence in the 12 months preceding the survey. Incidents were most likely to take place in women's own homes (37 %) and to be perpetrated by a family member or a relative (32 %), most often a man.

- While an average of 39 % of women in the EU experienced harassment in the 5 years preceding the survey, some groups of women are much more likely to be affected. These include women who self-identify as lesbian, bisexual or 'other' (57 %), women not citizens of the countries in which they live (51 %), women with disabilities (48 %) and women with a tertiary-level education (49 %). The daily use of social media is also accompanied by rampant online harassment and abuse against women (13 %). Among women and girls aged 16–29 years, the prevalence of online harassment is 25 % (FRA, 2021).

- Restrictive measures to tackle COVID-19 have resulted in a surge of intimate partner violence against women. The risk of violence is especially high among already disadvantaged groups, including older women, women and girls with disabilities, migrant women, homeless women and victims of trafficking. The European Institute for Gender Equality (EIGE) reports a sharp increase in demand for victim support services, which are already struggling to continue operations, reach victims, find new support methods and deal with added strain on staff (EIGE, 2021a).

Thematic focus: health

Gender inequalities in health

Gender differences in health status

- Overall, women tend to report worse health than men. In the 27 Member States of the EU (EU-27), 66 % of women and 71 % of men perceive their health to be good or very good. In all age groups, health limitations tend to have a greater effect on the activities of daily living in women than in men. The greater likelihood of women experiencing poor health also manifests in data on healthy life years. Women and men in the EU can expect to be in good health until 65 and 64 years of age ([9]), respectively. However, as women tend to live longer, more of their life is spent in poor health – an average of 19 years, compared with 14 years for men.

- Looking at mental well-being specifically, the same trend can be seen, with women being more likely to report poor mental well-being. Analysis of the World Health Organization Five Well-Being Index (WHO-5) – where a score of 100 represents the best imaginable well-being while scores of 50 or lower indicate risk of depression – shows that the self-rated mental health index is higher for men (66 points) than for women (62 points). Analysis of self-assessed mental well-being across population groups shows that women report lower levels of mental well-being regardless of family composition, age, income, country of birth and disability.

([8]) Compared with the same months of the previous year.
([9]) Eurostat, 'Healthy life years by sex (from 2004 onwards)', https://ec.europa.eu/eurostat/web/products-datasets/-/hlth_hlye, 2019.

Health and risk behaviours

- Overall, health and risk behaviours are clearly gendered in the EU. There are persistent gender gaps in health-promoting behaviour, such as healthy eating and physical activity. While more women meet the World Health Organization (WHO) target of consuming five portions of fruit or vegetables a day (14 %) ([10]), more men meet the target of 180 minutes of physical activity a week (47 %) ([11]). However, more men engage in high-risk behaviours such as tobacco smoking and hazardous drinking. These gendered health and risk behaviours are already visible in adolescence, and the gap between men and women widens with age.

Access to health services

- Universal access to health services has not yet been achieved in the EU. Gender inequalities and gender norms intersect with socioeconomic, geographic and cultural factors and create structural barriers when accessing healthcare. Several population groups, such as lone parents, older people, migrants and people with disabilities, and within each of these groups women in particular, stand out as being highly vulnerable to unmet healthcare needs. Overall, about 7 % of women and 6 % of men with disabilities report unmet needs for medical services in the EU, but the levels are much higher in Estonia (29 % of women and 23 % of men), Romania (25 % of women and 23 % of men) and Greece (25 % of women and 22 % of men). In Denmark, Sweden, Hungary, Bulgaria, the Netherlands and Luxembourg, among those with disabilities, men are more likely than women to report unmet medical needs.

- Many factors can inhibit access to medical services, such as the cost associated with them, experiences of discrimination and issues related to cultural sensitivity and a lack of gender sensitivity. The cost of medical services as a barrier to access is more frequently mentioned by people aged 65 years or older than by the general population (40 % of women and 34 % of men aged 65 or older, compared with 33 % of women and 29 % of men in the adult population as a whole). Data shows that large segments of the EU population would find it difficult to pay for unexpected dental care (41 % of women and 35 % of men), mental health services (39 % of women and 33 % of men) and other hospital or medical specialist services (32 % of women and 29 % of men) ([12]).

- The COVID-19 pandemic has further exacerbated barriers to access to healthcare services in the EU either as a result of deferment and deprioritisation of certain medical procedures or because of fear of infection. In particular, the European Foundation for the Improvement of Living and Working Conditions (Eurofound) COVID-19 e-survey found that 21 % of respondents had missed a medical examination or treatment during the pandemic. This proportion was highest in Hungary, Portugal and Latvia. In spring 2021, 18 % of respondents were experiencing a health issue for which they could not get treatment (Eurofound, 2021c).

([10]) Eurostat, 'Daily consumption of fruit and vegetables by sex, age and educational attainment level', https://ec.europa.eu/eurostat/web/products-datasets/-/hlth_ehis_fv3e

([11]) Eurostat, Persons performing physical activity outside working time by duration in a typical week, educational attainment level, sex and age', https://ec.europa.eu/eurostat/web/products-datasets/-/ilc_hch07.

([12]) European Quality of Life Survey (EQLS), 2016. Respondents were asked, for each type of medical service, 'How easy or difficult would it be for you to cover expenses for each of the following services, if you needed to use it tomorrow?' The percentages in the text are the proportions responding to 'Rather difficult' or 'Very difficult'.

Health dimensions in focus

Sexual and reproductive health

- Sexual and reproductive health and rights (SRHR) are heavily gendered within the EU. Although 95 % ([13]) of women in the EU can meet their need for contraceptives, health inequalities still exist. Availability, access, cost and stigma issues around contraceptives introduce barriers to SRHR, especially for young people. Laws, policies and comprehensive sexuality education vary across Member States (BZgA and IPPF EN, 2018). Access to safe abortion and high-quality maternal care remains unequal across the EU, especially for vulnerable groups such as young women and migrants.

- Severe gender data gaps persist in key areas of SRHR, ranging from comprehensive data on contraceptive use to disaggregated epidemiological data on sexually transmitted diseases (STDs) in the EU. Gender bias frames sexual and reproductive health (SRH) as a concern mainly for women and girls, leading to caveats. In particular, men are overlooked in the data collection concerning SRH, and the needs of men in the areas of reproductive health are underexplored in the scientific literature.

The COVID-19 pandemic

- The data shows that the likelihood of being infected with COVID-19 is similar for women and men ([14]), but men are at higher risk of severe disease and have a higher risk of death, with gender differences increasing with age. Data from the European Centre for Disease Prevention and Control (ECDC) for 10 EU Member States shows that, as of June 2021, overall, 8 % of women and 10 % of men infected with COVID-19 were hospitalised; however, among those aged 70–79 years, 24 % of women and 33 % of men were hospitalised. For patients aged 80 years or older, the rate of hospitalisation reached 31 % for women and 45 % for men. Since the beginning of the pandemic, men have accounted for 55 % of COVID-19 deaths. The risk of dying from COVID-19 is higher for men than for women in almost all EU countries for which data is available, with the exception of Lithuania and Slovenia.

- Women have been disproportionately exposed to infection by COVID-19 as a result of being over-represented among essential workers and frontline workers. Eurostat data shows that women represent 88 % of personal care workers, 84 % of cleaners and helpers, 73 % of education workers and 72 % of health professionals in EU countries ([15]). A study of 10 European countries, including seven Member States ([16]), found that infections among working-age women far outnumber those among working-age men until about the age of 60 years. The authors found that higher rates of infection among women have been linked to their presence in the caring professions, especially healthcare (Tomáš Sobotka et al., 2020). This is consistent with findings that poor working conditions, including the lack of appropriate occupational health and safety measures and precarious employment, contribute to high infection levels in women-dominated frontline sectors (OECD, 2020b; Pelling, 2021; Shallcross et al., 2021).

- Emerging evidence points to significant numbers of people with COVID-19 continuing to have symptoms weeks or even months after contracting the virus (Dennis et al., 2020).

([13]) UN Database, 'Family planning indicators', https://www.un.org/development/desa/pd/data/family-planning-indicators, 2017.

([14]) At the time of writing, over half of all COVID-19 cases in EU countries for which data is available were among women (52 % among women and 48 % among men). Source: The Sex, Gender and COVID-19 Project, Global Health 50/50, the African Population and Health Research Center and the International Center for Research on Women. Accessed from https://globalhealth5050.org/the-sex-gender-and-covid-19-project/ on 25 June 2021. EU: authors' elaboration for (BG, HR, CY, MT, data was not available). Updated on 21 June 2021.

([15]) EIGE, COVID-19 web page, https://eige.europa.eu/covid-19-and-gender-equality/essential-workers. Data from EU-LFS, 2018.

([16]) Belgium, Czechia, Denmark, Germany, Italy, Norway, Portugal, Spain, Switzerland and the United Kingdom.

Women of working age, people with disabilities, those living in deprived areas and people working in care professions are most likely to be affected by 'long COVID' (Ayoubkhani, 2021). Most of those affected report that symptoms adversely impact their day-to-day activities.

- Apart from the direct health consequences of the virus, there are also secondary impacts on physical and mental health. These are likely to be gender specific and long-lasting. Major stressors include social isolation, fear of infection for oneself and loved ones, grief and financial distress. In spring and early summer 2021, mental well-being was at its lowest level since the outbreak began, with large segments of the population at risk of depression (Eurofound, 2021c). Women have had lower levels of mental well-being than men in each of the three pandemic waves, with the lowest levels recorded among working-age women during the third wave. Evidence is mounting on the profound mental health toll of the pandemic on frontline workers, particularly in the care sector. The true extent of the pandemic's mental health consequences will take time to unfurl, with experts warning that the peak may come long after the pandemic is controlled.

- The restrictions and economic uncertainties resulting from the COVID-19 pandemic have given rise to a 'shadow pandemic' of gender-based violence; in particular, there has been a surge in intimate partner violence. Forced cohabitation brought about by lockdowns and economic and labour instability are considered stressors associated with an increase in intimate partner violence (Buller et al., 2018; Buttell and Ferreira, 2020; Jarnecke and Flanagan, 2020). Furthermore, the increase in psychological distress during lockdowns (S. K. Brooks et al., 2020; Gillespie et al., 2021) is another risk associated with intimate partner violence (Clemens et al., 2019; Curtis et al., 2019; Straus and Douglas, 2019). Lockdown measures may have compounded risks of violence against vulnerable groups such as women with disabilities; homeless women, undocumented migrants or migrants with temporary visas; families with low socioeconomic status or children; and lesbian, gay, bisexual, transgender, intersex, queer,+ (LGBTIQ*) couples (Arenas-Arroyo et al., 2020; De Schrijver et al., 2021; Flatau et al., 2020; Pleace et al., 2021; Segrave and Pfitzner, 2020; Zero and Geary, 2020).

Introduction

The COVID-19 crisis may have started a year and a half ago, but it is far from over. It has reversed years of progress on women's rights and gender equality – and exposed serious challenges. We are living not just a public health crisis, but also an economic and social crisis. Employment and working conditions have undergone seismic changes, with different impacts on women and men. Growing evidence shows that women bear the brunt of upheaval, suffering more acute socioeconomic consequences of the crisis.

Action is critical. In 2020, the European Commission presented its 2020–2025 gender equality strategy. Although developed before the pandemic, it sets out key actions in heavily affected crisis areas and commits to the inclusion of a gender equality perspective in all EU policy areas. The recovery and resilience facility, which came into force in February 2021, aims to mitigate the socioeconomic impact of the pandemic and make European economies and societies more sustainable and resilient. Acknowledging that women have been particularly affected by the pandemic, it requests that Member States set out how national plans will contribute to gender equality and equal opportunities for all. As countries struggle to tackle COVID-19, strategies addressing gender inequalities will be key. For these strategies to be effective, women – often on the frontline of local and national responses – should be heard.

Since 2013, the Gender Equality Index has been recognised by EU institutions and Member States as a key benchmark for gender equality in the EU. The 6th edition of the Index covers a range of indicators in the domains of society and life most affected by the COVID-19 crisis. Although Index scores are mostly based on 2019 data, and therefore cannot capture the full impact of the crisis on gender equality, the report provides ample evidence of the pandemic's negative repercussions on women in the domains of work, money, knowledge, time, power and health. It also addresses the spike in violence against women and how the most disadvantaged and marginalised groups of women and men in society have borne the brunt of the impact.

Health, the thematic focus of this report, explores an additional three dimensions – health status (including mental health), health behaviours and access to health services. It also provides a gender and intersectional analysis of SRH and the COVID-19 pandemic.

Chapter 1 presents the results of the Gender Equality Index 2021, and key trends since 2010 and since the 5th edition of the Index. The convergence analysis reveals an evolution of disparities on gender equality across Member States and provides a broader context for the main findings. Chapters 2–7 summarise the policy context, key outcomes of core domains and COVID-19's toll on gender equality in those areas. Developments in the domain of violence are covered in Chapter 8, while the thematic focus on health is explored in Chapter 9.

1. Gender equality in the European Union at a glance

1.1. Progress is an uphill struggle

The Gender Equality Index score for the EU-27 is 68.0 points out of 100 ([17]), which is a 0.6-point improvement since the 5th edition in 2020. The score is only 4.9 points higher than in 2010 (Figure 1). With gender equality inching forward by only 1 point every 2 years, it will take nearly three generations to achieve gender parity at the current pace. And even that projection is threatened by COVID-19. The pandemic presents a real risk, not only slowing progress, but also rolling back fragile gains made since 2010 (Figure 1).

The greatest gender inequalities are in the domain of power, with a score of 55.0 points. The silver lining, however, is that this domain is advancing faster than others. Its score has risen by 1.9 points in 1 year and by 13.1 points since 2010. Much of this progress is due to outstanding developments in women's participation in economic and political decision-making in several Member States.

The domain of knowledge, with the second lowest score, of 62.7 points, has seen a 0.1-point decrease since the 2020 Index. Its score has improved by a mere 2.9 points in total since 2010, reflecting the fact that gender segregation in some fields of study in tertiary education is entrenched.

With a score of 65.7 points, dropping by 0.3 points since 2010, the domain of time is alone in regressing to below 2010 levels. It reveals persistent and growing gender inequalities in time spent in caring and social activities. Lack of data means that the latest developments in this domain cannot be assessed. This reiterates the need for more frequent time-use data to better track progress in this area, particularly on monitoring unpaid work. EIGE will fill the gap in the near future by collecting EU-wide data on time spent on unpaid care and social activities by women and men.

The domain of work, despite having the third highest score, 71.6 points, continues to exhibit gender inequalities in employment and deep gender divides in some economic sectors and occupations. With its score increasing by 0.2 points in 1 year, and by a mere 1.9 points since 2010, gender equality in this domain remains a major issue in almost all Member States.

Scoring 82.4 points, the domain of money has seen an improvement of 0.9 points over 1 year, and of 3.3 points since 2010. However, progress in some areas, such as reducing the risk of poverty and equalising income distribution among women and men, overall, has been negative since 2010. The risk of poverty for women fractionally decreased between 2018 and 2019, but the data does not yet reflect the impact of COVID-19 in this area.

([17]) The Gender Equality Index 2021 is calculated for the EU-27. For comparability, all previous scores were recalculated for the EU-27.

Figure 1. Ranges of Gender Equality Index scores (2019) and changes over time

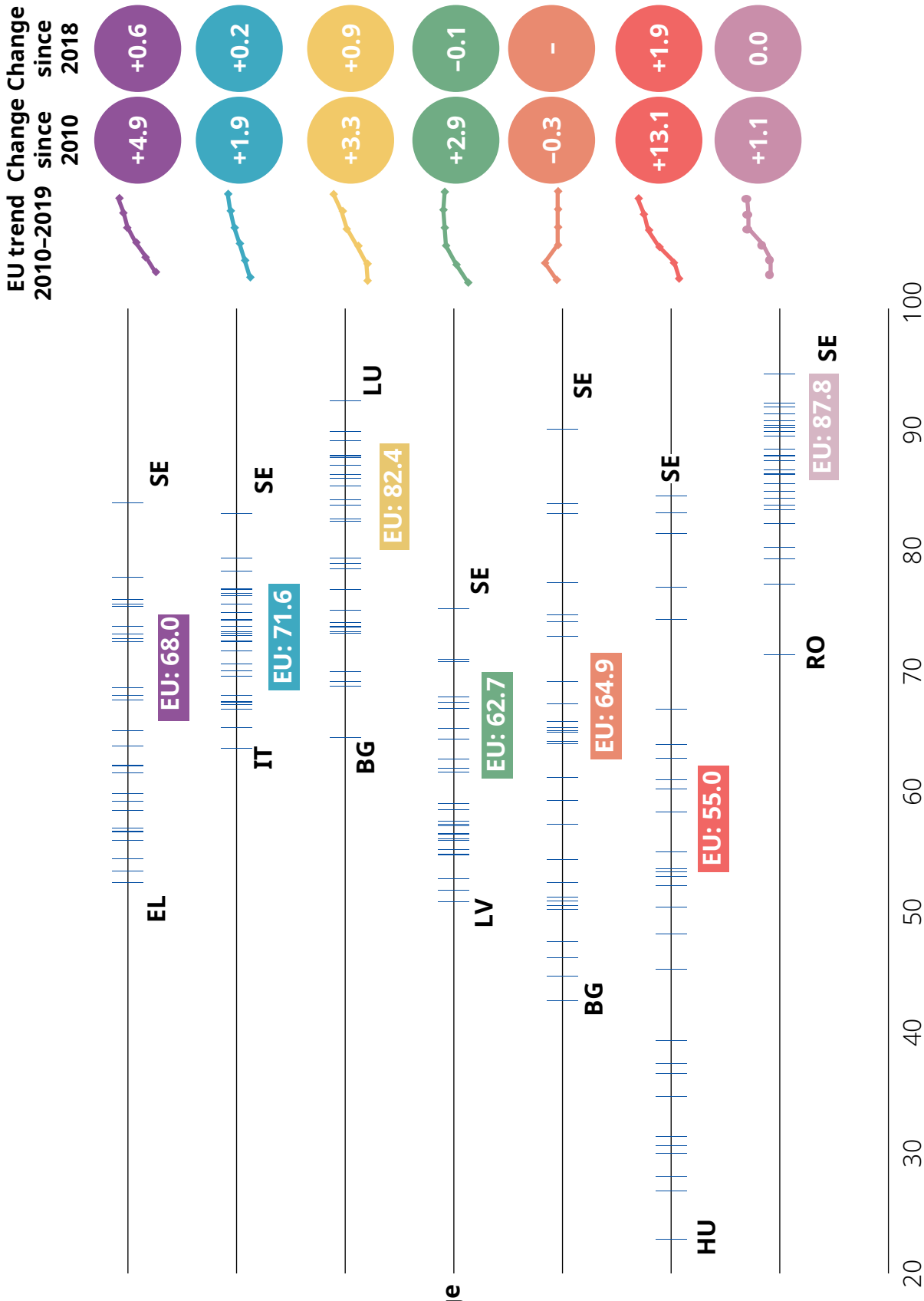
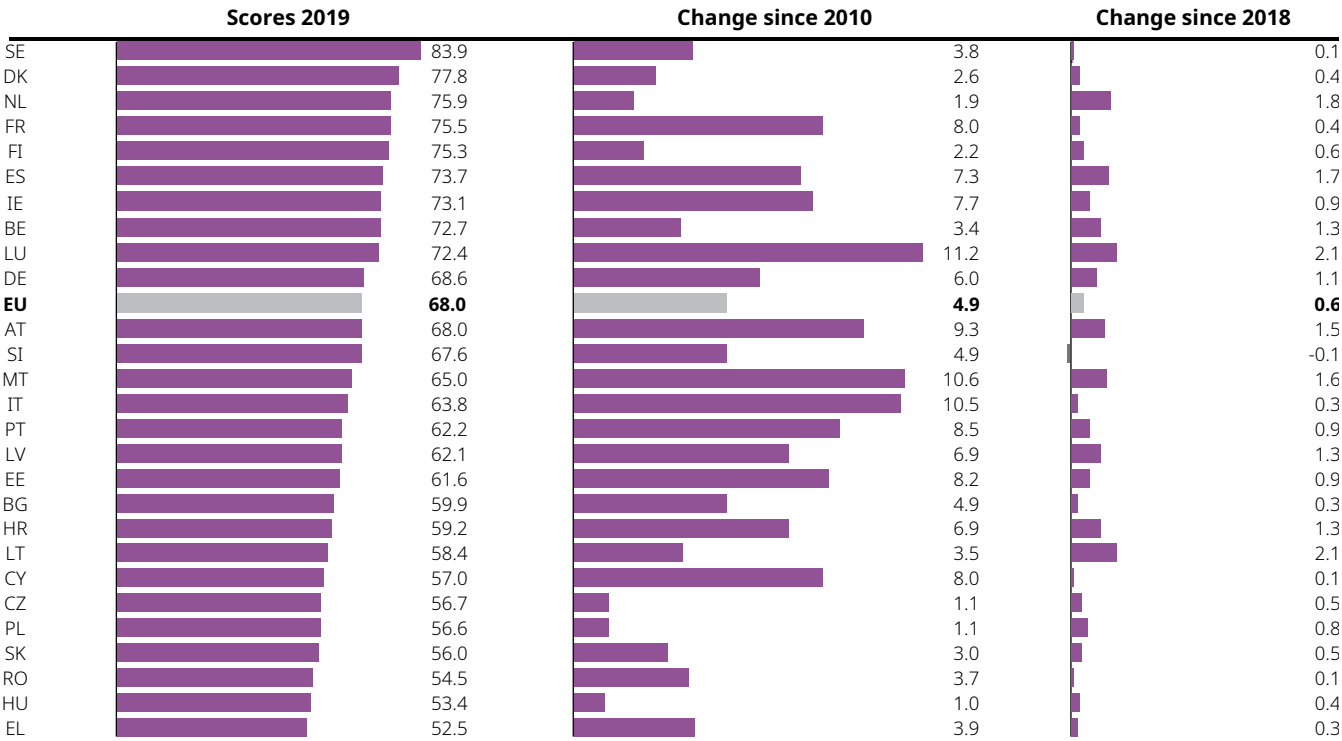


Figure 2. Gender Equality Index scores (changes compared with 2010 and 2018)



Gender equality levels vary considerably among Member States (Figure 2). Ten countries are above the EU average, nine of them scoring more than 70 points on the Index. Sweden and Denmark maintain their top two status, as in the previous edition and since 2010. The Netherlands climbed to third position, jumping two places in 1 year. France and Finland each dropped by one position, now ranking fourth and fifth, respectively. Ten Member States scored lower than 60 points, with Greece, Hungary and Romania struggling the most to advance gender equality.

Since the previous edition, the greatest increases in Index scores have been in Luxembourg, Lithuania and the Netherlands, by about 2 points or more. Austria, Croatia, Germany, Latvia, Malta and Spain have seen rises of between 1 and 1.7 points. Slovenia's score, however, decreased by 0.1 points.

Since 2010, most progress on gender equality has been in Luxembourg (+ 11.2 points), Malta (+ 10.6 points), Italy (+ 10.5 points), Austria (+ 9.3 points) and Portugal (+ 8.5 points). In Croatia, Cyprus, Estonia, France, Germany, Ireland, Latvia and Spain, Index score increases ranged between 6.0 and 8.2 points. The least progress on gender equality since 2010 has been in Czechia, Hungary and Poland, where the increase has been around 1 point. The pace of change in the remaining 11 countries has been slow, with scores improving by between 1.9 and 5 points since 2010 (Figure 2).

1.2. Decision-making driving change, segregation blocking it

Achievements in gender equality from 2010 differ considerably across domains and countries. From both short-term (2018–2019) and longer-term (2010–2019) perspectives, progress has been most marked in the domain of power, with this domain alone accounting for around two thirds (71 %) of the improvement in the overall 2021 Index score. since the previous edition (Table 1). The contribution of other domains is much lower, while that of the domain of time is negative over the longer term.

Since 2010, the score for the domain of power has increased by 13.1 points in the EU, reflecting gains in this area by nearly all Member States. Progress is most evident in France

(+ 29.0 points), Luxembourg (+ 27.8 points), Italy (+ 27.0 points), Germany (+ 24.5 points) and Spain (+ 24.3 points). Between 2018 and 2019, progress on gender balance in decision-making was fast-paced in Spain (+ 7.5 points) and the Netherlands (+ 6.8), with Belgium (+ 5.3 points), Lithuania (+ 5.1 points) and Luxembourg (+ 5.0 points) following suit. Only Bulgaria (– 1.3 points), Slovenia (– 2.0 points) and Romania (– 2.8 points) saw reversals (Table 2).

Table 1. Percentage contribution of different domains to Gender Equality Index progress scores in the short term (2018–2019) and long term (2010–2019) in the EU

	Work	Money	Knowledge	Time	Power	Health
Short term (2018–2019)	7	18	– 3	–	71	1
Long term (2010–2019)	6	8	12	– 11	62	2

NB: No new data was available in 2019 for the domain of time. Last data available as of 2016.

The domain of money accounted for 8 % of the total increase in the Index between 2010 and 2019 and for 18 % of the increase from 2018 to 2019. Countries that initially had lower gender equality scores for the financial and economic situations of women and men progressed faster. From 2018 to 2019, the following countries increased their scores: Romania by 6.1 points, Lithuania by 3.8 points, Latvia by 3.5 points and Estonia by 3.2 points. Sweden was alone in seeing its score fall, by 1.4 points.

While gender equality scores in the domain of work grew steadily from 2010, progress almost stalled in all Member States in 2018, largely because of gender segregation in employment. Only Malta (+ 1.4 points) and Luxembourg (+ 1.1 points) made gains, albeit small ones.

In the domain of knowledge, Latvia was alone in raising its score by more than 1 point (+ 1.6 points) from 2018 to 2019. However, there was regression in Malta (– 1.9 points) and Italy (– 2.9 points). Despite increased educational attainment of women and men in the EU, the gender divide in some fields of study persists, resulting in an overall reversal in the domain of knowledge.

Table 2. Changes in the Gender Equality Index and domain scores, by EU Member State, long term (2010–2019) and short term (2018–2019), in points

MS	Long-term increase/decrease (2010–2019)							MS	Short-term increase/decrease (2018–2019)						
	Index	Work	Money	Knowledge	Time	Power	Health		Index	Work	Money	Knowledge	Time	Power	Health
EU	4.9	1.9	3.3	2.9	-0.3	13.1	1.1	EU	0.6	0.2	0.8	-0.1	0.0	1.9	0.0
BE	3.4	2.2	4.4	0.2	-5.0	13.1	-0.2	BE	1.3	0.2	1.2	-0.6	0.0	5.3	-0.2
BG	4.9	1.7	3.7	4.8	-1.2	14.4	1.9	BG	0.3	0.6	2.2	0.3	0.0	-1.3	0.0
CZ	1.1	2.5	5.1	3.1	3.5	-2.9	0.6	CZ	0.5	0.4	2.1	0.1	0.0	0.4	0.0
DK	2.6	-0.4	5.5	-2.2	2.7	8.8	-0.8	DK	0.4	-0.3	2.3	-0.3	0.0	0.6	-0.2
DE	6.0	2.4	2.8	-1.6	-4.8	24.5	1.4	DE	1.1	0.3	1.1	0.7	0.0	3.3	0.1
EE	8.2	1.3	7.7	5.7	1.0	14.7	-0.5	EE	0.9	0.4	3.2	1.0	0.0	0.5	0.6
IE	7.7	3.0	2.3	2.1	3.4	21.2	0.6	IE	0.9	0.6	1.3	0.1	0.0	2.6	0.0
EL	3.9	1.7	-1.6	1.5	9.1	4.7	0.0	EL	0.3	0.9	1.2	0.1	0.0	0.0	0.3
ES	7.3	1.9	1.3	4.4	3.2	24.3	1.7	ES	1.7	0.5	0.6	0.3	0.0	7.5	0.2
FR	8.0	1.7	2.8	5.0	0.7	29.0	0.7	FR	0.4	0.4	-0.7	0.7	0.0	1.6	0.0
HR	6.9	2.9	5.4	1.9	1.2	16.9	2.3	HR	1.3	0.2	1.4	0.2	0.0	3.9	0.1
IT	10.5	2.4	0.5	5.2	4.2	27.0	2.1	IT	0.3	0.4	0.4	-2.9	0.0	3.4	0.0
CY	8.0	0.1	1.9	0.5	5.4	14.6	1.5	CY	0.1	-0.2	0.9	-0.2	0.0	0.2	-0.1
LV	6.9	1.7	9.8	1.7	3.8	15.6	2.0	LV	1.3	0.3	3.5	1.6	0.0	1.0	0.9
LT	3.5	1.6	9.1	1.8	-1.6	6.4	-0.1	LT	2.1	0.1	3.8	-0.1	0.0	5.2	0.3
LU	11.2	5.4	0.6	4.5	-1.1	27.8	0.1	LU	2.1	1.1	2.4	0.8	0.0	5.0	0.4
HU	1.0	2.0	2.5	2.7	0.2	-0.6	1.3	HU	0.4	0.0	1.3	-0.2	0.0	0.7	-0.3
MT	10.6	11.7	5.0	-0.2	9.9	16.6	1.7	MT	1.6	1.4	1.6	-1.9	0.0	4.7	0.3
NL	1.9	2.0	0.4	0.5	-2.0	7.1	-0.1	NL	1.8	0.5	0.8	0.1	0.0	6.8	0.2
AT	9.3	1.5	4.9	5.4	5.2	19.8	0.8	AT	1.5	0.4	1.0	0.5	0.0	4.0	0.0
PL	1.1	0.9	7.2	-0.2	-1.7	0.9	1.7	PL	0.8	-0.1	1.2	0.4	0.0	1.5	0.2
PT	8.5	1.8	1.8	6.4	8.8	18.7	0.5	PT	0.9	0.3	0.8	0.8	0.0	2.5	0.2
RO	3.7	-0.4	9.3	5.6	-0.3	3.9	1.4	RO	0.1	-0.1	6.1	0.4	0.0	-2.8	0.1
SI	4.9	1.1	3.4	1.6	4.6	11.9	1.0	SI	-0.1	-0.1	0.7	0.7	0.0	-2.0	0.9
SK	3.0	2.0	4.9	2.1	6.4	1.2	0.7	SK	0.5	0.2	0.0	0.4	0.0	1.1	0.0
FI	2.2	1.0	3.8	3.3	-2.7	5.2	0.0	FI	0.6	0.1	0.8	0.3	0.0	2.4	0.2
SE	3.8	2.7	0.1	4.5	5.6	6.7	1.4	SE	0.1	0.2	-1.4	1.0	0.0	0.3	0.1

NB: Green indicates an increase of > 1 point and red a decrease of > 1 point. For the domain of time, data for 2019 is not available.

1.3. Small drop in disparities in gender equality across the European Union, but COVID-19 could change that

Although gender equality gains among Member States vary widely, progress, especially in some countries, has somewhat reduced disparities across the EU. Recent advances could be wiped out as consequences of the COVID-19 pandemic unfold. Understanding the evolution of disparities across Member States and their potential implications for upward economic and social convergence – a fundamental objective of the EU – is critical.

Upward convergence on gender equality – improving performance in Member States while simultaneously reducing gaps across the EU – would see inequalities between women and men dissipate. The first convergence analysis was introduced in the Gender Equality Index 2019 report (EIGE, 2019c). This edition provides an updated analysis of convergence patterns in the Index between 2010 and 2019, building on a policy brief jointly produced by Eurofound and EIGE (Eurofound/EIGE, 2021). Despite steady progress over the period, the evolution of Index scores shows that disparities between Member States widened between 2011 and 2014. This was mainly driven by countries' different responses to gender inequalities in economic and political decision-making. While disparities subsequently narrowed, they widened again in 2019. Several countries had gained quickly on the EU average, while those below it in 2010 improved their performance at a slower pace and fell further behind. A few countries were still in the same position in 2019. Nevertheless, there is a general upward convergence trend in the EU.

Closer examination of the performance of individual Member States reveals four different trends relative to the EU average (Figure 3).

a) Flattening. The national Gender Equality Index score is higher than the EU average, but is rising more slowly than the EU average (BE, DK, NL, FI and SE).

b) Outperforming. The national Gender Equality Index score is above the EU average and is improving at a faster rate than the EU average. As a result, the gap between the two is increasing (DE, IE, ES, FR, LU, AT and SI).

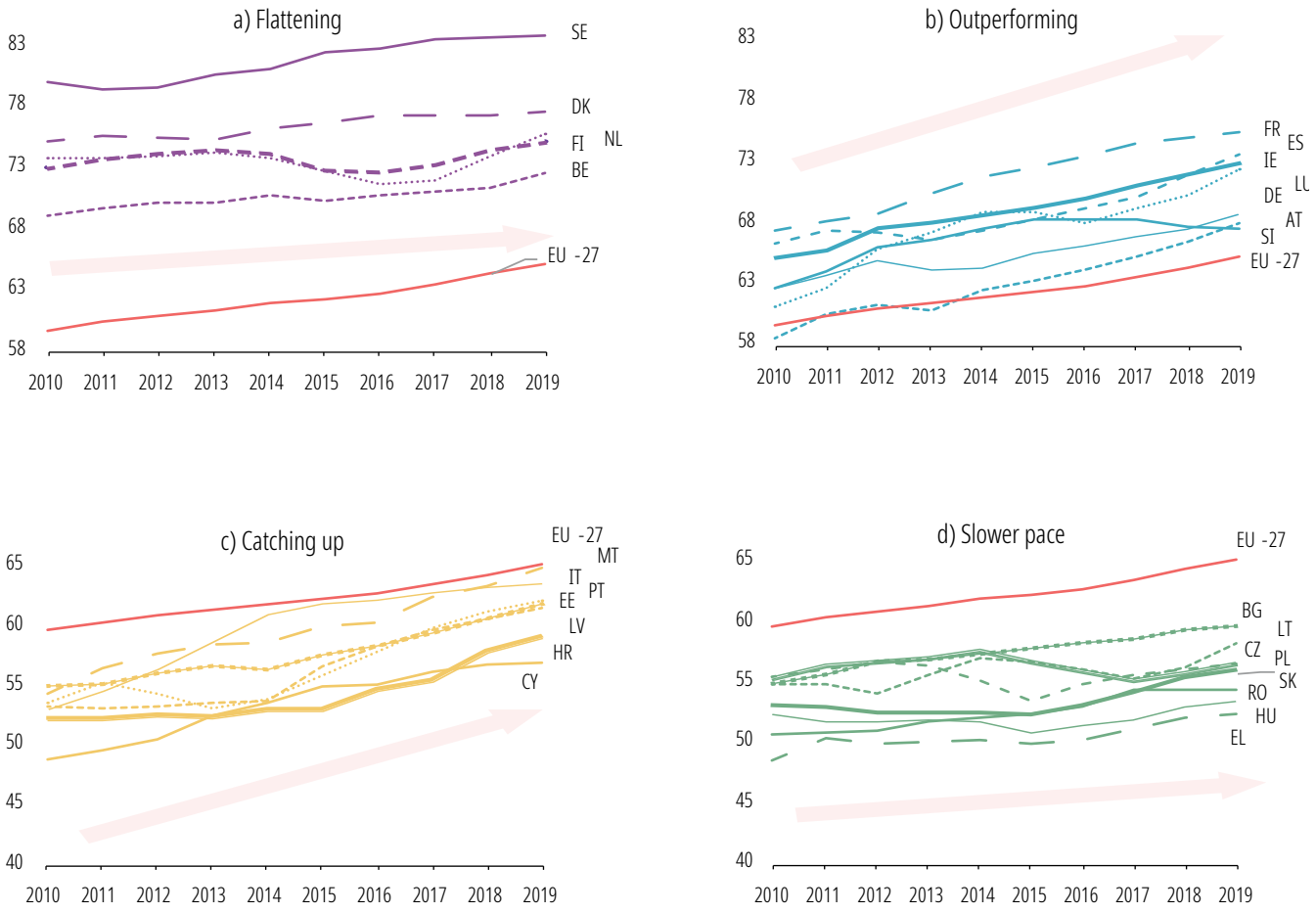
c) Catching up. The national Gender Equality Index score was initially below the EU average, but is improving more quickly than the EU average, reducing the gap (EE, HR, IT, CY, LV, MT and PT).

d) Slower pace. The national Gender Equality Index score is both lower than the EU average and improving at a slower rate, increasing the gap over time (BG, CZ, EL, LT, HU, PL, RO and SK).

Progress trends between 2010 and 2019 show that the greatest strides in gender equality have been mainly in southern EU countries. In France, Italy, Cyprus, Luxembourg, Malta, Austria and Portugal, the Index score increased by more than 7.5 points. Among Baltic countries, Estonia saw an impressive rise of 7.3 points. Generally, countries with lower levels of gender equality are progressing faster, while top-performing countries are slowing down. When Member States are positioned against Sweden, first placed in the Index, it can be seen that a modest reduction in disparity was achieved from 2010 to 2019. This is indicative of long-term progress in upward convergence (Eurofound/EIGE, 2021).

While the 2021 Index score shows meagre progress on gender equality between 2010 and 2019, the socioeconomic consequences of COVID-19 and their disproportionate effects on women may shift upward convergence to divergence and a downward trend in gender equality. The 2022 edition of the Gender Equality Index will examine the pandemic and its socioeconomic toll on gender equality.

Figure 3. Gender Equality Index scores and convergence patterns (2010–2019) by EU Member State



2. Domain of work

Gender inequalities in the domain of work remain entrenched (EIGE, 2020a). They are reflected in lower levels of employment and higher levels of underemployment for women, as well as in gender segregation in the job market and related pay challenges (see Chapter 3). Gender norms and stereotypes are key pillars of gender inequalities in the world of work, with unequal distribution of care, family and other household duties a major barrier to women's equal participation in the workforce (EIGE, 2020e).

Most women still face cultural norms, including leaving jobs or substantially reducing paid work time to meet care needs. This has consequences for personal income, training and reskilling opportunities (EIGE, 2019e). For men, care and family duties are not a structural constraint to having jobs. However, they more often face challenges when reducing their work hours to take on more care responsibilities at home, such as resistance from employers or co-workers.

Focusing on 2019 for this analysis is important to better understand how the COVID-19 crisis is impacting job opportunities for women and men, particularly for those with multiple disadvantages in the labour market. The crisis is exposing, as never before, the crucial links between paid and unpaid work, and between the economic and health spheres.

Critical to people's lives, work also impacts well-being and health through social, physical and psychosocial hazards, including the risk of injury or occupational disease and stress, to name just a few. This leads to diverse outcomes for women and men depending on how much they work, the type of job they have and in which sector they work (Leka and Jain, 2010). Better quality of work is related to better individual health (Barnay, 2016; Henseke, 2018), and precarious employment is related to worse health outcomes (Benach et al., 2014; Siegrist et al., 2016). This implies that gender inequalities in the labour market are reflected in gender inequalities in health. Generally, policies promoting employment and better working conditions are linked to improved population health and fewer gender-based health inequalities (Naik et al., 2019).

Various recent EU policies tackle the important nexus between gender equality, work and work-related dimensions of our lives. Key objectives of the EU's 2020–2025 gender equality strategy (European Commission, 2020b) include closing gender gaps and addressing the under-representation of marginalised women in the labour market, ensuring equal participation across different sectors of the economy. The Commission's recommendation on effective active support to employment calls for policy support, backed by EU funding, to those most adversely effected by the COVID-19 crisis. This includes women, older workers and persons with disabilities (European Commission, 2021b).

The recommendation also promotes job creation and job-to-job transitions from sectors in decline to developing sectors and those lacking skilled workers, for example the information technology and care industries. The European Pillar of Social Rights Action Plan (European Commission, 2021d), which sets a headline target of at least 78 % of people aged 20–64 years in jobs by 2030, acknowledges that achieving this goal requires 2019 gender employment gaps to be halved at least. The plan notes that an increase is needed in the provision of formal early childhood education and care to better reconcile professional and private lives, and to support women's participation in the labour force.

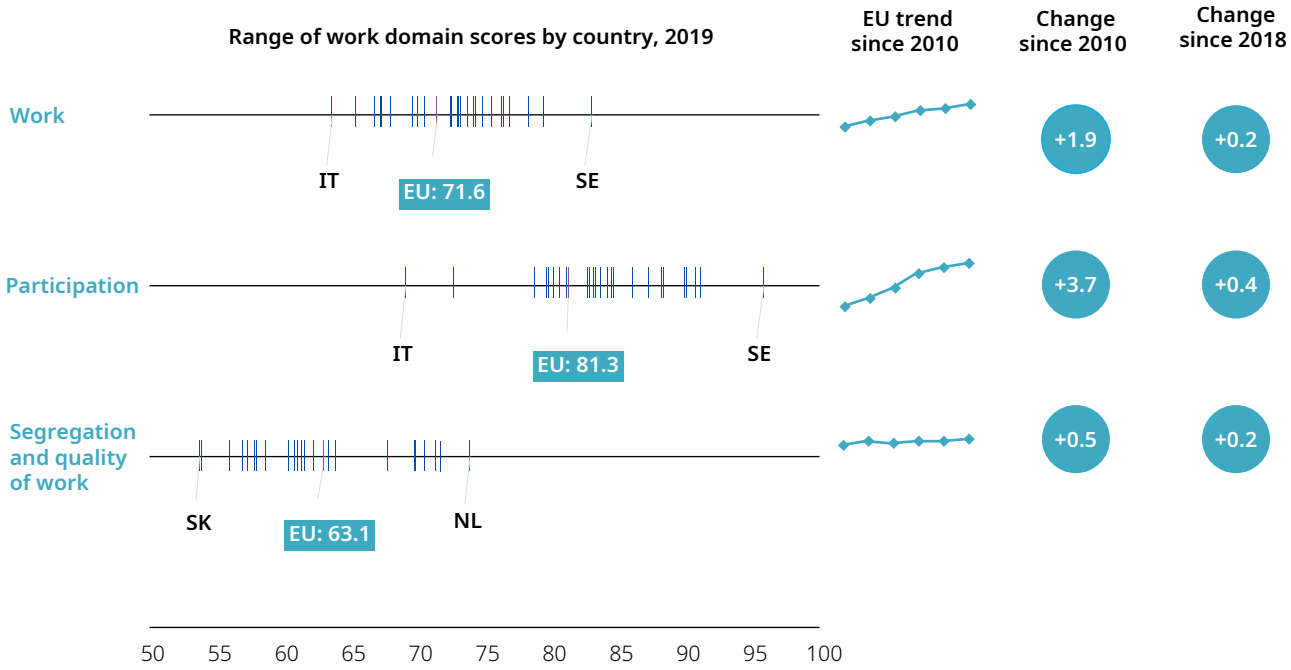
2.1. Fragile pace of change since 2010

The domain of work ([18]) is among the domains to have experienced slowest progress in the EU-27 since 2010. Its score increased by only 0.2 points in 2019, following an increase of only 0.3 points in 2018 (Figure 4). This slowdown was anticipated in the 5th Index, as progress during 2010–2018 was largely driven by recovery from the 2008 economic crisis and the relative stability after the crisis (EIGE, 2020g). Given the impact of the COVID-19 pandemic on women in the workforce, the score for 2019 is worrying.

Progress in this domain has been minimal in part because few gains have been made in the participation subdomain. The score increase in this subdomain was low, at 0.4 points, in 2019, lower even than 2018, when it increased by 0.5 points. The subdomain of segregation and quality of work made even less progress in 2019, increasing by only 0.2 points. Since 2010, the score for this subdomain has risen by only 0.5 points overall. Such creeping gains in the area of gender segregation in the labour force underlines the fragility of gender equality progress and the intractability of the challenge faced across the EU (Figure 4).

The progress noted above does not take account of changes in two indicators because of a lack of data availability. Specifically, an indicator on being able to take a few hours off during a working day to take care of personal or family matters and a Career Prospect Index remain unchanged, as the most recent data is from 2015. Consequently, uncertainty remains as to what extent gender equality progress or regress should be attributed to such important aspects of work–life balance, given the low Index score of 63.1 points for the subdomain of segregation and quality of work.

Figure 4. Scores for the domain of work and its subdomains (2019), and changes over time



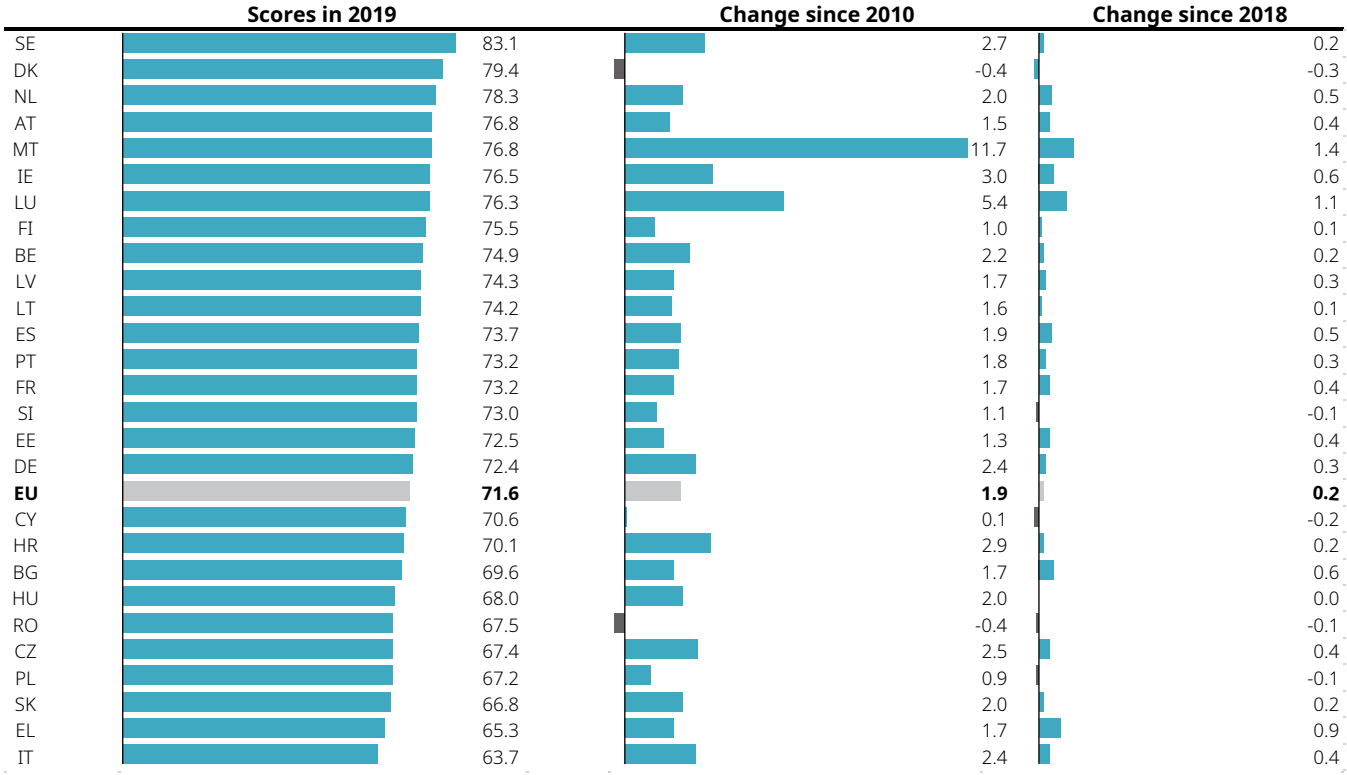
([18]) The domain of work measures the extent to which women and men can benefit from equal access to employment and good working conditions. The subdomain of participation combines two indicators: the rate of FTE employment and the duration of working life. Gender segregation and quality of work are included in the second subdomain. Sectoral segregation is measured through women's and men's participation in the education, human health and social work sectors. Quality of work is measured by flexible working-time arrangements and Eurofound's Career Prospects Index.

The relatively high Index score of 81.3 points in the participation subdomain masks enormous gender gaps across the EU and in forms of employment. For example, women's FTE employment rate in 2019 was 16 p.p. lower than men's (see Section 2.2.). The gender gap was particularly large in Malta (21.8 p.p.), Italy (20.1 p.p.) and the Netherlands (19.2 p.p.). The situation in Italy is particularly concerning, with the women's FTE employment rate of 31.4 % being at least 10 p.p. below the EU-27 average, and the lowest in the EU. Gender gaps in FTE employment rates also reflect the fact that a higher proportion of women than of men are employed in non-standard and often precarious, jobs, including part-time jobs.

The low score for the subdomain of segregation and quality of work reflects the fact that progress in meeting a series of gender equality challenges has come to a standstill. For example, women continue to dominate the education, health and social work employment sectors, even in countries traditionally achieving higher employment participation rates for women. For example, the gender difference in these sectors amounts to 30.4 p.p. in Finland, to 30 p.p. in Denmark, to 29.8 p.p. in Sweden, to 28.4 p.p. in Belgium and to 26.5 p.p. in the Netherlands.

With tentative overall progress in the domain of work, country-level developments are especially important (Figure 5). They indicate both sustained challenges and signs of progress. In 2019, negative score changes in this domain were recorded in five countries: Poland, Romania and Slovenia saw a decrease of – 0.1 points, with greater declines in Cyprus (– 0.2 points) and Denmark (– 0.3 points). The case of Denmark reflects the fragility of gains made in previous years; the decline recorded in 2019 was the greatest contributor to an overall decline of 0.4 points since 2010. Romania is the only other country to have scored negatively over the same period, and by the same amount (– 0.4 points).

Figure 5. Scores for the domain of work (2019) and changes since 2010 and 2018, by EU Member State

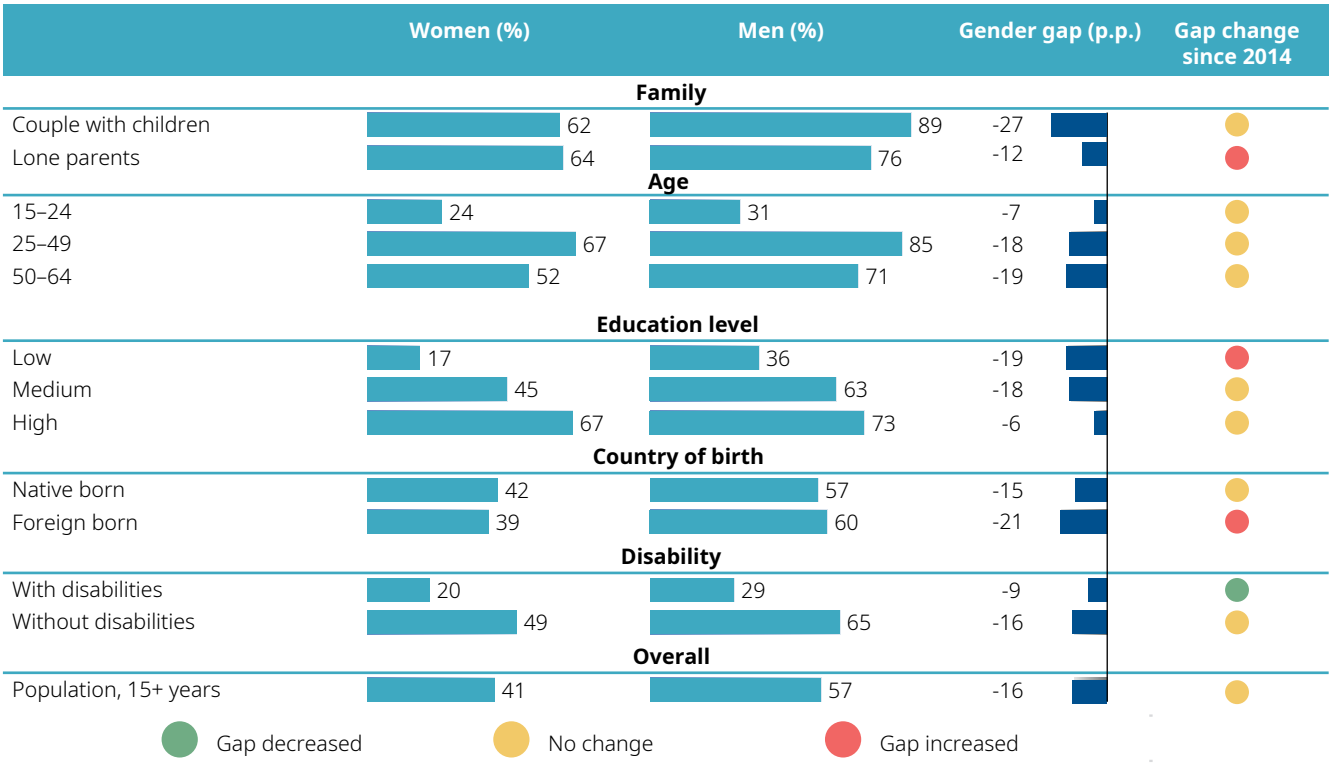


The news is more positive elsewhere. Rapid gains in the domain of work continue in Malta, which recorded a 1.4 point increase in 2019, the largest of any EU country. Nevertheless, the annual change was lower than in 2018, when there was a gain of 2.1 points, indicating that Malta's progress is flattening. Other countries recording notable positive change in the Index score include Greece (+ 0.9 points), Bulgaria and Ireland (+ 0.6 points), and the Netherlands and Spain (+ 0.5 points points). Overall, Sweden remains on top, with a score of 83.1 points, followed by Denmark (79.4 points) and the Netherlands (78.3 points). The lowest scores in this domain are for Italy (63.7 points), Greece (65.3 points) and Slovakia (66.8 points), despite all making progress in 2019.

2.2. Unpaid childcare still hindering women from working full time

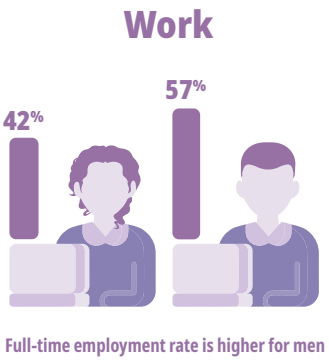
FTE employment rates are widely divergent across population groups, and consistently disadvantageous for women. As Figure 6 shows, the largest gender gap – 27 p.p. – in FTE employment in 2019 was among couples with children, with 62 % of women, compared with 89 % of men, in this family grouping working full time. The second highest FTE employment gender gap, of 21 p.p., is among foreign-born women and men. This is followed by people with low educational qualifications, at 20 p.p. This group also had overall low rates of people working full time in 2019 – only 17 % of women and 36 % of men. FTE employment rates in 2019 for all groups of women ranged from 17 % for those with low educational qualifications to 67 % for those aged 25–49 years or for those with high educational qualifications. Among men, the lowest FTE employment rate, of 20 %, was for men with disabilities and the highest, of 89 %, was for men in couples with children (Figure 6).

Figure 6. FTE employment rates by sex, family composition, age, education level, country of birth and disability (%, 15+ years, EU, 2019)



Source: Authors' calculation, European Union Labour Force Survey (EU-LFS). The European Union Statistics on Income and Living Conditions (EU-SILC) for disabilities is used (IE, IT, 2018).

Migrants face a host of barriers to employment, and often find it difficult to access better-quality jobs. For example, migrant women are usually limited to working in low-paid care jobs (Addati, 2018; EIGE, 2020c, 2021d). FRA (2019) reports very large gender gaps in employment rates among migrant populations in the EU. In particular, among people of North African origin, women are considerably less likely than men to be in paid work, with the gender gap ranging from 19 p.p. in France to 40 p.p. in Italy. Similarly, in Austria, the employment rate among women of Turkish origin is more than 45 p.p. lower than for men of Turkish origin (FRA, 2019).



Although FTE employment rates have been increasing for women and men – rising from 39 % in 2014 to 42 % in 2019 for women and from 55 % to 57 % in the same period for men – persistent and large gender gaps are cause for concern. This includes the gap between women and men in couples with children, highlighting how unpaid care duties remain a major obstacle to women taking on paid jobs. This enduring gap across time also points to the failure to implement the structural change that is necessary to accelerate progress in the area of FTE employment among women with children. The COVID-19 crisis has exacerbated the situation. Despite unpaid care acting as a major buffer in managing the spread of COVID-19 and reducing the degree of economic lockdowns (Klatzer and Rinaldi, 2020), those taking on most of that unpaid care – namely parents, especially mothers – accounted for most job losses (EIGE, 2021c).

FTE employment gender gaps among people with low educational qualifications and the foreign born also increased in 2019 compared with 2014. The gap increase among the latter group is worrying because it could signal a strengthening of gender stereotypes and norms, and because there is mounting evidence that foreign-born people are disproportionately affected by the COVID-19 crisis (EIGE, 2021c).

Although the employment gap between women and men with disabilities declined in 2019, this finding should be treated with caution and further monitored. This group is relatively small, and a major contributor to the change was the statistical adjustment of the Gender Equality Index data to an EU-27 level of analysis, excluding the United Kingdom.

2.3. Women bear the brunt of the impact of COVID-19 on jobs

The COVID-19 crisis is distinctive in its gendered impacts across the sectors of employment. Women are over-represented among 'essential' workers, including in the health and care sectors, victim support services, education and food retail (EIGE, 2020c). Their frontline status means that not only are they among those most exposed to COVID-19, but they also experience high levels of work-related stress and emotional exhaustion (Barello et al., 2020). Emerging studies point to, for example, particularly high burnout levels among women healthcare workers with children younger than 12 years, who are struggling to manage the dual burden of increased workload and more care duties (Duarte et al., 2020).

Jobs losses during the crisis have also been concentrated in sectors in which women make up the bulk of the workforce. During the first lockdown in 2020, 1.5 million women across the EU lost jobs in highly feminised and crisis-hit sectors such as the retail trade, hospitality, residential care, domestic work and clothes manufacturing (EIGE, 2021c). Most of these sectors did not recover during the year.

Although large numbers of both women and men lost their job, EIGE research (2021c) shows that it was young women, aged 15–24 years, who fared worst in the first COVID-19 wave. Among this

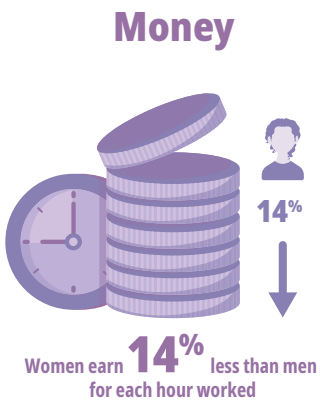
group, employment in quarter 2 of 2020 shrank by more than 10 % compared with the same quarter in 2019; the corresponding figure for men of the same age was 9 %. Figures vary substantially across groups of women and men, with over 2 % of women and men aged 15–64 years losing their job. Again, those with low educational attainment or who are foreign born were worst affected. The employment rate for women with low educational attainment dropped to 34 % (compared with 51 % in 2019), and that for foreign-born women dropped to 50 % (compared with 69 % in 2019), eradicating decades-long gains.

According to EIGE research (2021c), recovery in the summer of 2020 brought more men than women back to the labour market. Men recovered 1.4 million jobs, women only 0.7 million. Employment growth among women aged 25–49 years was slow, at 0.3 %, while for men of comparable age the figure was more than double that, at 0.7 %. The difference underlines the major hurdles women face in returning to the labour force at any time, but which have become more challenging because of ongoing unpaid care duties during COVID-19 restrictions (Klatzer and Rinaldi, 2020).

The shallow recovery in the summer of 2020 indicates that the socioeconomic impact of the crisis might have much longer-lasting adverse effects on women than on men, especially for groups facing the greatest challenges in getting, or being able to, work (EIGE, 2021c). Data for the last quarter of 2020 confirms this. The Eurostat index of total actual hours worked reveals that time in paid jobs fell by 6.1 index points for women and by 4.3 index points for men, compared with first-quarter data ([19]). Particularly worrying is the employment situation for specific groups of people, such as migrant women. The employment rates for women aged between 15 and 64 years and born outside the EU-27 dropped during the last quarter of 2020, following some recovery over the summer ([20]). In contrast, employment rates for men of the same age group and born outside the EU-27 increased throughout the third and fourth quarters of 2020.

([19]) Authors' calculations based on Eurostat database, https://ec.europa.eu/eurostat/web/products-datasets/-/lfsi_ahw_q.
([20]) Authors' calculations based on Eurostat database, https://ec.europa.eu/eurostat/web/products-datasets/-/lfsq_ergacob.

3. Domain of money



In 2019, access to financial resources remained, overall, still more restricted for women than for men. According to Eurostat, in the EU in 2019, gross hourly earnings for women were, on average, 14 % lower than for men. Low hourly gross earnings of lone parents, especially of lone mothers, is of particular concern (see Section 3.2). It results in women's level of economic independence remaining far lower than men's, and the feminisation of poverty is a serious concern for the EU.

Underlying causes of gender inequality in the domain of money are diverse and often interlinked. Motherhood and the unequal distribution of unpaid childcare between women and men make it harder for women to commit more time to paid work (EIGE, 2019e). The overall share of women in part-time work is greater since they balance paid jobs and unpaid care work to a greater extent than men (see Chapter 2, 'Domain of work', and Chapter 5, 'Domain of time'). Job segregation also contributes to income inequality, as women predominate in sectors and professions that are less well compensated (EIGE, 2019c).

Economic situation and financial resources, particularly income, are crucial social determinants of the health of both women and men. A higher income supports improvement in health, and better health enables an individual to earn a higher income (Deaton, 2002; Smith, 1999). Income could be causally related to health in two ways: it directly affects the material conditions necessary for biological survival, such as nutritious food and safe homes, and it indirectly affects social participation and life opportunities, such as sport and well-being activities, that could have an impact on health and health-related risks (Lynch et al., 2004; Marmot, 2002). There is a significant income-related variation in self-reported poor health between women and men across countries, even if levels of income or standards of living are comparable (Furnée et al., 2011). The design of a healthcare system is also crucial. Level of income determines whether healthcare is affordable and accessible because it affects an individual's ability to pay indirect costs, such as payments for diagnosis and treatment, out of their own pocket.

Although the right to equal pay for equal work or for work of equal value has been a cornerstone of EU treaties for more than 60 years, and despite a wealth of policies to redress gender inequality of income, women still earn less than men, on average, as reported above. The European Pillar of Social Rights enshrines equal opportunities to access financial resources, the principle of equal pay for jobs of equal value, rights to adequate minimum income benefits, and equal opportunities for women and men to acquire pension rights.

Addressing the gender pay gap and introducing binding measures on pay transparency are also high priorities for the EU. As Member States have been slow to implement, even partly, the 2014 Commission recommendation on pay transparency ([21]), a binding measures proposal was presented by the European Commission in 2021([22]). This includes the right of employees to know the pay levels of those doing work of equal value and the obligation for companies with at least 250 employees to report their gender pay gap. In a further effort to reduce the gender pay gap, and acknowledging that women make

([21]) Commission Recommendation 2014/124/EU of 7 March 2014 on strengthening the principle of equal pay between men and women through transparency Text with EEA relevance, https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX:32014H0124.

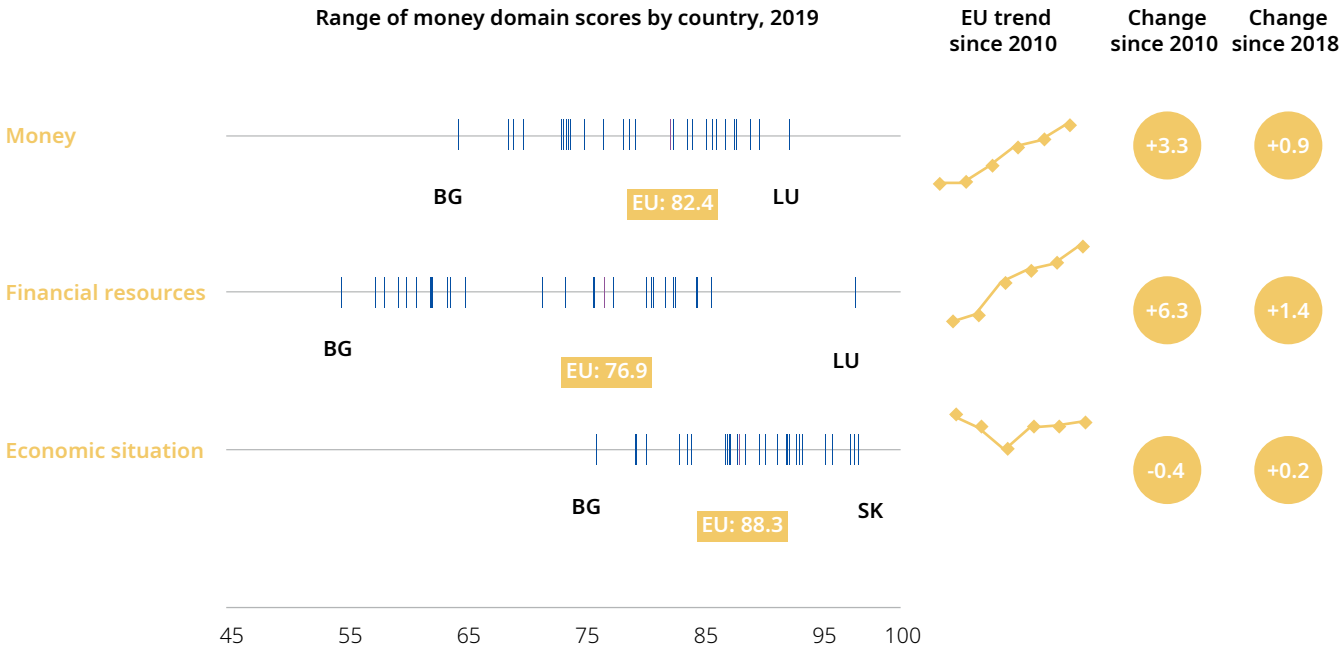
([22]) European Commission (proposal on pay transparency), https://ec.europa.eu/transparency/documents-register/detail?ref=COM(2021)93&lang=en.

up the majority of low-wage earners, EU Directive 2020/682 on adequate minimum wages in the EU, implemented in October 2020 ([23]) sets out proposals to reduce gender pay and pension gaps through sufficient minimum earnings.

3.1. Earnings and income equality still out of reach

With a score of 82.4, the domain of money ([24]) improved by 0.9 points in 2019 (Figure 7). This represents continued, if slow, progress in this domain, with the score rising by only 3.3 points since 2010. Among EU member States, Luxembourg ranks first and Bulgaria last. Overall growth in the domain of money is driven by the access to financial resources subdomain, whose score has risen by 1.4 points since 2018 and by 6.3 points since 2010. Here too, Luxembourg and Bulgaria bookend the country rankings. However, an EU-27 score of 76.9 points means that there is still much to do on women's access to financial resources. The pace of change in the economic situation subdomain is similarly disappointing, with an increase of just 0.2 points since 2018. Here, Slovakia ranks first and Bulgaria, once more, ranks last. Alarmingly, the poverty gender gap for the EU as a whole was wider in 2019 than in 2010, by 0.4 points.

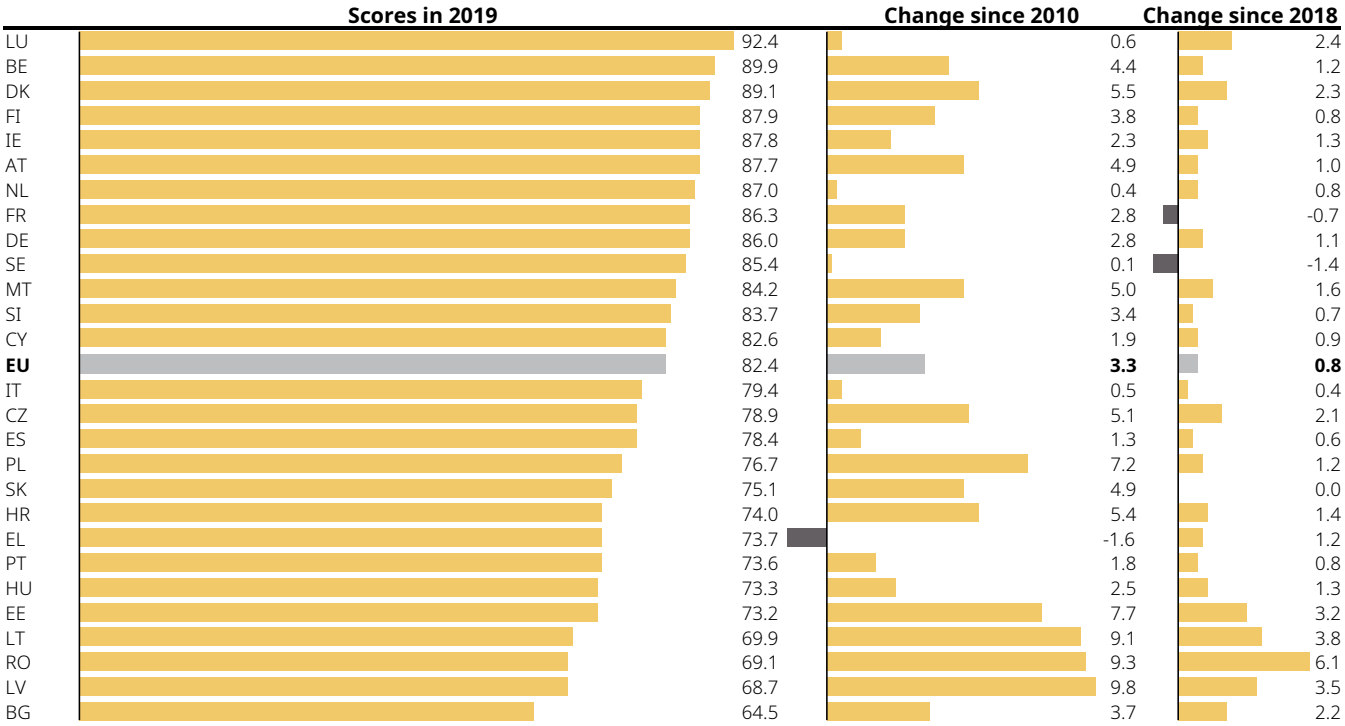
Figure 7. Scores for the domain of money and its subdomains (2019), and changes over time



([23]) Directive COM/2020/682, https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A52020PC0682.

([24]) The domain of money measures gender inequalities in access to financial resources and in the economic situation. The subdomain of financial resources includes women's and men's mean monthly earnings from work and mean equivalised net income (from pensions, investments, benefits and any other source in addition to earnings from paid work). The subdomain of economic situation captures women's and men's risk of poverty and the income distribution among women and men.

Figure 8. Scores for the domain of money (2019), and changes since 2010 and 2018, by EU Member State



3.2. Single women, particularly in old age, are at highest risk of poverty

In 2019, the country with the highest score in the domain of money was Luxembourg, with 92.4 points, and the country with the lowest score was Bulgaria, with 64.5 points (see Figure 8). Progress has been made in nearly all countries since 2018, particularly Romania (+ 6.1 points), Lithuania (+ 3.8 points), Latvia (+ 3.5 points) and Estonia (+ 3.2 points). The countries that have made the greatest leap forward since 2010 are Latvia (+ 9.8 points), Romania (+ 9.3 points), Lithuania (+ 9.1 points) and Estonia (+ 7.7 points). By contrast, since 2018, Sweden's score has dropped by 1.4 points and France's has dropped by 0.7 points. Slovakia is alone in having recording no change since 2018. Greece is the only country to have regressed since 2010, with its score dropping by 1.6 points (Figure 8).

Family composition, age, educational attainment, migration status and (dis)ability influence income disparities between women and men. While income gaps are less visible for couples with or without children, single people and lone parents suffer striking gender inequalities. Lone mothers earn 2.125 PPS ([25]) less than lone fathers, but highest income gap is between single women and single men, with women earning 2.706 PPS less than men (Figure 9).

Over a lifetime, income inequalities widen, with the result that the gender gap is greatest among older people. Women aged 65 years or older receive 1.934 PPS less than men. Known as the gender pension gap, this phenomenon has multiple causes. These include fewer years in employment because of the motherhood penalty, job segregation, differences in pension systems, and work intensity and pay over a lifetime (EIGE, 2015). Across the EU, the gender pension gap remains wide, despite having decreased from

([25]) PPS is an artificial currency that accounts for differences in price levels between Member States.

35 % in 2010 to 30 % in 2018 ([26]). Pensions are the most important source of income for older people; therefore, gender gaps in this area result in a higher risk of poverty among pension-age women. Single women face the greatest financial hardship in old age as they cannot rely on survivor pensions or the income of a partner (European Parliament, 2016b).

3.3. COVID-19 exacerbates women's economic vulnerability and hardship

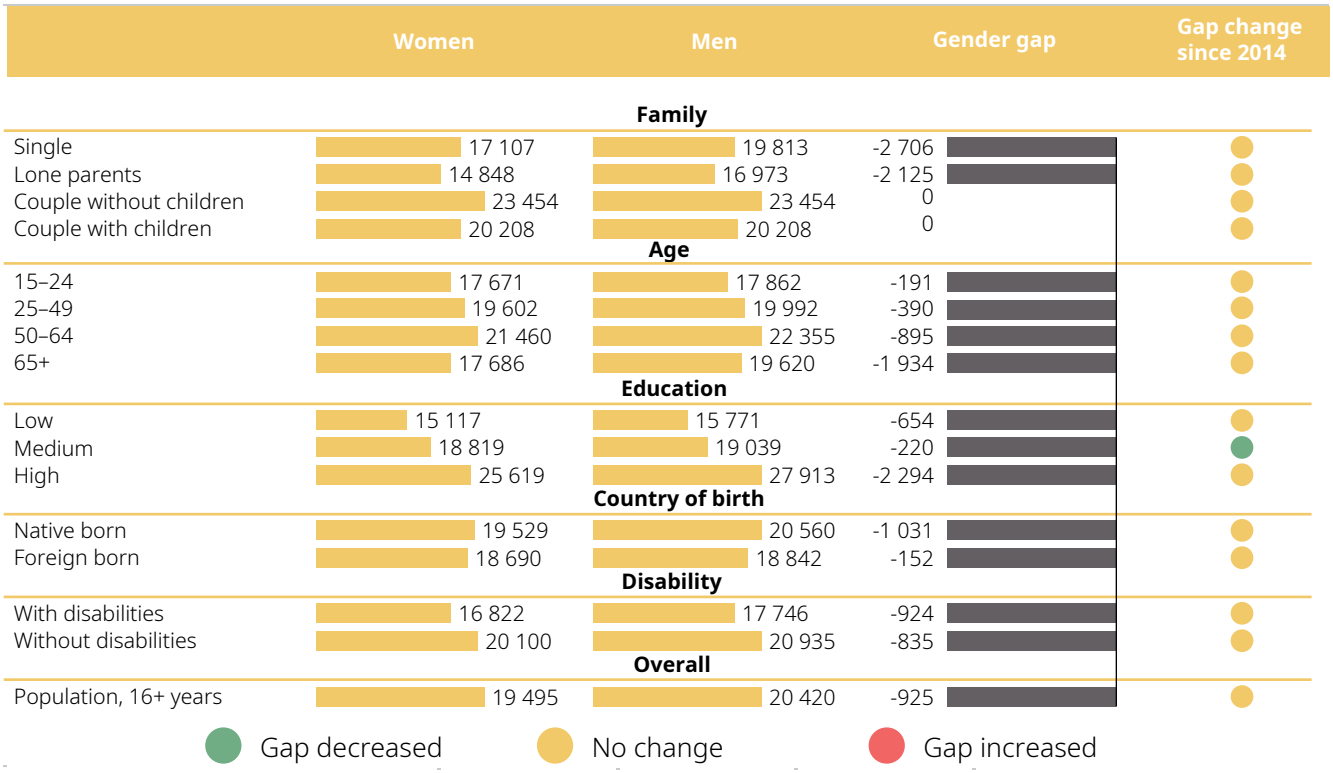
Poverty or social exclusion risks were already higher for women than for men in the EU before the pandemic (EIGE, 2020g). Women were already more likely than men to be in unpaid, low-paid or temporary jobs. The COVID-19 crisis is likely to worsen women's economic situation, as their over-representation in sectors badly hit by lockdowns means that they are more likely than men to lose their job or have their working hours reduced (EIGE, 2021c; ILO, 2021). Women aged between 15 and 24 years were the group most likely to lose their job in the first half of 2020 (Eurofound, 2021a), given that they are employed in high numbers in hospitality, retail, arts and entertainment.

The closure of schools and childcare services further limited parents' employment possibilities, especially mothers, and increased the risk of poverty in households with dependent children. Eurofound's COVID-19 online surveys show that households with children struggle to make ends meet much more than those without (Mascherini and Bisello, 2020). The COVID-19 pandemic is likely to have increased the poverty risk, especially for lone mothers and their children.

The extent to which the burden of the COVID-19 crisis falls on women and on men depends on pre-crisis inequalities and how recovery response policies mitigate the effects of the pandemic. Since spring 2020, all Member States introduced some income support measures to those affected by the pandemic. However, women were less able than men to access income support either because a protection scheme was not available in the sectors of their work or, if it was, provided lower benefits, or because they did not meet eligibility criteria. Women predominantly work in sectors, types of firms or jobs that were not or less covered by specific crisis-related job protection schemes (Rubery and Tavora, 2020). Furthermore, women have more difficulties meeting eligibility criteria due to shorter or interrupted careers, which are of importance, for example, to access unemployment or parental leave benefits. The type of income support women receive, compared with men, reflects their different positions in the job market, as well as their disproportionate burden of care duties. Gender-sensitive recovery needs to address the gender pay gap by promoting equal share of care responsibilities and by better valorising those working in frontline, low-paid and precarious jobs, such as carers, nurses and cleaning staff.

([26]) EU-SILC survey, https://ec.europa.eu/eurostat/web/products-datasets/-/ilc_pnp13.

Figure 9. Mean equivalised net income by sex, family composition, age, education level, country of birth and disability (PPS, 16+ years, EU, 2019)

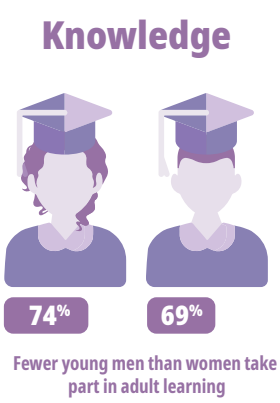


Source: Authors' calculation, EU-SILC, 2019 (IE, IT, 2018).
NB: The equivalised net income is calculated at the household level, taking into account all sources of income of all members of the household. resulting total income is split between members of couple, hence explaining the absence of gender gap for couples.

Income gaps are more difficult to assess for hard-to-reach populations such as undocumented migrants and the Roma. These groups are more likely to participate in informal and infrequent work, making it harder to report their income levels. A study of six Member States found that Roma and Travellers reported struggling to make ends meet. In Sweden and the Netherlands, Roma are about 13 times more likely than the general population to live in poverty (FRA, 2020c). Roma women are also more likely to perform unpaid care work, leading to an employment gap of 18 p.p. with Roma men (FRA, 2016).

4. Domain of knowledge

Equal access to quality education is a key driver of change in the work, money and power domains, and is essential for gender equality. Educational attainment continues to steadily increase among both young women and men, with women now outpacing men. Gender segregation remains the key challenge in this domain. The previously upwards trend in the proportion of men studying education, health and welfare, humanities and the arts has plateaued, as has the upwards trend in the proportion of women studying science, technology, engineering and mathematics (STEM). Participation in adult learning decreases with age, and engaging hard-to-reach groups remains a challenge.



Education, training and lifelong learning have always been high on the EU policy agenda but are now critical in an increasingly digitalised economy and for recovery from the COVID-19 pandemic. The European Pillar of Social Rights Action Plan emphasises the importance of adults, particularly from disadvantaged groups, upskilling and reskilling to increase their employability, boost innovation, close the digital skills gap and ensure social fairness. The action plan also set a target of 60 % of adults undertaking training each year by 2030 ([27]). Reskilling and upskilling are also policy priorities in the recovery plan for Europe.

Equally important to tackle is segregation in education – the concentration of women and men in different fields of study and subsequent careers, including teaching. The 2020–2025 EU gender equality strategy stresses the importance of addressing gendered choices, while the 2021–2027 digital education action plan aims to boost the number of women in STEM by providing digital skills through education and training. Through the updated European Skills Agenda, the Commission aims to work closely with Member States on measures promoting gender balance in ICT-related jobs.

The COVID-19 pandemic led to the closure of education facilities and a forced shift to digital education. Digital technologies, while enabling many pupils, students and adult learners to continue learning, proved to be a major barrier for others. Many families in difficult socioeconomic situations had little or no access to the equipment required for online learning, and many parents lacked the digital skills or time needed to help their children. Adding to these barriers is the fact that the majority of educators had little, if any, experience of online teaching. For lone parents and working couples with children, especially in younger ages, there were additional difficulties due to need to continue working despite increased care responsibilities at home.

Tackling gender norms and inequality in this domain could have major benefits not only on gender-balanced learning and careers, but also in other areas. As reported in Section 9.1., well-established empirical evidence highlights how education impacts health by affecting behaviour, including the use of preventive health services (OECD, 2006). It has been found that education substantially affects health outcomes, even after factoring in characteristics such as income level and family background. This suggests that educational policies have the potential to substantially improve health (WHO, 2015). Nonetheless, research evidence points that due to gender norms educational impact on health outcomes for women and men is different (Cutler and Lleras-Muney, 2007).

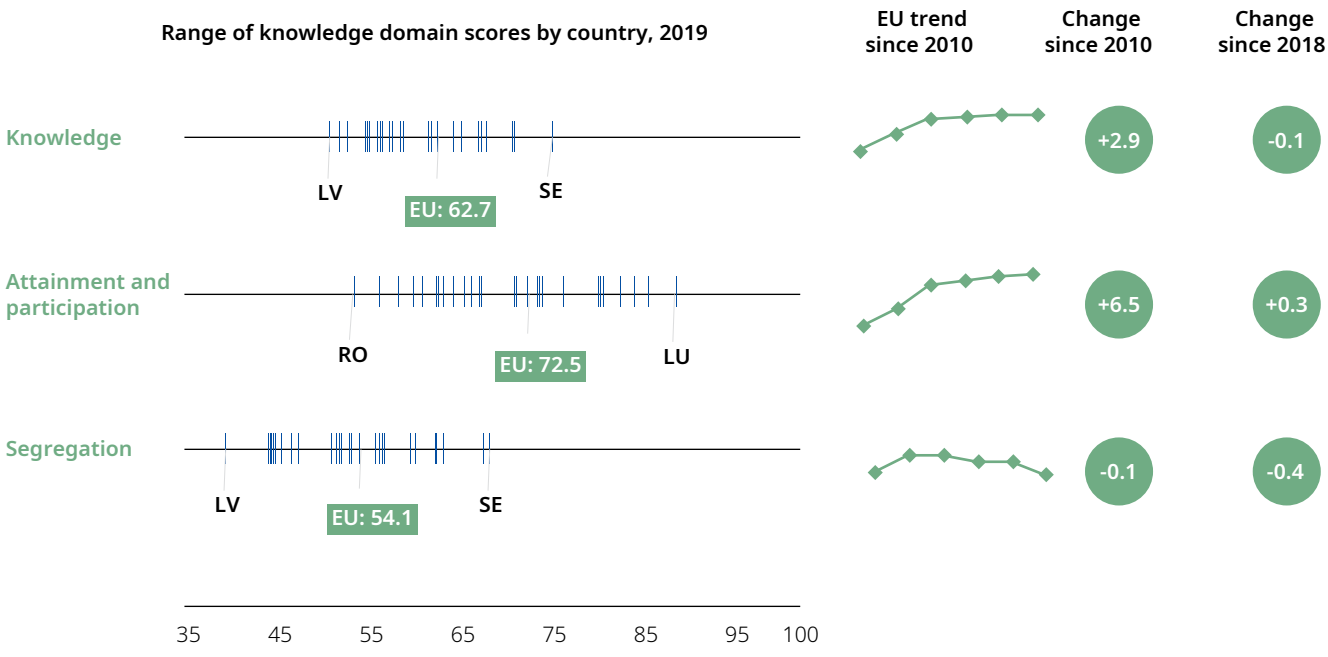
([27]) The Gender Equality Index indicator on women's and men's participation in education and training measures the participation during the preceding 4 weeks.

4.1. Snail-pace progress comes to a halt

With an overall EU score of 62.7 points, the domain of knowledge ([28]) has seen almost no change since the 2020 Index. The score improved by only 2.9 points overall between 2010 and 2019 (Figure 10), with the subdomain of attainment and participation driving that progress. Although this subdomain's score increased by 6.5 points from 2010 to 2019, there was little change between 2018 and 2019. Gender segregation in education remains a major block to gender equality in the EU. Not only has there been no progress since 2010, but the score for this subdomain actually fell by 0.4 points in 2019.

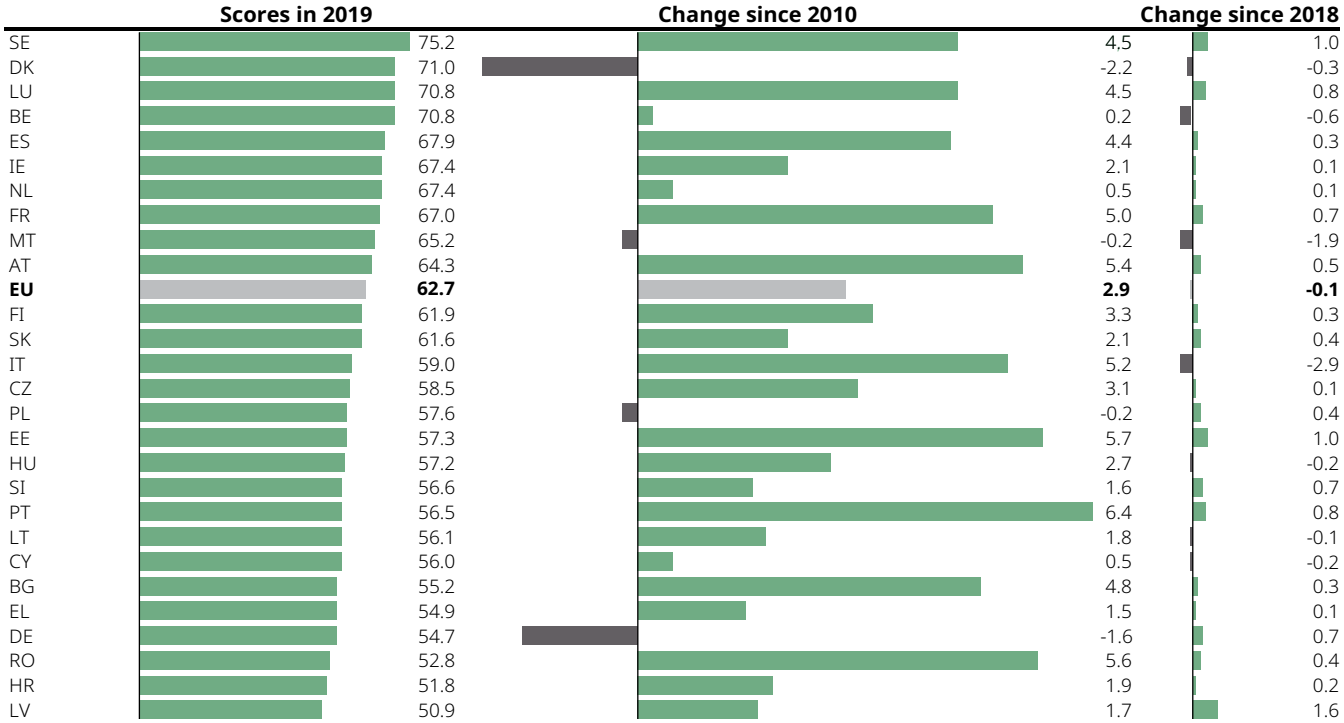
In 2019, the four top-performing countries in the domain of knowledge were Sweden, Belgium, Denmark and Luxembourg, all with scores higher than 70 points. At the opposite end of the spectrum were Greece, Germany, Romania, Croatia and Latvia, all with scores lower than 55 points. Most Member States saw little to no change in their domain score between 2018 and 2019. France, Slovakia and Latvia were the exceptions, with decreases of 2.9 points and 1.9 points and an increase of 1.6 points, respectively (Figure 11). The majority of Member States did, however, register a modest rise in their overall knowledge domain score from 2010 to 2019. The greatest progress was made in Lithuania (+ 6.4 points), Poland (+ 5.7 points) and Romania (+ 5.6 points). The most regress was in Belgium (– 2.2 points) and Germany (– 1.6 points).

Figure 10. Scores for the domain of knowledge and its subdomains (2019), and changes over time



([28]) The domain of knowledge measures gender inequalities in educational attainment and lifelong learning, and gender segregation in education. The subdomain of educational attainment is measured by two indicators: the percentages of women and men who are graduates of tertiary-level education and the participation of women and men in formal and non-formal education and training over their life course. The second subdomain targets gender segregation in tertiary education by looking at the percentages of women and men students in the education, health and welfare, humanities and arts fields.

Figure 11. Scores for the domain of knowledge (2019), and changes since 2010 and 2018, by EU Member State

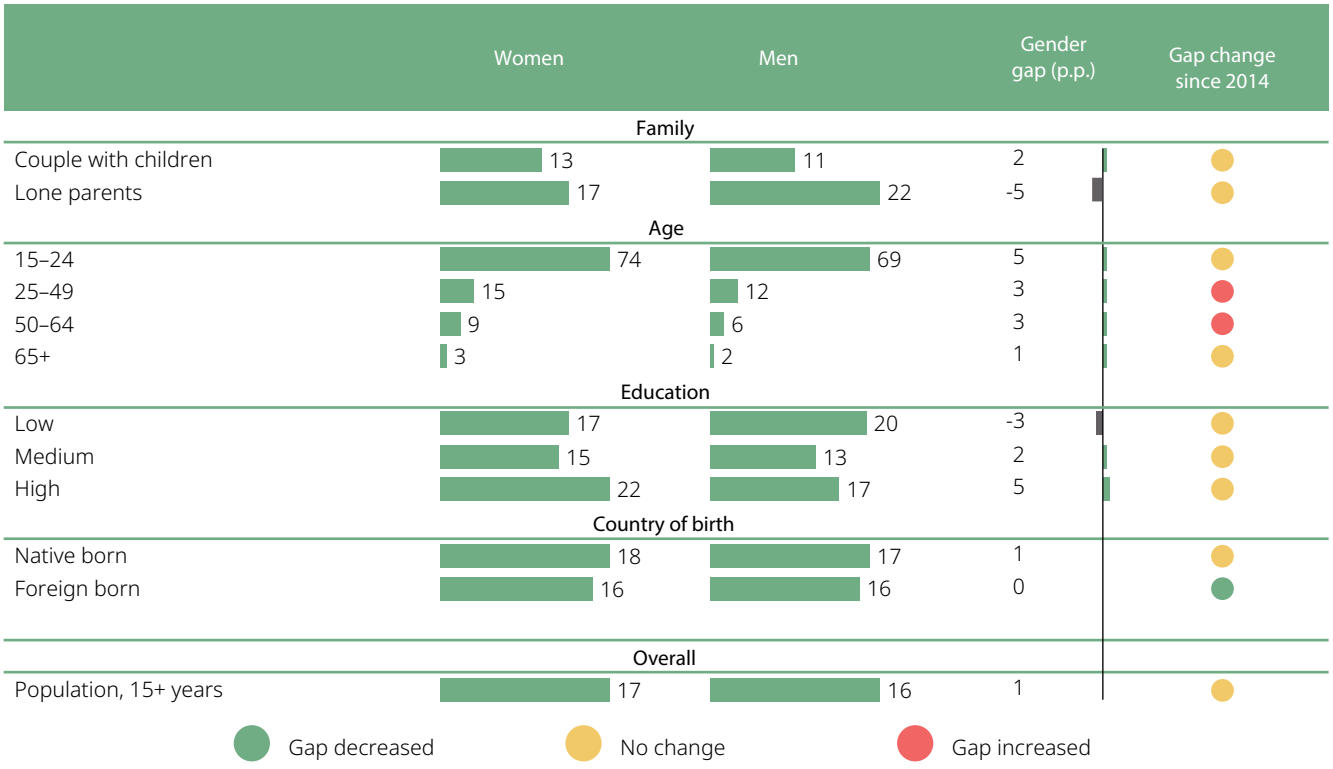


4.2. Hard-to-reach groups would benefit most from adult learning

In a highly digitalised world, women and men need a wide range of knowledge, skills and opportunities, and to keep developing them throughout life. Without the right skills, both women and men are likely to end up in poor-quality jobs, to be unemployed or to be underqualified to exploit new career opportunities (European Commission, 2015b). Yet only 17 % of women and 16 % of men older than 15 years of age were in formal or informal education or training in the EU in 2019 – despite a small overall increase since 2010. The highest rates of adult learning in 2019 were among women and men aged between 15 and 24 years (74 % and 69 %, respectively), as most were still in formal education (Figure 12). However, these figures are significantly lower among those aged 25–49 years, to 15 % for women and 12 % for men. Among women and men approaching or in retirement, learning rates are in single digits.

Older people, economically inactive women and men, and people lacking basic literacy and numeracy skills are hard-to-reach groups for adult learning policies, although they could benefit the most. According to an OECD survey of adult skills in 17 EU Member States (OECD, 2013), one in five adults has a low level of literacy, while one in four has a low level of numeracy. Targeted adult learning policies improving basic skills would have positive outcomes for economic growth and competitiveness, increase inclusive and active citizenship, reduce social inequality and improve mental and physical health (European Commission, 2015a).

Figure 12. Participation of women and men in formal or non-formal education and training, by family composition, age, education level and country of birth (%, 15+ years, EU, 2019)



Source: Authors' calculation, EU-LFS.

One in five respondents to a FRA Roma pilot survey in 11 EU Member States reported that they could neither read nor write. Portugal (35 %), Romania (31 %) and France (25 %) had similarly high rates. In all 11 participating EU countries, more Roma women than men said that they could not read or write, with illiteracy rates especially high among women aged 45 years older.

4.3. School closures due to COVID-19 reinforce and add new inequalities in education and unpaid work

The COVID-19 pandemic has had a major impact on national education systems, with facilities either rapidly shifting to new modes of digital learning or providing no services at all. Though the transition to remote learning was challenging for all actors and at all education levels, it was especially difficult at nursery and primary school levels, as parents had to be more heavily involved in the educational process. In this highly gender-segregated sector, even the youngest educators lacked adequate levels of digital competence to quickly transition to remote learning (Carretero et al., 2021; Di Pietro et al., 2020). Not all children had access to the same level of resources for home schooling, such as laptops, reliable broadband connection and parental support – all important factors in learning outcomes. The Joint Research Centre estimated that girls and boys from lower socioeconomic backgrounds were more likely than their more privileged peers to lack access to internet connection and a quiet room for studying (Di Pietro et al., 2020). On average, these children were generally lower performers pre-pandemic, and it is highly likely that educational inequalities have widened since.

School and childcare service closures have increased the care burden and created new forms of unpaid care for working parents, including home schooling. Across the EU, it is mostly

women who have supported their children with online schooling during the pandemic and who are more dissatisfied with this type of schooling than their partners (EIGE, 2021c). In Portugal, for instance, 77.5 % of mothers helped children younger than 16 years with their schoolwork, compared with 41.3 % of men ([29]). Lone mothers are particularly exposed to the negative consequences of closed schools and childcare services given their lower financial resources and the impossibility of sharing care demands (Alon et al., 2020).

([29]) Preliminary findings of a survey carried out by the Observatory for Education Policies and Professional Development of the University of Coimbra.

5. Domain of time

How individuals spend their time is a fundamental aspect of gender equality. The amount of time spent in paid work, rest and recreation, or caring for others has knock-on effects on many other aspects of a person's life. This includes their health. The burden of unpaid care is increasingly regarded as a determinant of health. Policies promoting women's participation in the labour force and easing their burden of care – such as policies to improve public services or to increase fathers' access and take-up of parental leave entitlements – link to lower levels of gender inequality in health (Palència et al., 2017). As discussed in Section 9.1., work–life conflicts affect mental health.

Although more women than ever before are now actively part of the labour force, unequal gender roles persist at home. Even in dual-earning households, it is mostly women who provide direct care and do housework (ILO, 2018; Kan et al., 2011). When high-quality, affordable care services are limited, women are still expected to assume a greater share of unpaid care of children, older people and people with disabilities (EIGE, 2019c). With this workload exploding at home, in hospitals and in care homes during the pandemic, the crisis has underlined the importance of both paid and unpaid care work for societies and economies to function well. However, resistance to change in gendered social norms, especially men's involvement in care duties, remains the chief obstacle to a fairer distribution of unpaid work.

Various EU initiatives aim to change the status quo. The EU 2020–2025 gender equality strategy identifies closing gender gaps in caring roles as a priority (European Commission, 2020b). The Council conclusions, approved under the German Presidency in December 2020, called for efforts to reduce gender gaps in care work to be stepped up (European Commission, 2021a). The European Pillar of Social Rights Action Plan includes a call for Member States to complete the transposition of the Work–life Balance Directive ([30]) by August 2022 (European Commission, 2021d). The directive includes new labour rights, such as parental and carers' leave, and aims to ease inherent tensions in combining paid work with caring responsibilities (EIGE, 2021d). It also recommends revising the Barcelona targets and increasing formal early childhood education and care provision ([31]).

5.1. Gender inequalities in use of time live on

The absence of updated data on time use has meant continued reliance on 2016 data. This has resulted in no change to the score for the domain of time ([32]) since the 2020 Index, and a negative longer-term rating for 2010–2019.

As shows, the EU score of 64.9 points for this domain masks a wide variation in national scores, which range from 42.7 points in Bulgaria to 90.1 points in Sweden. As a result,

([30]) Directive (EU) 2019/1158 of the European Parliament and of the Council of 20 June 2019 on work-life balance for parents and carers and repealing Council Directive 2010/18/EU, https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX:32019L1158.

([31]) In 2002, the Barcelona European Council set objectives for the availability of high-quality and affordable childcare facilities for pre-school children, through two targets: 90 % of children from age 3 years until mandatory school age and 33 % of children younger than 3 years. The Barcelona objectives (and their related targets) were restated in the European pact for gender equality (2011–2020) and referred to in the Europe 2020 strategy. While these high-level commitments have been translated into concrete progress in recent decades, childcare service provision remains very inconsistent between countries with several falling short of the Barcelona targets, especially for children younger than 3 years (EIGE, 2021d).

([32]) The domain of time measures gender inequalities in the allocation of time to care and domestic work and social activities. The first subdomain, of care activities, measures gender gaps in women's and men's involvement in the care and/or education of their children, grandchildren and older and disabled people. It also measures their involvement in cooking and housework. The second subdomain explores how many women and men engage in social activities. Concretely, it measures gender gaps in women's and men's participation in sport, cultural or leisure activities outside the home, combined with their engagement in voluntary and charitable activities.

the time domain has the second broadest dispersion of country scores in the Gender Equality Index, after the domain of power. Gender inequality is higher in the social activities subdomain, with a score of 61 points in 2019, than in the care subdomain (69.1 points) (Figure 13).

Since 2010, the overall domain score has fallen by 0.3 points, the result of two opposing trends at the subdomain level over the same time frame: a rise of 3.7 points in the score for the care subdomain and a drop of 4 points in the score for the social activities subdomain. These trends are important to keep in mind as research has shown that participation in social activities contributes to one's subjective well-being (Brajša-Žganec et al., 2011). Access to leisure time and activities, while essential for quality of life, is largely determined by time pressures from both paid and unpaid work (European Parliament, 2016a).

In 2019, the best-performing countries in the domain of time were Sweden, the Netherlands, Denmark, Finland and Estonia, in that order. Scores ranged from 90.1 points in Sweden to 74.7 points in Estonia. The worst-performing countries were Bulgaria, Greece, Slovakia, Portugal and Romania, in that order, with scores of 50 points or lower.

Figure 13. Scores for the domain of time and its subdomains (2019), and changes over time

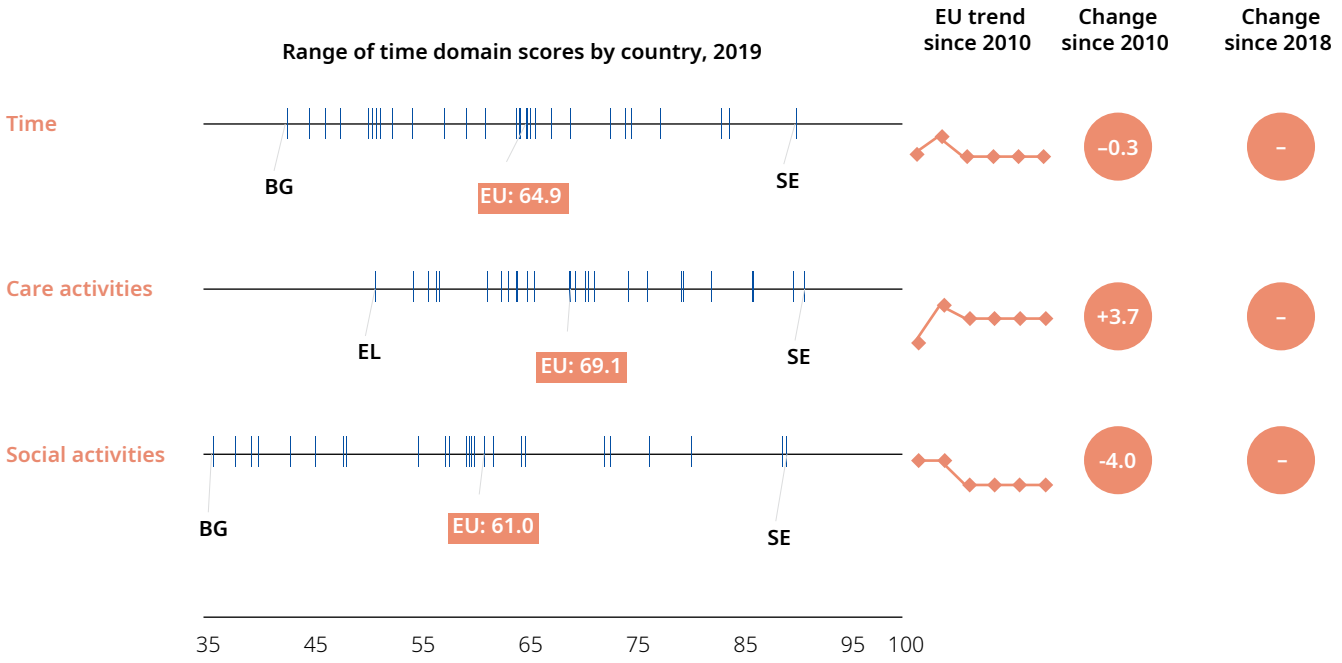
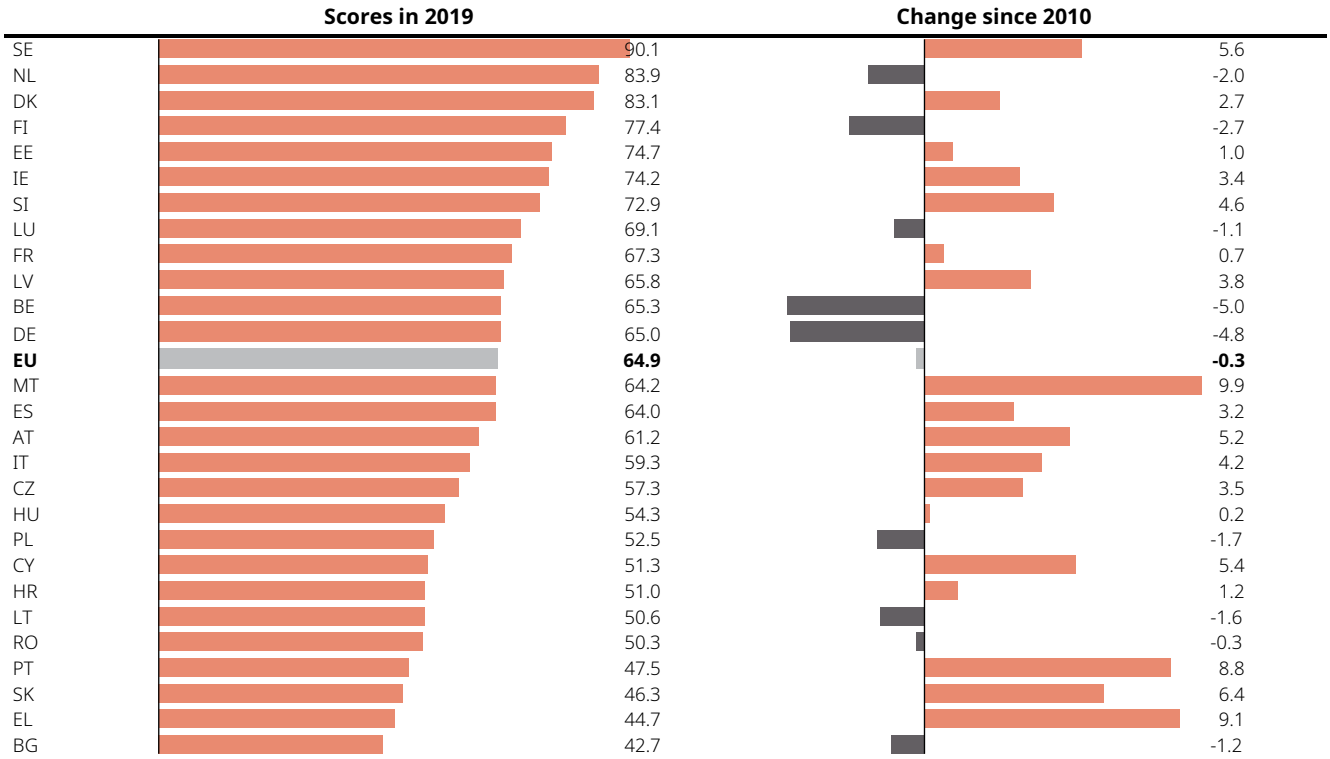


Figure 14. Scores for the domain of time (2019) and changes since 2010, by EU Member State



Since 2010, nine Member States have seen their scores fall: Belgium, Bulgaria, Germany, Lithuania, Luxembourg, the Netherlands, Poland, Romania and Finland. Countries seeing the most regression are Belgium (– 5 points), Germany (– 4.8 points) and Finland (– 2.7 points). In most EU countries scores increased over the same time frame. Malta has seen a 9.9-point increase, and there have been increases in Greece (+ 9.1 points) and Portugal (+ 8.8 points). Estonia and Croatia have seen more modest improvements, with increases of 1.0 and 1.2 points, respectively. France (+ 0.7 points) and Hungary (+ 0.2 points) saw minimal change (Figure 14).

5.2. Gender differences on household chores entrenched from childhood

Housework is the most unequally shared of the three most common forms of unpaid care, the other two being childcare and long-term care for older people and people with disabilities and other chronic conditions ([33]).

([33]) About 93 % of employed women regularly undertake unpaid housework (daily or several times a week), compared with 53 % of employed men, a gender gap in participation of 40 p.p.; for comparison, the gender gap for childcare is 13 p.p. (EIGE 2021d, p. 16).

About 91 % of women with children spend at least an hour per day on housework, compared with 30 % of men with children. The latest available data shows that employed women spend about 2.3 hours daily on housework; for employed men, this figure is 1.6 hours. Gender gaps in housework participation are the largest among couples with children, at 62 p.p. (Figure 15), demonstrating an enduring imbalance in unpaid care responsibilities within families ([34]).

Research shows that the parental role model is the primary mechanism for entrenching gender roles in terms of housework responsibilities, ensuring they pass from one generation to the next, especially from fathers to sons (Giménez-Nadal et al., 2019). Although the smallest gender gaps in housework participation are among those aged 18–24 years (20 p.p.), only 19 % of young men spend an hour on cooking and housework a day, compared with 39 % of young women (Figure 15). As most young people of this age live with their parents ([35]), it is clear that adolescent girls and young women do more unpaid work in the childhood home than their male counterparts – and gender roles, divisions and habits start early.

Figure 15. Women and men cooking and/or doing housework every day by family composition, age, education level, country of birth and disability (%, 18+ years, EU, 2016)

	Women	Men	Gender gap (p.p.)
Family			
Couple with children	91	30	61
Lone parents	86	60	26
Age			
18 to 24	39	19	20
25 to 49	81	31	50
50 to 64	83	33	50
Education			
Low	81	30	51
Medium	78	31	47
High	74	35	39
Country of birth			
Native born	78	32	46
Foreign born	82	31	51
Disability			
With disabilities	78	40	38
Without disabilities	78	30	48
Overall			
Population, 18+ years	78	32	46

Source: Authors' calculation, Eurofound, European Quality of Life Survey (EQLS), 2016.

([34]) For example, data from the 2015 European Working Conditions Survey (EWCS) shows that women living in couples with children spend more than twice as much time on care work as women living in couples without children (5.3 hours per day, compared with 2.4 hours).

([35]) According to Eurostat, in 2019, among young people in the EU-27, the average age at leaving the parental home was 27.1 years for men and 25.2 years for women, https://ec.europa.eu/eurostat/web/products-datasets/-/yth_demo_030.

The burden of unpaid care work is greater for women in non-standard and low-paid jobs. EWCS data shows that women in temporary jobs or without a formal contract spend twice as much time providing unpaid care daily as women employed in permanent jobs (EIGE, 2021d). One reason is the lack of economic resources to rely on external services. Yet women in irregular and temporary jobs are unable to access more stable jobs because of their substantial care responsibilities. In addition, FRA data shows that in most EU countries migrant women are less likely than native women to be in paid work because of care duties (FRA, 2019).

Education levels affect the likelihood of women and men spending an hour a day on housework and cooking – in opposing ways. While the share of women spending this much time on housework decreases with higher educational level (81 % of those with a low level of education, 78 % with a medium level and 74 % with a high level), the opposite is true for men (Figure 15). This is consistent with EIGE (2021d) findings showing that highly skilled employed women often outsource household chores to cut their time spending this much time on housework so that they can engage more in paid work. Outsourcing cooking, cleaning, ironing, gardening, caring for pets, etc., has grown because there are more women in paid jobs and little headway has been made on men assuming more unpaid care duties at home (Barone and Mocetti, 2011; Forlani et al., 2015; Raz-Yurovich, 2014; Raz-Yurovich and Marx, 2019). Housework services are often provided by migrant women or women from a lower socioeconomic background, and the resulting income is frequently undeclared. It is a development that transfers gender inequalities within households into the global care chain (Morel and Carbonnier, 2015).

5.3. Unpaid care workloads and social isolation affect well-being

The COVID-19 pandemic has profoundly affected individuals' opportunities as regards time use and space. Multiple lockdowns, movement restrictions, the closure of leisure and educational facilities and an unprecedented shift to teleworking resulted in millions of people in the EU spending virtually all their time at home. For those caring for others, the situation has led to acute trade-offs in dividing time between paid work, care duties and leisure activities (EIGE, 2021c).

With restrictions largely preventing external care services or help from grandparents, friends and neighbours, care has been provided mainly from within the family. The introduction of home schooling as a new and additional form of unpaid work for parents (see Chapter 4) affected families with young children the most (Eurofound, 2021b). As a result, spending more time on unpaid care duties has caused acute work–life tensions for women and men (Craig and Churchill, 2020; EIGE, 2020b, 2020g, 2021c; Eurofound, 2021c; European Commission, 2021a).

Although the pandemic has led to a modest increase in time spent by men on unpaid care, particularly fathers who lost jobs and men in couples with women in essential work (EIGE, 2021c), the impact has been dramatic on mothers of children younger than 12 years, lone mothers and women engaged in informal care (Eurofound, 2021b). A survey by Eurocarers ([36]), the leading network of informal carers in the EU, and composed overwhelmingly of women, has revealed a 17 % increase in the weekly care workload, that care is more intense and that more people are becoming informal carers (European Commission, 2021h).

The ensuing strain is reflected in low levels of life satisfaction among families with children (Eurofound, 2021b). Women in particular consistently had lower levels of mental well-being across the three pandemic waves (see Figure 48). The lowest levels of well-being were among women

([36]) The survey was carried out from between the 24th November 2020 and 8th March 20201

aged 18–34 years and 35–49 years during the third wave (42 points).

Social isolation and increased time spent at home, combined with health and financial stressors, are thought to account for a surge in intimate partner violence (EIGE, 2021a; Šimonović, 2020; WHO, 2020b) and child abuse (Calvano et al., 2021; Katz, 2021) during the pandemic.

6. Domain of power

In terms of progress on gender equality in key decision-making positions in major political, economic and social institutions, the EU is only halfway towards equality (European Commission, 2021a). Although the domain of power has seen the most improvement of all domains since 2010, progress has been slow and uneven. Women account for only one in three members of EU national parliaments. Women remain substantially under-represented in corporate boardrooms: 30 % in 2021. In large companies, less than 1 in 10 board presidents or CEOs are women. Despite women's growing involvement in research funding, media content and sports policies, their opportunities to influence decisions in these sectors remain limited.

There are many reasons for the systemic under-representation of women in decision-making positions. These include gender roles and stereotypes, the heavy burden of housework and care duties, which limits women's ability to be active in public life, discriminatory employment practices and gender-based violence. Concerns are also mounting over rampant online harassment of women in leadership, which further discourages women from engaging in public debate or running for office (EIGE, 2020a).

The glaring absence of women in COVID-19 emergency decision-making is having a direct impact on people's lives. Ensuring gender balance in decision-making on disease prevention and response in all countries can strengthen governments' responses (OECD, 2020a). The benefits of gender balance in crisis management extend beyond the immediate consequences of the pandemic to the longer-term ramifications of COVID-19 on gender equality (EIGE, 2021c).

Political representation and access to decision-making are now more frequently included among social determinants of health (SDH) (Bhui, 2018; Gerry McCartney et al., 2021), and are sometimes referred to as a political determinant of health (Ottersen et al., 2014). A 2020 WHO report found that the gap in life expectancy is correlated with the degree of political equity, and the benefit was greater for men (WHO Regional Office for Europe, 2020). In addition, Van de Velde et al. (2013) found that a high degree of macro-level gender equality, especially with more women in political decision-making, is associated with lower levels of depression in both women and men.

EU institutions have increasingly turned their attention to women's representation in political and economic decision-making ([37]). The European Commission brought the issue to the political fore in 2012. It proposed a directive to improve the gender balance among non-executive directors of listed companies, with a minimum target of 40 % of the under-represented sex. Since then, the directive has been blocked in the Council.

Gender balance in decision-making is one of the three main pillars of the EU gender equality strategy 2020–2025. It underlines the importance of having women in leadership positions across political, economic and social s (European Commission, 2020b). The Commission has also adopted the European democracy action plan. It envisages actions to mainstream equality at every level to better enable democratic engagement, including gender balance in politics and decision-making (European Commission, 2020a).

([37]) EIGE's Gender Statistics Database shows that, as of May 2021, the European Parliament comprises 39 % women and 61 % men. As regards the European Commission, 2019 was the best year to date in terms of gender-balanced appointments, with 12 women (44 %) and 15 men (56 %), as Member States responded to a call from President of the European Commission Ursula von der Leyen for gender parity in nominations. The replacement of the Irish Commissioner in October 2020 has improved the balance still further, to 13 women (48 %) and 14 men (52 %).

6.1. Decision-making gains drive gender equality progress

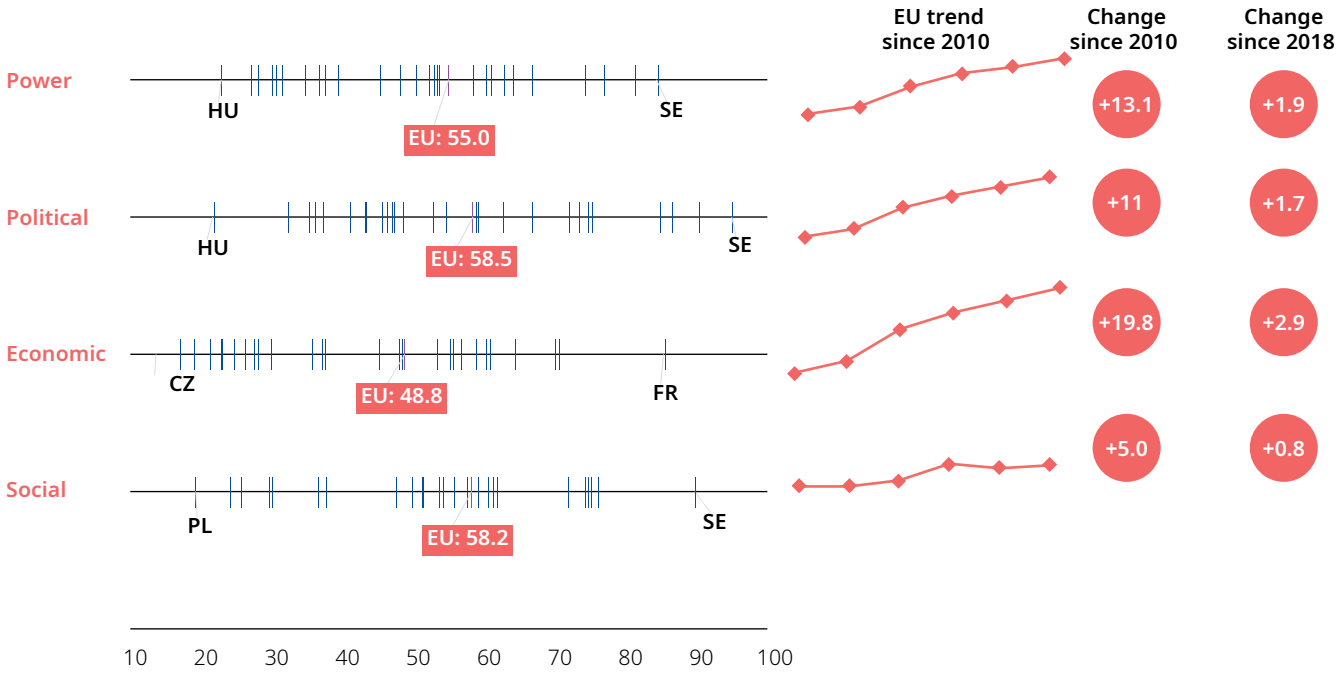
Since 2010, the EU score for the domain of power ([38]) has increased by 13.1 points, and between 2018 and 2019 it increased by 1.9 points. Nevertheless, the overall score of 55 points remains the lowest of all the domains (Figure 16).

Gender balance gains in the subdomain of economic decision-making, such as on boards of the largest companies and national central banks, has driven overall progress. There was an increase of 2.9 points between 2018 and 2019, and of 19.8 points in total since 2010. This change was triggered by binding legislative measures and other government actions in several countries. These peaked between 2012 and 2016 and have noticeably slowed since.

Gender equality in political decision-making has advanced by 1.7 points since 2018, and by 11 points overall since 2010. Here, too, government action has driven progress. From 2010 to 2019, countries with legislative electoral quotas have, on average, nearly doubled the proportion of women in parliament, compared with those without such quotas (+ 9.3 p.p. compared to + 4.8 p.p.) (EIGE, 2020a).

Progress on having more women in decision-making in research, the media and sport has been marginal, with a score increase of 0.8 points since 2018 and of 5.0 points between 2010 and 2019. These are the lowest increases of all power subdomains (Figure 16). The biggest gender imbalance is in sports, with just 17 % of women on the boards of the 10 most popular national sports federations in 2020.

Figure 16. Scores for the domain of power and its subdomains (2019), and changes over time



([38]) The domain of power measures gender equality in the highest decision-making positions across the political, economic and social spheres. The subdomain of political power looks at the representation of women and men in national parliaments, government and regional/local assemblies. The subdomain of economic power examines the proportions of women and men on the corporate boards of the largest nationally registered companies and national central banks. The subdomain of social power includes data on decision-making in research funding organisations, public broadcasters and the most popular national sports' federations.

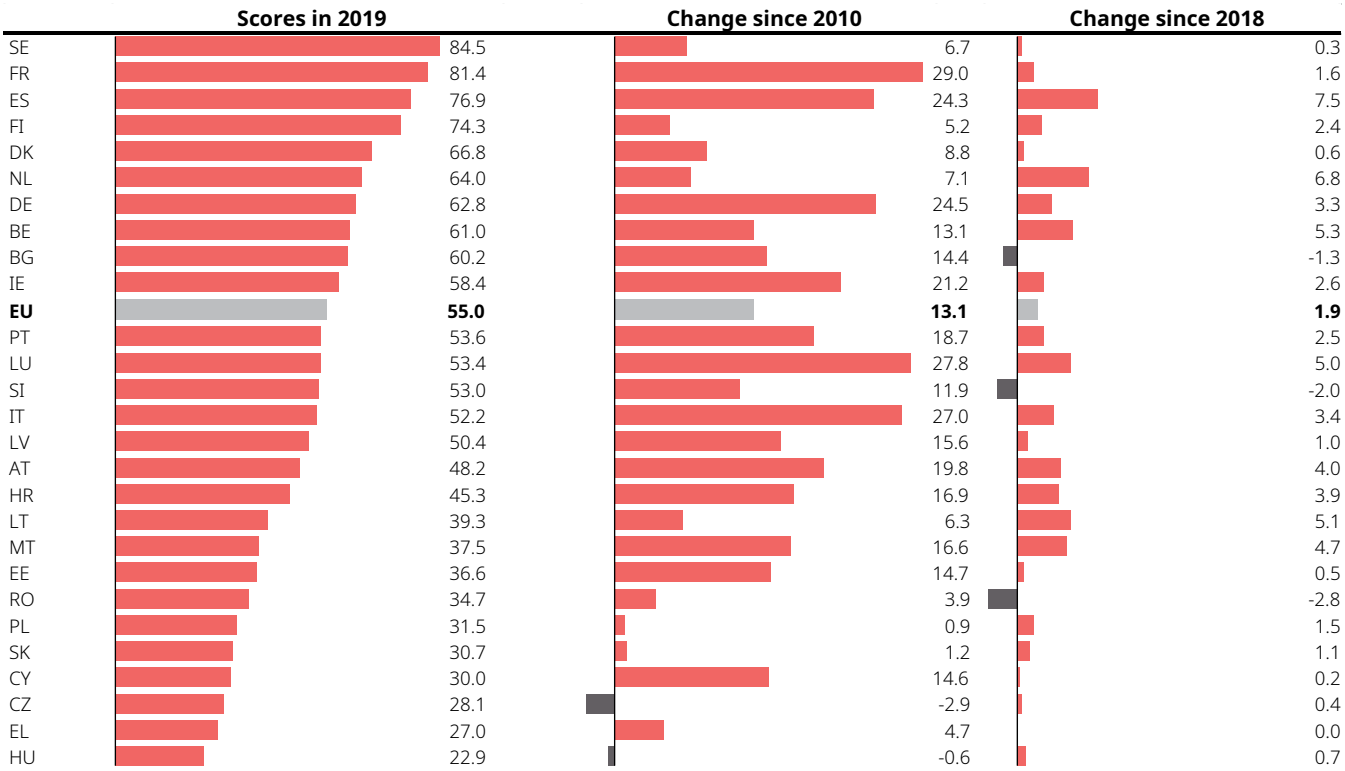
Nationally, gender balance in decision-making has been making rapid progress since 2010 in France (+ 29.0 points), Luxembourg (+ 27.8 points), Italy (+ 27.0 points), Germany (+ 24.5 points) and Spain (+ 24.3 points). For 11 other countries (IE, AT, PT, HR, MT, LV, EE, CY, BG, BE and SI), score gains in the domain of power vary from 21.2 points in Ireland to 11.9 points in Slovenia. All other countries score gains in the domain of power is below 10 points, and for Czechia (-2.9) and Hungary (-0.6) is negative.

Since 2018, the greatest advances have been in Spain (+ 7.5 points) and the Netherlands (+ 6.8 points), followed by Belgium (+ 5.3 points), Lithuania (+ 5.1 points) and Luxembourg (+ 5.0 points). The countries that have regressed since 2018 are Romania (– 2.8 points), Slovenia (– 2.0 points) and Bulgaria (– 1.3 points) (Figure 17).

Spain gained ground on gender balance in several decision-making bodies and institutions in 2019, particularly in government and on the boards of public broadcaster RTVE and the 10 most popular national sports federations. The Netherlands has moved closer to gender parity on the governing boards of the national central bank and the Netherlands Organisation for Scientific Research, while Belgium saw significant improvement in gender balance in the central bank (on the board of directors and the Council of Regency) and in government. Progress in Luxembourg and Malta was similarly driven by greater gender balance on the boards of both national central banks, a public broadcaster in Luxembourg (Radio 100.7) and the Malta Council of Science and Technology. In Lithuania, more women are now in parliament and government following elections in 2020, and more women are on the board of the national central bank.

However, gender parity in decision-making suffered a setback among public broadcasters in Bulgaria (BNR - Bulgarian National Radio, BNT – Bulgarian National Television) and Romania (TVR – Romanian Television), while in Slovenia there were reversals in government, parliament and on the board of the national broadcaster RTV Slovenija.

Figure 17. Scores for the domain of power (2019), and changes since 2010 and 2018, by EU Member State



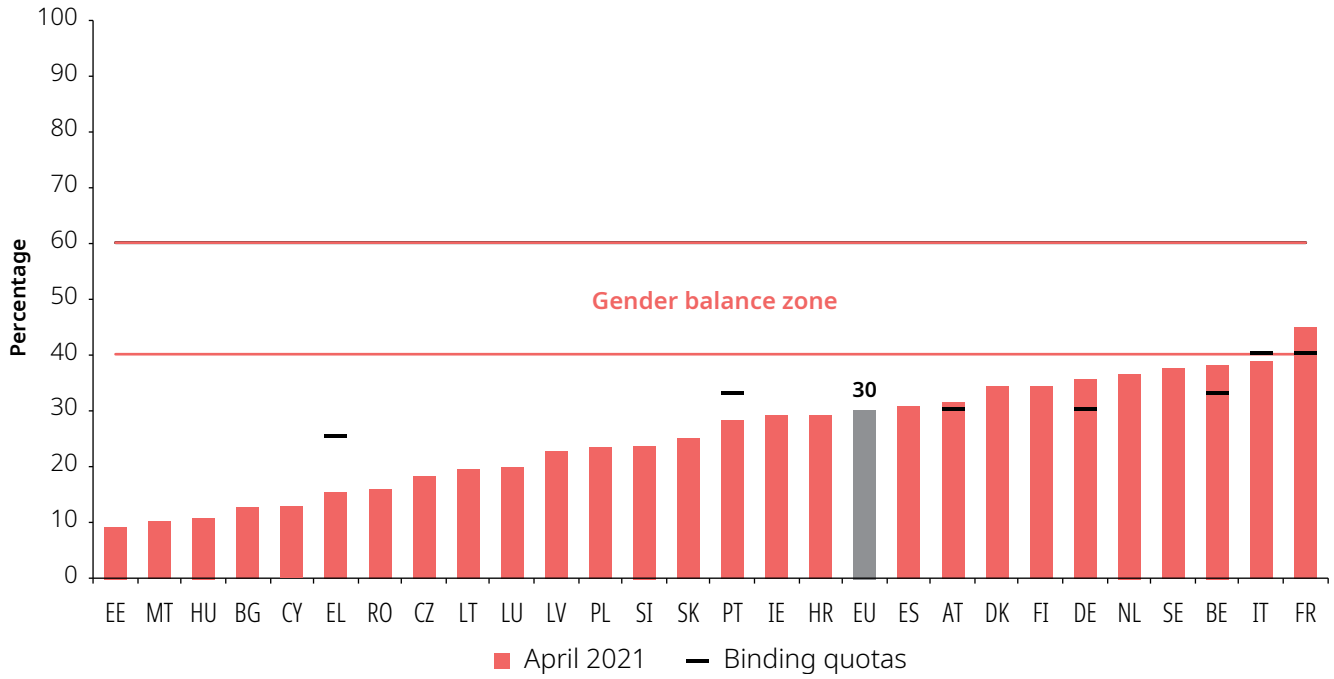
6.2. Legislative action makes a difference

Women's representation in corporate leadership is improving, albeit slowly. In 2021, 30 % of board members of the largest publicly listed companies in Member States were women. Although this figures is an all-time high, it is still the lowest annual increase since 2010. Legislative action in a few countries may have driven boardroom progress, but there is still much to do.

France remains the only EU country to have at least 40 % of each gender on the boards of the largest companies, with women holding 45 % of all positions. Belgium, Italy and Sweden are close behind, with around 38 % of board members being women. In Denmark, Germany, the Netherlands and Finland, women account for 33 % of board members. Elsewhere, men still heavily outnumber women. In 10 Member States, women hold less than 20 % of board positions, while in Estonia, Hungary and Malta they account for 10 % or even less (Figure 18).

Overall, 23 % of the largest companies in the EU have at least 40 % of each gender on their boards. However, nearly one in five still have all-male boards. In Bulgaria, Estonia and Hungary, more than half the largest companies have no women board members at all.

Figure 18. Participation of women on the boards of the largest quoted companies (supervisory boards or boards of directors) and binding quotas, by EU Member State (%, April 2021)



NB: National gender quota targets: FR, IT (40 %), BE, PT (33 %), DE, AT (30 %), EL (25 %).
Source: EIGE Gender Statistics Database, Women and Men in Decision-Making (WMID).

Various Member States have acted to promote more gender-balanced representation in corporate leadership. Adopted strategies vary from 'soft' measures, to encourage companies to self-regulate and take independent action, to 'hard', regulatory, approaches. These include applying legally binding quotas for minimum representation for each gender, with sanctions for non-compliance in some cases.

So far, seven Member States have taken legislative action to rectify gender imbalance in boardrooms by setting quotas for a minimum level of the under-represented sex – France and Italy

(40 %) ([39]), Belgium and Portugal (33 %), Germany and Austria (30 %) and Greece (25 %). Greece introduced quotas in July 2020 when updating the legal framework on corporate governance.

Nine other Member States (DK, IE, ES, LU, NL, PL, SI, FI and SE) have taken a softer approach ([40]). Spain has equality legislation that recommends a minimum of 40 % of each gender on company boards, but the recommendation is not enforceable. Meanwhile, Slovenia has a 40 % legislative quota when nominating government representatives to the boards of public companies; however, non-compliance is not sanctioned. Other countries in this group have preferred to encourage companies to self-regulate to redress boardroom gender imbalance. The remaining 11 Member States (BG, CZ, EE, HR, CY, LV, LT, HU, MT, RO and SK) have not taken any substantive action.

Quota targets have been met in France (October 2016), Germany (October 2017), Belgium (April 2019) and Austria (October 2019). Italy achieved its initial target of 33 % in October 2017, and now, with 39 % of women on boards, it is close to reaching the 40 % target set in October 2019. Of the two remaining countries with established gender quotas, Portugal has seen significant progress (women's representation on boards has increased from 16 % in October 2017 to 28 % in April 2021) but in Greece the quota was introduced too recently (July 2020) to have made much difference and, as at April 2021, women make up just 15 % of board members.

The impact of binding gender quotas is clear. In April 2021, women accounted for 38 % of the board members of the largest listed companies in six Member States with binding quotas. In countries with 'soft' measures, the figure was 31 %, and in countries where no action was taken it was 16 %.

Quotas have led to the rate of change more than tripling – from 0.9 p.p. per year prior to quotas to 3 p.p. per year afterwards. The rate of change in countries with 'soft' measures is 1.5 p.p. per year, whereas, in countries without any initiatives, it idles at just 0.3 p.p. per year. At the current rate of change, countries with binding quotas will take around 4 years to achieve boardroom gender parity. In countries with 'soft' measures, parity could take about 13 years. For those taking no specific action it will take at least a startling 125 years ([41]).

Legislative assemblies and executive governments at all territorial levels largely fail to reflect the gender diversity of the population they represent. Women remain significantly under-represented in many cases. Progress on gender balance in political decision-making is extremely slow. At the start of 2021, women made up 33 % of members of the single/lower house of national parliaments in the EU overall. While this marks an all-time high, it is not balance.

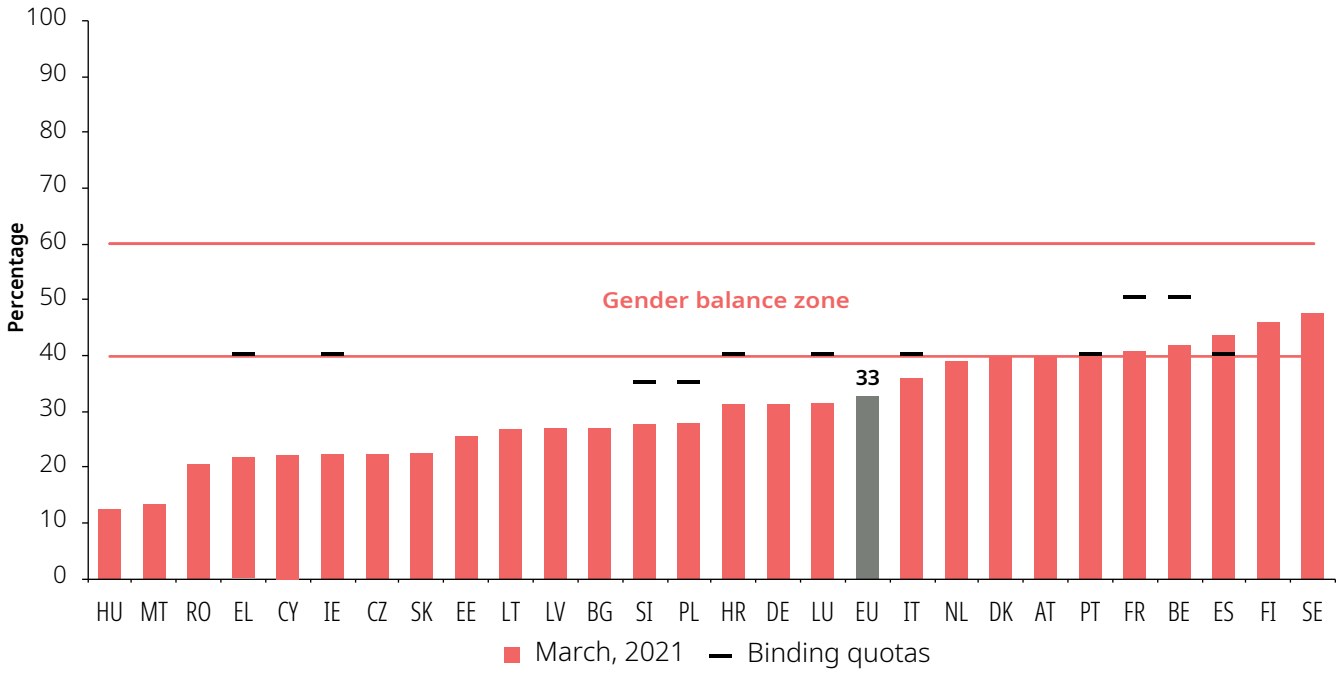
Nationally, parliaments in Belgium, Denmark, Spain, Austria, France, Portugal, Finland and Sweden have at least 40 % of each gender. The Netherlands is close behind, at 39 %. Representation is lowest in Hungary and Malta, where women make up less than one in seven members of parliament (Figure 19).

([39]) In Italy, the quota was initially set at 33 % in 2011, but it was increased to 40 % in October 2019.

([40]) In the Netherlands, a legislative proposal for a 33 % gender quota applicable to the supervisory boards of listed companies was submitted to parliament on 6 November 2020. The proposal also plans to make it obligatory for companies to set targets for improving the gender balance of management boards and other senior positions. The date on which the new law will enter into force has, however, not yet been announced.

([41]) Greece has been included in the no-quota group, as legislation was passed only in July 2020.

Figure 19. Share of women in single/lower houses of parliament (%, EU, March 2021)



NB: Quotas: BE, FR (50 %); IE, EL, ES, HR, IT, LU, PT (40 %); PL, SI (35 %).
Source: EIGE Gender Statistics Database, WMID.

Since France and Belgium introduced legally binding quotas, in 2000 and 2002, respectively, 11 Member States have introduced legislation setting minimum gender quotas on candidate lists put forward by political parties in national parliamentary elections. The most recent legislation was adopted in Luxembourg (2016) and Italy (2017). In 2019, both Greece and Portugal raised their quotas from 33 % to 40 %.

Ireland, Spain, Luxembourg, Poland and Slovenia all show accelerated progress after adopting quotas. Poland's progress is the most striking. Figures for women parliamentarians oscillated between 20 % and 22 % from 2004 to 2011. After the quota introduction and the 2011 elections, the figure rose to 24 %. By 2021, 28 % of Polish members of parliament were women. In Slovenia, although the quota was adopted in 2006, it came into full effect only in the 2011 elections, following which the percentage of women parliamentarians jumped from 17 % to 36 %. However, progress was short-lived. Following the 2018 elections women accounted for just 24 % of members of parliament, rising slightly to 27 % by March 2021.

Analysis shows that legislated quotas generally have a positive impact. In countries with quotas, the average annual rate of change of the proportion of women in the single/lower house has, on average, increased slightly, from 0.8 p.p. per year pre-quota adoption to 0.9 p.p. per year afterwards. However, the post-quota rate of change is nearly three times faster than in Member States without quotas, where the rate of change is 0.3 p.p. per year. At current rates of change, countries without measures in place are projected to take more than 60 years to achieve gender parity in parliament, while countries with binding quotas are expected to take less than 20 years.

6.3. Gender-balanced decision-making is imperative post pandemic

The lack of women's presence in decision-making bodies established globally to tackle COVID-19 is extraordinary, despite calls for this to be redressed (WHO, 2020g). Although women make up 70 % of health professionals and 80 % of health associate professionals in the EU (EIGE, 2018b), this majority does not translate

into leadership roles in the health sector, or in politics. During the pandemic and until March 2021, only one in four EU health ministers and 4 out of 10 junior/vice-ministers were women.

The small number of women in decision-making positions or as experts in key roles influenced the composition of the national task forces set up everywhere to tackle the pandemic. Assessing the gender gap in these bodies, a recent study by van Daalen et al. (2020) emphasised the exclusion of gender-diverse voices. Covering 87 UN Member States, the study found that only 3.5 % of 115 COVID-19 decision-making and expert task forces had gender parity. In 85.2 % of cases, men were in the majority. Such extensive gender gaps in decision-making strengthens unequal power structures and weakens COVID-19 responses, potentially costing lives.

With gender a key determinant of health, women's inclusion in crisis response decision-making is crucial (Davies and Bennett, 2016). The European Commission (2021a) has also recognised the need for more women to be part of pandemic response decision-making to take gender differences into consideration.

7. Domain of health

Significant gender inequalities persist in the EU in all areas, despite progress in recent decades. In the health domain ([42]), these include major disparities in life expectancy and self-assessed health status. There are also large gender differences in health-impacting behaviour. Men tend to engage more in risky behaviour such as smoking and excessive drinking. They are less involved in healthy pursuits, including physical activity and eating fruit and vegetables. Access to health and dental care also reveals disparities, especially when gender is analysed with other social factors such as age, education and disability.

The COVID-19 pandemic has undoubtedly placed an unprecedented strain on health systems (OECD/European Union, 2020) It has also exposed how gender and social inequalities impact people's health, for example the high toll paid by frontline and essential workers (EIGE, 2020b, 2020c; OECD, 2020a). The critical need for more gender-sensitive data and analysis to inform responses to the pandemic has been reiterated (European Commission, 2021a; GlobalHealth 50/50, 2020; WHO, 2020c).

The European Pillar of Social Rights Action Plan acknowledges the right to timely access to good-quality, affordable healthcare for all – both preventive and curative (European Commission, 2019). The action plan recognises the need for gender equality of access to long-term care services, healthy working environments and social protection, and emphasises that health status does not depend only on biological factors but is also influenced by numerous social determinants. Health, therefore, requires a multidisciplinary approach. The EU gender equality strategy has reaffirmed this commitment to integrating gender with all European Commission health initiatives (European Commission, 2020b).

Measures to better monitor access to healthcare, to improve access to healthcare for key population groups such as people with disabilities and to reform long-term care provision in the EU are proposed in the social rights action plan (European Commission, 2021d).

This Index's thematic focus on health (Chapter 9) explores in greater detail the three dimensions of the health domain – health status, health behaviour and access to health services. It also analyses, from gender and intersectional perspectives, three other specific areas: SRH, mental health and the COVID-19 pandemic.

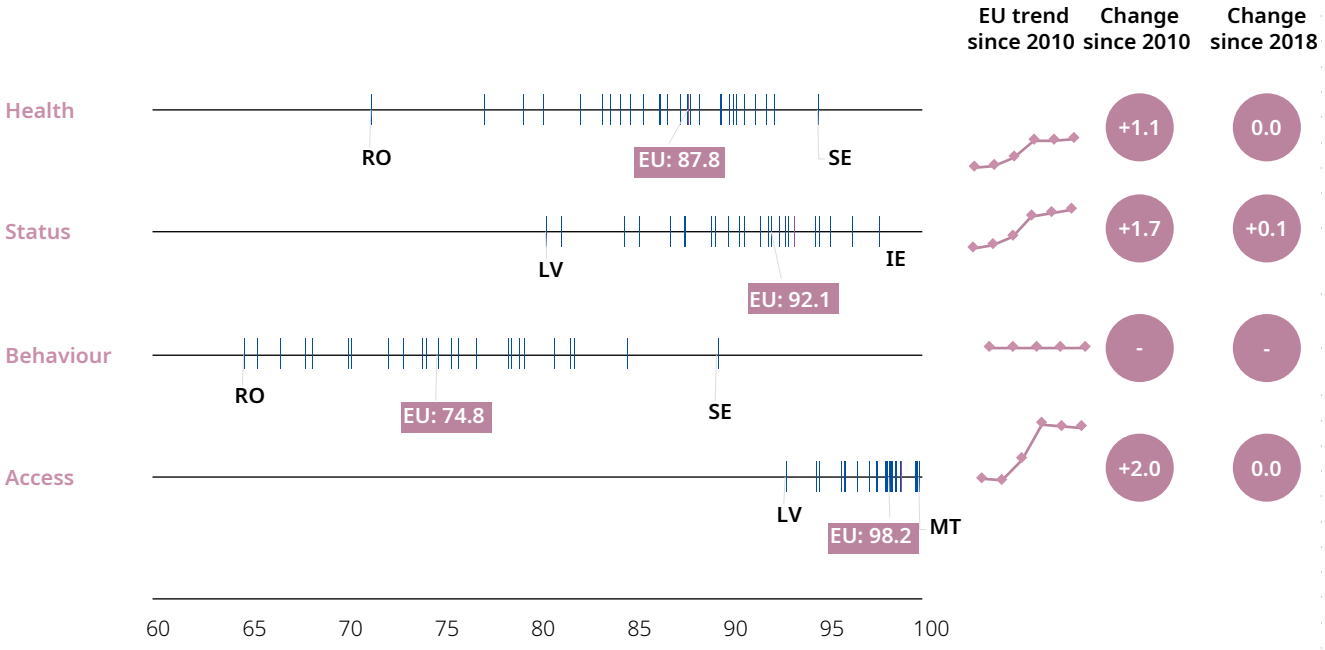
7.1. Enduring health inequalities stall progress

With data from 2019, the Gender Equality Index 2021 primarily reflects the pre-pandemic period, and the subdomain of health behaviour has not been updated because of a lack of fresh data. The domain of health has, at 87.8 points, the highest score of all six domains (Figure 20). Yet progress has been negligible since 2010 – an increase of just 1.1 points. Score improvements since 2010 have been similarly marginal for the subdomains of access to health services (+ 2 points) and health status (+ 1.7 points) (Figure 20).

Access to health services achieved the highest score among the health subdomains, at 98.2 points. This is also the subdomain that has seen the most progress since 2010 – 2 points. Nationally, Malta ranks first, although all top five countries scored above 99 points (DE, LU, MT, NL and AT). Section 9.1.3 explores in greater depth some of the gaps in healthcare access affecting key population groups in the EU.

([42]) The domain of health measures three health-related aspects of gender equality: health status, health behaviour and access to health services. Health status looks at the gender differences in life expectancy, self-perceived health and healthy life years (also called disability-free life expectancy). This is complemented by a set of health behaviour factors based on WHO recommendations: fruit and vegetable consumption, engagement in physical activity, smoking and excessive alcohol consumption. Access to health services looks at the percentage of people who report unmet medical and/or dental needs.

Figure 20. Scores for the domain of health and its subdomains (2019), and changes over time

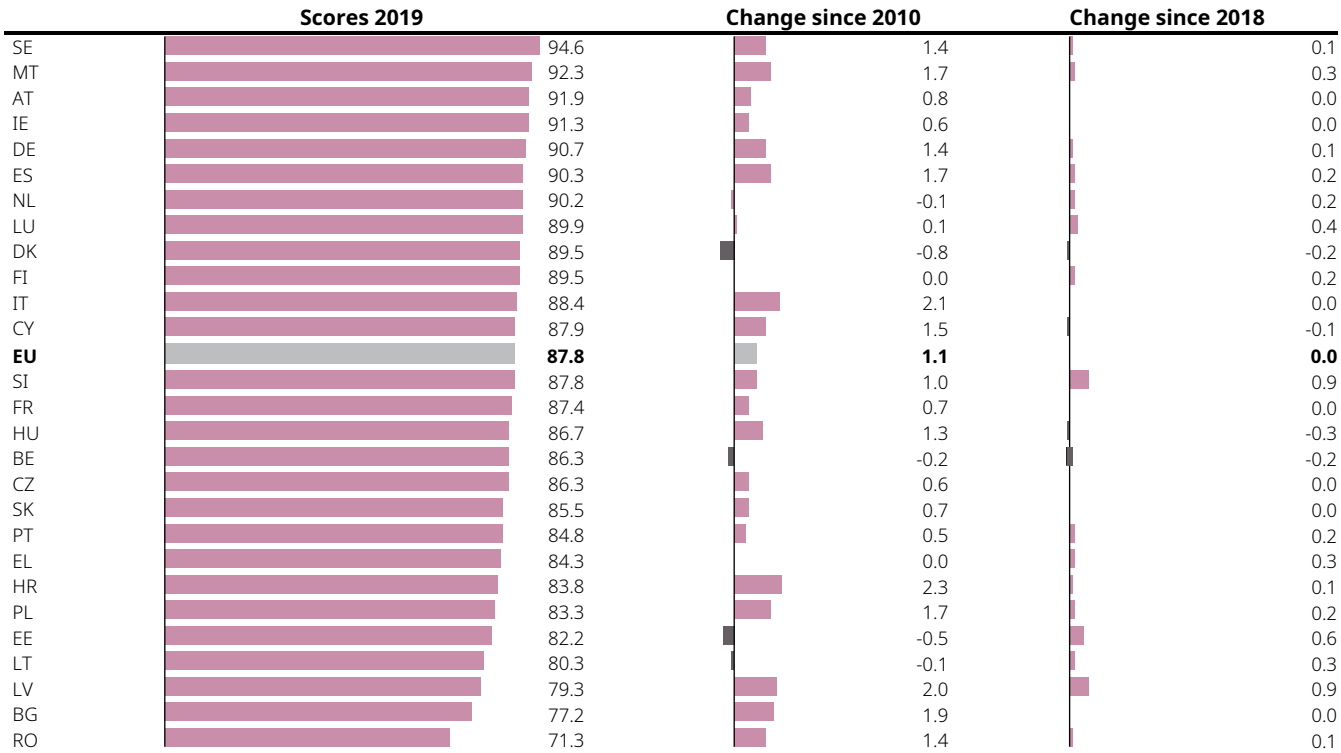


The subdomain of health status is less dynamic, in both scores and ranks. The EU score has risen by 1.1 points since 2010, and has seen no change since 2018.

The largest gender inequalities are found in the health behaviour subdomain, for which the EU score is 74.8 points. As discussed in Section 9.1.2, gender norms and relations affect health behaviours. Men are more likely to smoke and drink excessively, while women face multiple obstacles to physical activity. Such behaviours are major health determinants. Adopting practices that promote health is critical to preventing non-communicable diseases (NCDs) such as cardiovascular diseases, hypertension and cancer – the largest cause of premature mortality in the EU (Table 3 of the thematic focus). The EU's Beating Cancer Plan emphasises the importance of tackling risk factors, and has the objective of creating a 'tobacco-free generation'. The aim is to reduce the percentage of the population using tobacco to less than 5 % by 2040, compared with around 25 % today (European Commission, 2021c).

Regular physical activity is known to be important for good mental health and well-being (Stubbs et al., 2017); therefore, health behaviours such as physical activity are a key dimension of public health, both physical and mental. This is particularly important at present as the COVID-19 pandemic is known to have caused significant levels of mental distress (see Section 9.1.). Despite this, the most recent data on this subdomain is from 2014, hampering efforts to monitor progress effectively. A body of evidence shows that legislative and public policies can be effective in changing behaviour (WHO, 2014), but regular data collection and analysis are essential to monitor the effectiveness of national approaches.

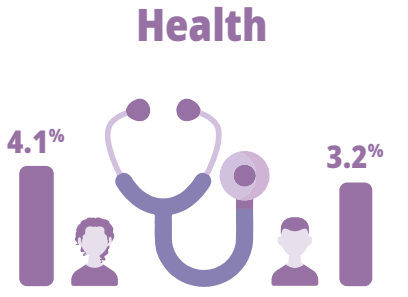
Figure 21. Scores for the domain of health (2019), and changes since 2010 and 2018, by EU Member State



The score for the health domain and its subdomains has remained unchanged since the previous Index edition. The five top-performing countries in this domain in 2019 were Sweden, Malta, Austria, Ireland and Germany, all with scores of above 90 points (Figure 21). At the tail end were Romania, Bulgaria, Latvia, Lithuania and Estonia, with scores ranging from 82.2 points in Estonia to 71.3 points in Romania. Since 2010, 13 countries have improved their health domain score by at least 1 point. Croatia has the highest overall score increase, 2.3 points, but significant overall gains have also been made in Bulgaria, Italy and Latvia. However, scores in five countries have declined (BE, DK, EE, LT and NL).The score changes in 2019, which range from a from trivial increase of+ 0.9 points in Latvia and Slovenia to a decline of – 0.3 points in Hungary, reveal that short-term progress on health has flatlined.

Cost is a key obstacle to accessing healthcare

Universal access to health services has not been fully achieved in the EU. About 3.3 % of women and 2.8 % of men report unmet needs for medical examinations. Across different population groups, gender clearly intersects with other social factors to hamper access to health. Certain groups are more likely to report unmet medical examination needs: women and men with disabilities (women, 6.6 %; men, 6 %), lone parents (women, 4.7 %; men, 4.6 %), women with a low level of education (4.2 %) and those over 65 years (4.1 %) (Figure 22).

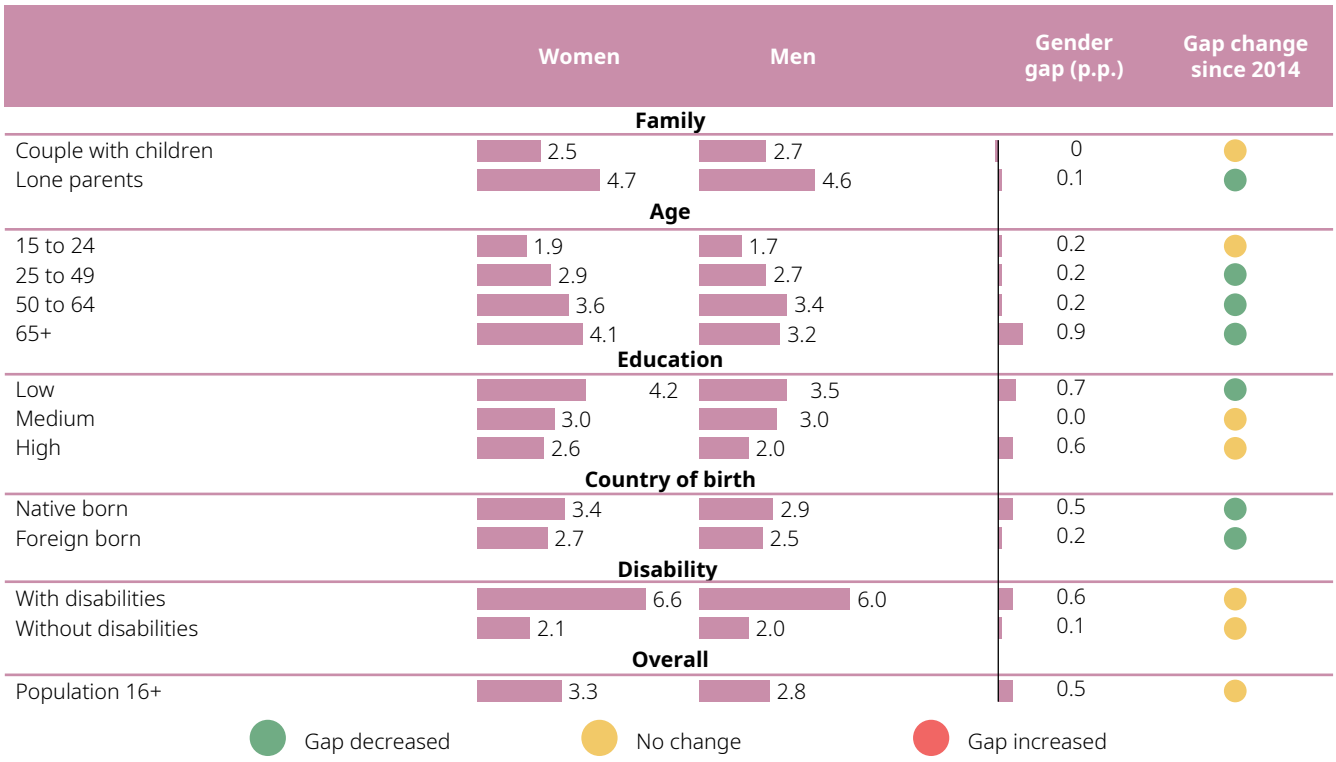


Women aged over 65 have greater unmet needs for medical examinations than men the same age

There are important variations among countries on unmet medical examination needs for women and men with disabilities, with Estonia and Romania recording the highest levels (see Figure 36 in par. 9.1.3.).

The most common reason cited for unmet healthcare needs is cost. Women are more likely to mention finances as an obstacle to seeking healthcare, with 33 % of women and 29 % of men saying that they cannot afford it ([43]). Women and men with disabilities and women with a low level of education are more likely than others to have little income because they either are not in paid work or are in precarious jobs (EIGE, 2017b).

Figure 22. Women and men with unmet needs for medical examination, by family composition, age, education level, country of birth and disability (%, 16+ years, EU, 2019)



Source: Authors' calculation, EU-SILC, 2019 (IE, IT, 2018).

A wealth of evidence documents LGBTQI+ women's and men's disadvantaged health status and healthcare access (Elliott et al., 2015; Fedewa and Ahn, 2011; FRA, 2020a; Rosenkrantz et al., 2017). LGBTI people across Europe still face discrimination when accessing healthcare, with 16 % of survey respondents reporting that they have felt discriminated against by healthcare or social services staff in the preceding 12 months because they are LGBTI (FRA, 2020a). Trans people report especially high levels of insensitive and disrespectful behaviour towards them by healthcare personnel (Edwards, 2012).

([43]) Authors' calculations based on Eurostat, 'Unmet needs for medical examinations, by sex, age, and reasons in the EU (%), https://ec.europa.eu/eurostat/web/products-datasets/-/hlth_silc_14, 2019.

7.2. COVID-19 lowers life expectancy for men and birth rates

Despite an intensifying vaccine roll-out, at the time of writing the COVID-19 pandemic is still not under control in the EU. Though the full effects of the pandemic on people's health are not clear, they are likely to be far-reaching. By July 2021, COVID-19 had claimed more than 730 000 lives and infected 33 million people. This represents 7 % of the EU population. The burden of infection and death has been unevenly spread across countries and population groups. The greatest numbers of cases are reported in the largest countries, such as Germany, Spain, Italy and Poland ([44]). However, the highest shares of cases by population are in less populated countries – Czechia, Luxembourg, Slovenia and Slovakia – with rates ranging from 11 % in Luxembourg to 16 % in Czechia.

Section 9.2.2. explores the specific ways in which women and men are affected by COVID-19 in terms of infection and health outcomes. It also examines some of the gendered consequences of the pandemic restrictions on health, including mental health and exposure to gender-based violence.

Among the pandemic's more obvious effects on public health is a drop in life expectancy. In 2020, life expectancy in most EU countries was lower than in 2019. Preliminary data shows that life expectancy fell slightly more for men than for women, except in Spain. The largest decreases were for men in Poland and Lithuania (– 1.5 years) and in Romania (– 1.4 years), and for women and men in Spain (– 1.6 years and – 1.4 years, respectively) ([45]). The drop in men's life expectancy, while possibly temporary, is related to higher numbers of COVID-19 fatalities and higher rates of excess mortality among men in most EU countries (see Section 9.2.2.).

The pandemic has also been linked to a decline in the number of births registered in late 2020 and early 2021, especially in the countries most affected by the outbreak ([46]). Data from the Short-Term Fertility Fluctuations points to a drop of 10 % in Hungary in January 2021, 13 % in France and 17 % in Estonia ([47]). The highest fall (of 20 %) – a real 'baby crash' – was in Spain (Tomas Sobotka et al., 2021). The combination of significant health risks, psychological distress and, economic uncertainty – including large-scale job losses – and much more unpaid care work for women during the pandemic have been put forward as possible reasons for couples delaying or forgoing having children (Voicu and Bădoi, 2021). As Section 9.2.1 on SRH discusses, provision of and access to these services have varied greatly across the EU and over time. This could also have been a factor, especially for couples and individuals needing to conceive with medical assistance. With populations ageing across Europe, and Member States in southern and central Europe particularly affected by low birth rates, the fall in registered births during the pandemic is expected to exacerbate ongoing demographic challenges.

([44]) ECDC COVID-19 surveillance update, https://www.ecdc.europa.eu/en/cases-2019-ncov-eueea, accessed 7 July 2021.
([45]) Authors' elaboration based on Eurostat data 'Life expectancy by age and sex, https://ec.europa.eu/eurostat/web/products-datasets/-/demo_mlexpec, accessed 8 April 2021.
([46]) Compared with the same months of the previous year.
([47]) The Short-Term Fertility Fluctuations is an open access database, which supplements the Human Fertility Database by providing timely data on birth counts by month in selected countries, https://www.humanfertility.org/Docs/STFFnote.pdf.

8. Domain of violence

Violence against women is one of the most pervasive crimes of our time. It takes many forms, including physical, sexual, psychological and economic. It can occur among intimate partners, in broader domestic, professional and public settings, and in virtual spaces. Ageing, living with a disability, being a foreigner and other life circumstances can increase women's vulnerability to gender-based violence.

Freedom from violence and stereotyping is a key pillar of the 2020–2025 EU gender equality strategy ([48]). The EU strategy on victims' rights (2020–2025) ([49]) pays particular attention to the specific needs of victims of gender-based violence, building on the victims' rights directive ([50]). In 2017, the EU signed the Council of Europe Convention on preventing and combating violence against women and domestic violence (the Istanbul Convention) ([51]). The EU's accession to the Convention is a key priority for the Commission.

The domain of violence is considered an additional domain of the Gender Equality Index. Its particular status stems from conceptual and statistical considerations ([52]). Violence against women is the most coercive manifestation of gender inequalities. It is a major cause and consequence of the structural inequalities women face in employment, income, education, power distribution, unpaid care and health. Therefore, it has an essential place in gender equality debates and monitoring. However, the domain of violence statistically focuses on violence against women, not gender gaps, and is treated differently to the other Index domains.

The domain is based on a stand-alone three-tier structure of measurement (EIGE, 2017a). It enables monitoring of the extent of various forms of violence against women, determination of contextual factors for inter-country comparison and evaluation of developments over time in the EU:

1. **A composite measure** combines indicators on prevalence, severity and disclosure of the most common and widely criminalised forms of violence against women (physical violence, sexual violence and femicide). Based on data collected by FRA in 2012 (FRA, 2014), the EU composite measure score was 27.2 out of 100 (the higher the score, the greater the level of violence against women) (EIGE, 2017a). An update of this score will be available in 2024 following the completion of the next survey on violence against women led by Eurostat ([53]), complemented by a FRA and EIGE joint survey ([54]).

2. **Additional indicators** cover a broader range of forms of violence against women de-

([48]) The 2020–2025 EU gender equality strategy, https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX:52020DC0152.
([49]) The 2020–2025 EU strategy on victims' rights, https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX:52020DC0152.
([50]) https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32012L0029&from=EN
([51]) Council of Europe Convention on preventing and combating violence against women and domestic violence, https://rm.coe.int/168008482e.
([52]) Conceptually, acts of violence targeting women are the corollary of structural inequalities experienced by women in the fields of work, health, money, power, education and time use. From this point of view, violence against women brings an important aspect to the domains of the Gender Equality Index. From a statistical perspective, the domain of violence cannot be treated in the same way as the other domains of the Gender Equality Index because it does not measure gaps between women and men. Rather, it presents women's experiences of gender-based violence. Unlike other domains, the overall objective is not to reduce the gaps in violence between women and men, but to eradicate violence altogether (EIGE, 2013, p. 31). This fundamental difference between the other domains of the Gender Equality Index and the violence against women domain justifies the fact that this domain is treated differently.
([53]) The data collection phase is planned to take place between 2020 and 2022.
([54]) FRA and EIGE will collect data on violence against women (VAW II survey) in those EU Member States where national statistical authorities are not conducting national data collection in the context of the 'EU survey on gender-based violence against women and other forms of inter-personal violence' (EU-GBV survey), as coordinated by Eurostat. This encompasses up to 10 EU Member States that are not participating in the Eurostat initiative. The data will be published in Gender Equality Index 2024.

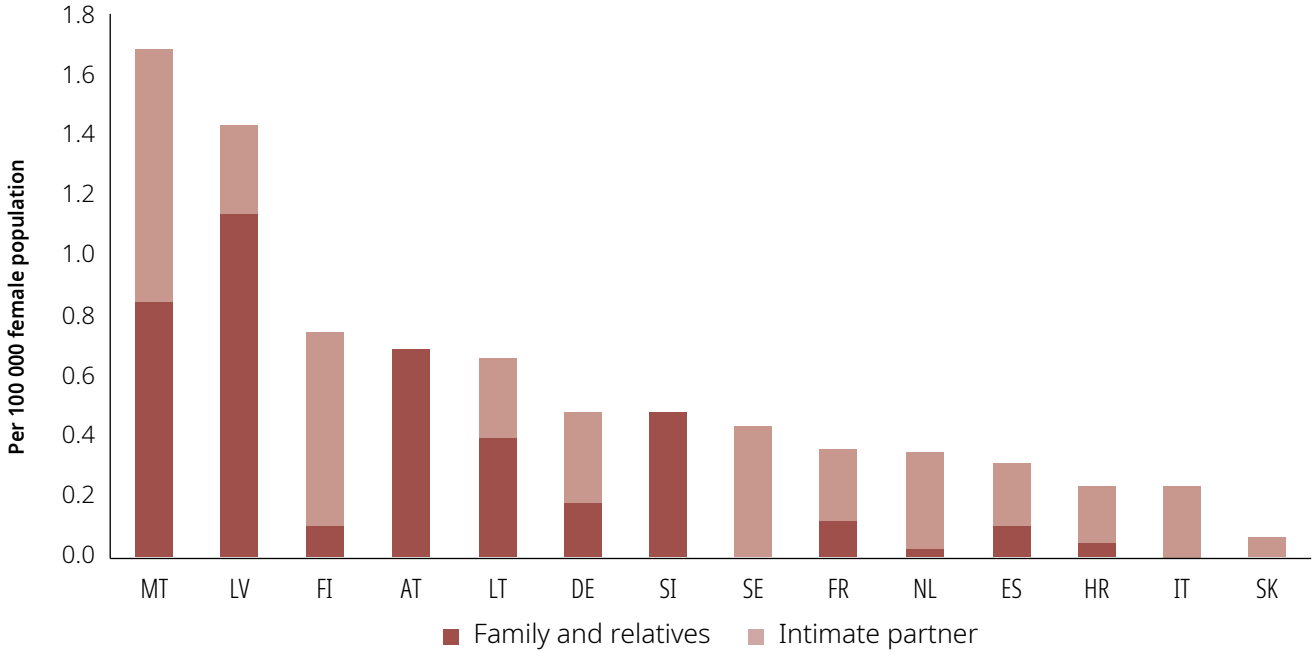
fined in the Istanbul Convention. These forms of violence, for example psychological violence, sexual harassment, stalking and female genital mutilation (FGM), are analysed separately to the composite measure because of a lack of consensus on definitions or a strong policy framework at national or EU level.

3. **Contextual factors** are structured around the Istanbul Convention provisions and cover six dimensions: policies, prevention, protection and support, substantive legislation, involvement of law enforcement agencies, and societal framework.

8.1. A dearth of evidence hampers true assessment of violence against women

The domain of violence cannot be updated regularly because of the serious lack of up-to-date prevalence data, even for the most severe forms of violence against women. Of all the indicators used to gauge the extent of this violence, the only regularly available data is for femicide. EIGE defines femicide as '[the] killing of a woman by an intimate partner and the death of a woman as a result of a practice that is harmful to women' ([55]). The challenge is to capture the gendered nature of femicide, as no Member State recognises it as a separate criminal offence. The killing of women falls under the legal term 'homicide'. Currently, EIGE is using a proxy indicator and data on intentional homicide by an intimate partner or family member provided by Eurostat (Figure 23). In 2018, more than 600 murders of women by an intimate partner or family member/relative were recorded in 14 Member States. The highest rates – calculated per 100 000 women – are recorded in Finland, Malta and Latvia. Intentional homicide by an intimate partner is also relatively high in Sweden. Owing to differences in the definitions of criminal offences and data collection processes at national level, the comparability and accuracy of data must be considered with caution.

Figure 23. Women victims of intentional homicide by an intimate partner or family member/relative by EU Member State (by 100 000 female population, 2018)



NB: Data related to the number of women victims of intentional homicide by family and relatives in 2018 is not available for Czechia, Greece, Italy, Cyprus, Hungary, Romania, Slovakia or Sweden. Data related to the number of women victims of intentional homicide by intimate partners in 2018 is not available for Czechia, Greece, Cyprus, Hungary, Austria or Romania. Slovenia recorded zero women killed by intimate partners in 2018.
Source: Eurostat, https://ec.europa.eu/eurostat/web/products-datasets/-/crim_hom_vrel.

([55]) https://eige.europa.eu/thesaurus/terms/1128

The killing of older women is a prevalent form of femicide as a result of the specific vulnerability of this group. Women aged over 65 years can become victims of their intimate partner, but also of men outside a partnership. A study by Dobash and Dobash (2015) shows that most murders of older women are committed by men from the neighbourhood. Perpetrators are often unemployed and chronically intoxicated. Women victims appear to be selected because of their 'extra' vulnerability – being a woman and older. The same research revealed that more than three quarters of homicide–suicides – in which a man kills a woman and then himself – involved an older woman being murdered by a male partner. In many of these cases, jealousy, possessiveness and the inability to cope with separation were apparent (Dobash and Dobash, 2015).

Since EIGE's composite measure of the extent of violence was first released in 2017, no new EU-wide comparable data has been available for other forms of violence included in it. FRA's 2019 Fundamental Rights Survey (FRA, 2021) provides some EU-wide data on experiences of physical violence and harassment among women and men. Owing to differences in survey aims and methodology, this data is not comparable to FRA's 2012 violence against women survey ([56]).

Data from the WHO Regional Office for Europe (2021b) shows that intimate partner violence affects a significant share of women at one point in their lives. In EU countries, prevalence estimates for 2018 range from 13 % of women aged 15–49 years in Croatia and Poland to 25 % of women of the same age in Latvia saying they have experienced violence from an intimate partner at one point in their lives (WHO Regional Office for Europe, 2021b).Data from the WHO Regional Office for Europe (2021b) shows that intimate partner violence affects a significant share of women at one point in their lives. In EU countries, prevalence estimates for 2018 range from 13 % of women aged 15–49 years in Croatia and Poland to 25 % of women in Latvia saying they have experienced violence from an intimate partner at one point in their lives (WHO Regional Office for Europe, 2021b).

According to the Fundamental Rights Survey, 8 % of women in the EU-27 experienced physical violence (excluding sexual violence) in the 5 years before the survey, and 5 % of women experienced physical violence in the preceding 12 months. However, 13 % of women experiencing violence in the preceding 5 years indicated that it was sexual. Incidents were mostly perpetrated in a woman's own home (37 %) by a family member or a relative (32 %), and, in most cases, by men. This confirms the significant role of intimate partner violence or domestic violence in women's experiences of violence.

The prevalence of physical violence against women differs across countries. Experience of violence in the previous 5 years ranges from 16 % in Finland and Estonia to 3 % in Malta and 2 % in Italy. Physical sexual violence is most prevalent in Greece (26 %), Portugal (22 %) and Spain (20 %) ([57]). For violence against women at home, rates are as high as 68 % in Portugal, 64 % in Estonia, 55 % in Croatia and 53 % in Austria.

The survey also revealed that 39 % of women across all age groups experienced harassment in the previous 5 years and 28 % of women experienced harassment in the preceding 12 months. For women aged 16–29 years, these rates were 61 % and 46 % for the preceding 5 years and

([56]) According to FRA (2021), the results of the violence against women survey should be considered a better reflection of women's experiences of violence – including intimate partner violence – whereas the Fundamental Rights Survey provides data on women's and men's experiences of selected forms of violence. Although respondents in the Fundamental Rights Survey could disclose experiences of violence irrespective of the type of perpetrator, the survey did not include specific measures used in the violence against women survey to support the disclosure of intimate partner violence, such as prevalence of sexual violence against women (FRA, 2021).

([57]) The results relating to prevalence of physical violence of a sexual nature in these three countries are flagged by FRA as statistically less reliable, because they are based on a small number of responses.

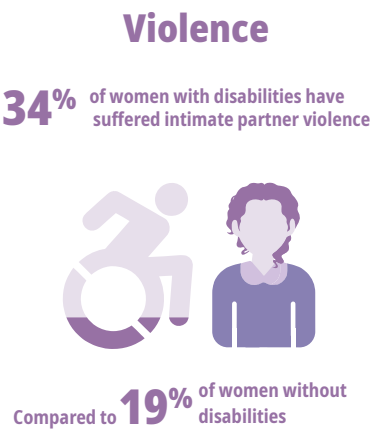
12 months, respectively. France (60 %), the Netherlands (59 %), Finland (57 %) and Germany (57 %) recorded the highest levels of harassment of women over the 5-year period. Of the women who experienced harassment in the preceding 5 years, 18 % said that the most recent incident was sexual in nature, with this figure rising to 30 % for women aged 16–29 years. Sexual harassment by strangers in a public setting is experienced disproportionately by women, who, as a result, often report that they avoid certain places and situations for fear of potential assault or harassment. Such worries reduce women's opportunities for engaging in public life.

Most incidents of physical violence and harassment are not reported to the police, particularly when the perpetrator is a family member or a relative. According to the Fundamental Rights Survey, only 22 % of such incidents are reported, which implies significant under-reporting of domestic and/or intimate partner violence. FRA's violence against women survey (FRA, 2014) results support this finding, as they showed that many women victims of physical and sexual violence contact doctors and health services, rather than the police.

Data recorded by authorities often underestimates the scope of gender-based violence. Pre-existing legal shortcomings in addressing various forms of violence against women are additional barriers to reporting. This includes not recognising psychological and economic abuse as a type of gender-based violence, or coercion-based rather than consent-based definitions of rape. As data-recording systems are rarely operated by specialists on gender-based violence, incidents are not always categorised and recorded comparably (EIGE, 2019f). To redress the situation, EIGE developed 13 indicators to help Member States meet the minimum requirements of the victims' rights directive and the Istanbul Convention, and to guide EU-wide administrative data collection by police and justice sectors on intimate partner violence and rape (EIGE, 2018a).

8.2. Inequalities heighten the risk of violence against women

While violence affects all women, some groups face a higher risk (EIGE, 2020a). The 2019 Fundamental Rights Survey (FRA, 2021) revealed higher harassment rates in the preceding 5 years among specific groups. These include women self-identifying as lesbian, bisexual or 'other' (57 %); women not citizens of where they live (51 %); women educated to tertiary level (49 %); and women with disabilities hampering their ability to take part in common activities (48 %).



The violence against women survey (FRA, 2014) also showed that disability substantially increases women's vulnerability to violence, especially from a close or intimate partner. About a third of **women with disabilities** (34 %) suffered intimate partner violence, compared with 19 % of women without a disability. Yet women with disabilities are usually missing from strategies to combat violence against women, and often are physically unable to access shelters and other facilities, forcing them to remain in violent situations (Mandl et al., 2014).

Increased social media use and digital technology advances have seen an upsurge in online harassment and abuse, particularly against **young women and girls**. In the EU, 13 % of women have overall experienced cyber-harassment. Among 16- to 29-year-olds, it is more prevalent, at 25 % (FRA, 2021). Consequently, girls and young women (aged 15–18 years) considerably restrict what they express online for fear of harassment, gossip and hateful comments (EIGE, 2019a). Eventually such violence can silence women and discourage them from taking a prominent role in public life. For example, about 4 out of 10 journalists have reported self-censorship following online abuse (EIGE, 2020a). Many women in public roles, especially

those fighting for the rights of women and minorities (politicians, lawyers, activists, etc.), are victims of gender-based cyber-harassment (European Parliament, 2018, 2021).

Since 2012, EIGE has been mapping the prevalence of **FGM** in the EU by estimating the number of women and girls (aged 0–18 years) at risk of FGM and identifying good practices to tackle it. The most recent assessment, carried out in Denmark, Spain, Luxembourg and Austria ([58]), shows that the risk of FGM is less pronounced when a woman or girl is in the EU (EIGE, 2021b). However, the risk increases when unmarried girls and women return to their country of origin. In Denmark, Luxembourg and Austria, girl asylum seekers are at a higher estimated risk of FGM than the general migrant population. This highlights the importance of having gender-sensitive asylum procedures in place to prevent FGM and protect girls at risk, and to help women and girls who have undergone FGM (EIGE, 2021b). The study also demonstrates the need to strengthen sensitivity to intersecting inequalities, including through culturally sensitive approaches in sexual and reproductive healthcare systems (see Section 9.2.1.).

FRA's second LGBTI survey, conducted in 2019 (FRA, 2020b), found that 1 in 10 **lesbian women** (10 %) in the EU-27 were physically or sexually attacked in the 5 years before the survey because of their sexual orientation. FRA's second LGBTI survey, conducted in 2019 (FRA, 2020b), found that 1 in 10 **lesbian women** (10 %) in the EU-27 were physically or sexually attacked in the 5 years before the survey because of their sexual orientation. Prevalence ranged from 16 % in Croatia to 3 % in Portugal. Only 16 % of lesbian women reported the most recent hate-motivated physical and sexual attack to any organisation, including the police. This was mostly because of fear of homophobic reaction. Harassment ([59]) is the most widespread form of violence against lesbian women, with 56 % experiencing in-person harassment for any reason in the previous 5 years and 11 % suffering cyber-harassment over the same time frame. In the 12 months before the survey, 48 % of lesbian women were harassed for any reason and 40 % were harassed because of their sexual orientation. Prevalence rates vary from 52 % in Latvia, 50 % in Lithuania and 48 % in Belgium to 22 % in Cyprus and 28 % in Malta and Portugal. Of the most recent incidents of hate-motivated harassment against this group, 71 % were perpetrated by men. In 62 % of cases, the perpetrator was unknown to the woman (FRA, 2020b) ([60]).

8.3. Gender-based violence amplified by the COVID-19 pandemic

Social distancing and restrictions on movement to contain COVID-19 have trapped women and girls at home with their abusers. If victims of violence had legal and social support networks, these were shattered, making it almost impossible to seek immediate support or to escape their situation.

Anti-COVID-19 measures can compound and connect different intersecting forms of discrimination against women and heighten the risk of violence against women belonging to vulnerable and marginalised groups. This includes older women, women and girls with disabilities, migrant women, homeless women and victims of trafficking, among others. For instance, lockdown and 'stay-at-home' orders exacerbate factors that put older women at particular risk of violence, for example loneliness, anxiety, depression, the financial dependency of caregivers and the dependency of older people on

([58]) Conducted in 2018 for Spain and in 2019 for Denmark, Luxembourg and Austria.

([59]) The questionnaire did not use the term 'harassment', to avoid varying interpretations. Instead, the specific acts of harassment were assessed. Specifically, it asked respondents if somebody had made offensive or threatening comments in person, such as insulting them or calling them names; had threatened them with violence in person; had made offensive or threatening gestures or stared at them inappropriately; had loitered, waited for them or deliberately followed them in a threatening way; had sent them offensive or threatening emails or text messages (SMS); or had posted offensive or threatening comments about them online – for example on Facebook or Twitter (FRA, 2020b).

([60]) EU-27: authors' calculations based on microdata.

caregivers, as well as alcohol and substance use among caregivers. The reduction of staff in long-term care facilities due to illness and self-isolation and the suspension of family visits have increased residents' isolation and the already high risk of violence, particularly against women (Šimonović, 2020).

The lack of comparable administrative or prevalence data on gender-based violence makes it difficult to capture the extent of any increase in gender-based violence during the pandemic. Since it began, media and women's organisations have reported a sharp increase in demand for services such as shelters or helplines for women victims of violence. For example, the 1522 helpline run by the Italian government received 5 031 telephone calls between 1 March and 16 April 2020, 73 % more than over the same period in 2019. In Spain, there was a 48 % increase in calls to helplines (Šimonović, 2020).

The COVID-19 crisis has exposed and exacerbated serious pre-existing gaps in the prevention of violence against women and in adequate available victim support services. An EIGE (2021a) study revealed that counter-pandemic measures introduced from March to September 2020 led to many major challenges for service providers. These include ensuring continuity of service delivery, finding new ways to provide support, meeting a surge in service demand, dealing with the strain on service provider staff, reaching victims, identifying the risk level of victims, and insufficient funding (EIGE, 2021a).

The study highlighted an important gap in crisis preparedness and crisis management planning during the pandemic's first wave. No EU Member State had a gender-sensitive disaster plan in place to address possible surges in violence against women. The COVID-19 outbreak prompted 11 countries to develop a national policy or action plan to address issues arising from an increased level of intimate partner violence, but in only three countries did the plan or policy include specific measures to tackle the issues (EIGE, 2021a).

Nevertheless, some interesting practices to protect women victims of violence were identified in the EIGE study. Eight countries used national legislation to deem support services essential, two countries used digital technology to continue criminal proceedings, and four countries introduced helplines or email/instant messaging services for victims. In addition, 11 countries provided more sheltered accommodation in either public housing or private hotels, but measures focused on removing perpetrators from the home were far less common (EIGE, 2021a).

Many victim support service providers have struggled with insufficient funding and have been forced to adapt to new ways of working, for example offering services remotely. Continuing uncertainty and spikes in COVID-19 cases and reported domestic violence cases have caused further stress. This has made it particularly difficult for service providers to ensure work–life balance for their own employees, and their health and safety. The EIGE study interviews show that support to cope with these challenges came from non-government service providers rather than from governmental institutions (EIGE, 2021a).

For many women and their children, the lack of immediate, specialised and long-term response to gender-based and domestic violence will have longer-lasting consequences than the COVID-19 pandemic. As the UN Special Rapporteur on violence against women recognises, the pandemic of gender-based violence preceded COVID-19 and will most likely outlast it (Šimonović, 2020).

9. Thematic focus

Introduction

Despite vaccine roll-outs gathering pace across the EU by mid 2021, the COVID-19 pandemic has continued to take lives, shattering initial hopes that the crisis would be short-lived. As the toll on human health and lives has grown, the intertwined social, economic and health dimensions of our lives have come into sharp relief. Although health was designated the thematic focus of the Gender Equality Index 2021 prior to the pandemic, COVID-19 has led to two important conclusions: challenges affecting people's health relate to their social and economic situation and socioeconomic inequalities are ultimately reflected in differentiated health outcomes.

This focus aims to bring together evidence on gender inequalities as a determinant of health and to explore how converging inequalities affect health outcomes. As reasons for unequal health outcomes between women and men vary, this chapter examines the role of social constructs, including masculinity and work–family roles. The focus also touches upon other broad causes of gender inequality, such as economic and public policy factors. Gender inequalities in health status, including mental health, risky health behaviours, access to health services and SRHR, are explored, while data and evidence are provided on the gendered impacts of the pandemic.

Defined by WHO, the SDH are the economic, social and environmental conditions in which people are born, grow, live, work and age, with these shaped by the global, national and local distribution of money, power and resources (WHO, 2008). Some of these factors promote health, such as better education, access to clean water and safe housing. Others can be detrimental, for example gender-based violence or gender inequalities in accessing medical services.

Different models have been proposed to understand and systematically analyse SDH. Common to these are the inclusion of a very wide range of individual social circumstances – income, education, employment, housing, neighbourhood conditions and social networks. Similarly, various structural factors, such as public policies on education, housing, health and the economy, as well as cultural contexts, are included. Social factors, individual or structural, typically receive much attention from academia and policymakers because these can be more easily modified through policy.

Individuals experience life in a gendered body with its biological endowment, implying that some health issues are sex specific, such as ovarian and prostate cancers. Gender inequality and gendered norms have an impact on health because exposure and vulnerability to disease and injuries, health-related behaviours and access to care differ between women and men. Gender-biased health research and healthcare systems also reinforce and reproduce gender inequalities (Heise et al., 2019; Sen and Östlin, 2008).

Living in a community also suggests that gender is socially constructed by norms upheld by institutional factors. This 'gender system' interacts with other power and privilege axes, for example race, class and ability, influencing an individual's social position in relation to others. Generally, a cross-cutting approach to health asserts that various factors are simultaneously at play when explaining health outcomes (Hankivsky and Christoffersen, 2008). This approach in health research, with gender an important dimension, is being increasingly taken in health inequality literature on European countries (EuroHealthNet, 2020; JAHEE; WHO, 2008, 2019e)

All domains of the Gender Equality Index have direct or indirect linkages to health inequali-

ties, with sources of inequalities ranging from individual to national levels (see Chapters 2–6 and 8). Employment, income and education are closely related and widely recognised as SDH, with gender being a significant layer to better understand inequalities in relation to these dimensions. Time use and unpaid care work, as measured by the domain of time, and access to decision-making, as reflected in the domain of power, are increasingly identified as important determinants of health (see Chapters 5 and 6). Violence per se has a direct effect on various dimensions of health, be it physical or mental. At the national level, it has also been argued that inequalities in population health, such as a gender gap in the health of older people, is more evident in gender-unequal countries (Bracke et al., 2020). A recent report also notes that, in countries with greater representation of women and greater gender equity in politics, men's health appears to improve and life expectancy increases for both women and men, with the benefit being greater for men (WHO Regional Office for Europe, 2020c).

Gendered patterns in the labour market are similarly reflected in health inequalities. Factors associated with unemployment that affect health include a lack of financial and social network resources, social isolation, stress and loss of self-esteem.

Employment can affect health directly through the physical work environment, for example exposure to toxins. Occupational cancers are estimated to account for more than 100 000 deaths a year in the EU (ETUI, 2018). Physical strain and psychosocial demands can lead to musculoskeletal disorders. According to EU-OSHA (2019), three out of every five workers in the EU report musculoskeletal complaints, with prevalence rates higher for women workers than for men. The mental health of employees can be adversely affected not only by discrimination, bullying and stress at work, but also by the financial strain that accompanies precarious employment conditions and a lack of rights and protection (Ferrante et al., 2019; Rönnblad et al., 2019). Gender differences in employment and working conditions have a major impact on work-related health outcomes for women and men. However, work-related risks to women's safety and health have been both underestimated and neglected compared with research on the work-related risks faced by men, and their prevention (EU-OSHA, 2013). Occupational health policies and prevention practices also continue to be built on a gender-neutral model of 'workers', although the referent is implicitly male (ETUI, 2021). The gender mainstreaming of occupational safety and health is, therefore, very important (ILO, 2013).

Income, material resources and education affect access to important factors directly influencing health. These include access to medical treatment, housing, food and knowledge on health and healthcare systems. The gender role here is often unexplored. In the rare cases where it has been explored, a systematic review of the effect of income change on health, for example, argues that higher income does not always mean significant positive change for women (Gunasekara et al., 2011).

The primary responsibility to provide health and social care lies with Member States. While the EU can complement and support national policy, it is unable to determine it except in a few areas, such as research and cross-border threats (E. Brooks et al., 2020).

Ensuring universal access to appropriate, affordable and quality healthcare is an EU policy priority. The European Pillar of Social Rights demonstrates this by making such access a right (European Commission, 2019). Universal healthcare coverage is also a target of Goal 3 of the UN Sustainable Development Goals (SDGs) (UN, 2015). To implement the SDGs in the EU, the Commission adopted a sustainable development package in 2016 to help Member States achieve this goal. In 2020, the EU gender equality strategy reaffirmed the commitment to integrate a gender perspective in all Commission health initiatives, for example the EU's Beating Cancer Plan (European Commission, 2021c).

To help address the growing need for health and social care among older people in an ageing population, the EU has implemented policies focused on 'active ageing'. These aim to improve

older people's health, ensure that health and social care systems are sustainable, and contribute to the competitiveness of EU industry (European Commission, 2018). The Green Paper on Ageing calls for reforms and investments in long-term services, as well as renewed efforts to reduce gender gaps in employment, pay and pensions to prevent old-age poverty and social exclusion, especially among women (European Commission, 2021g).

Access to mental healthcare has also been an EU priority for many years. The European Framework for Action on Mental Health and Well-being highlights the challenge of meeting the mental health needs of women, while stressing the need for health services to be gender sensitive (EU Joint Action on Mental Health and Well-being, 2016). In addition, a European Parliament resolution on promoting gender equality in mental health and clinical research emphasised the gendered aspects of mental health and called for further action by the Commission and Member States. It highlighted the importance of clinical trials reflecting the needs of those who would use the products, and called for the collection of sex-disaggregated data to identify gendered differences in side effects (European Parliament, 2017). The implementation of the Clinical Trials Regulation ([61]) may help address ongoing inequalities (EIWH, 2018).

Following reverses on women's rights and gender equality in the EU, a 2019 European Parliament resolution found that regression on key areas, such as SRHR, was common across Member States (European Parliament, 2019).

Yet another European Parliament resolution, in July 2020, on the EU's public health strategy post COVID-19, acknowledges that access to SRHR services has been affected by the pandemic, and that women, children and LGBTQI people have faced a higher risk of violence and discrimination (European Parliament, 2020). The European Parliament calls on Member States to guarantee learning on the cognitive, emotional, social, interactive and physical aspects of sexuality (sexuality education), ready access to family planning for women, and the full range of SRH services during or outside crises, including modern contraceptive methods and safe and legal abortion.

9.1. Gender inequalities in health in the European Union

9.1.1. Gender differences in health reflect lifelong inequalities

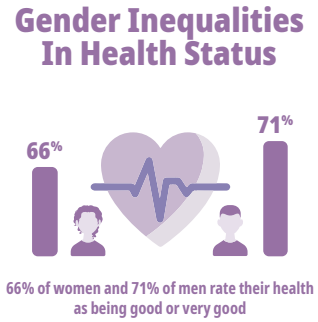
NCDs are the leading cause of poor health in the EU, with varying impacts on women and men. Exposure and vulnerability to NCDs is shaped by biological factors, as well as gender roles and norms (WHO, 2019g). In particular, gender-specific mental health disorders also have different impacts on health status. Poor mental health also contributes to the overall burden of NCDs, including cardiovascular diseases, diabetes and cancer ([62]) (Pikhart and Pikhartova, 2015; Stein et al., 2019).

This section covers specific aspects of the health status of the EU population from a gender perspective, namely self-reported health, health limitations, the main causes of premature death, mental well-being and the prevalence of mental disorders. It also explores how social determinants and gender norms affect health.

([61]) Clinical trials - Regulation EU No 536/2014, https://ec.europa.eu/health/sites/default/files/files/eudralex/vol-1/reg_2014_536/reg_2014_536_en.pdf.

([62]) Mental health is considered an important factor in NCDs, with a meta-analysis by WHO showing that psychosocial factors affect NCDs in Europe and, particularly, that 'Psychosocial distress may also have a direct effect on NCDs such as coronary heart disease independent of these other factors' (Pikhart and Pikhartova, 2015).

Men are more likely to perceive their health as good

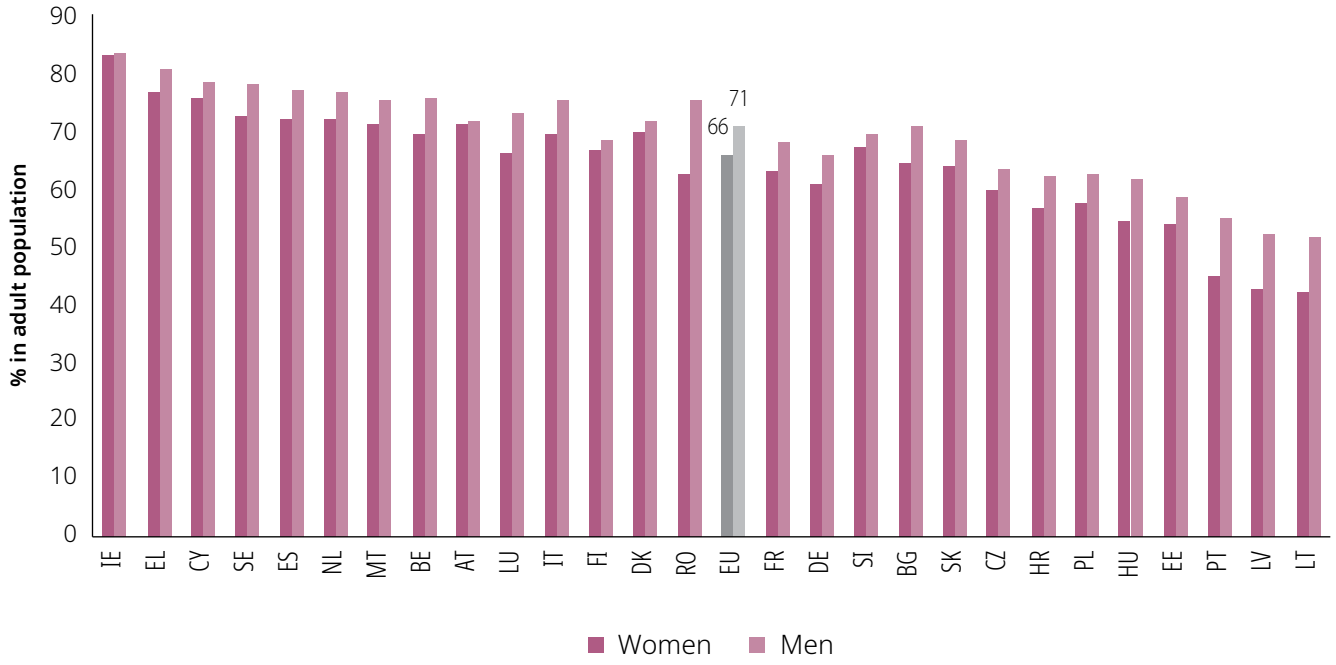


Self-reported health (self-rated health, self-assessed health or self-perceived health) is a person's subjective evaluation of their current health status (Lorem et al., 2017). Overall, women tend to report worse health than men (Nesson and Robinson, 2019), except on hearing problems and cardiovascular diseases (Caroli and Weber-Baghdiguian, 2016). In a 2002–2004 study of 59 countries globally, women reported significantly poorer health than men on all self-reported health indicators at all ages – although differences were smaller from 60 years onwards – and in all regions, with the smallest disparities in high-income European countries (Boerma et al., 2016).

In the EU-27, 66 % of women and 71 % of men perceive their health to be good or very good (Figure 24). Gender gaps in self-reported health are greater in Portugal, Latvia and Lithuania (10 p.p.), and in Romania and Bulgaria (9 p.p.). Only in Ireland do women and men equally perceive being in good health. The share of women considering themselves in good health is lowest in Hungary, Estonia, Portugal, Latvia and Lithuania.

Among adolescents, gender gaps in self-reported health are slightly more pronounced than for the adult population, with 30 % of girls and 39 % of boys rating their health as excellent ([63]).

Figure 24. Women and men perceiving their health as good or very good by EU Member State (%, 16+ years, EU, 2019)

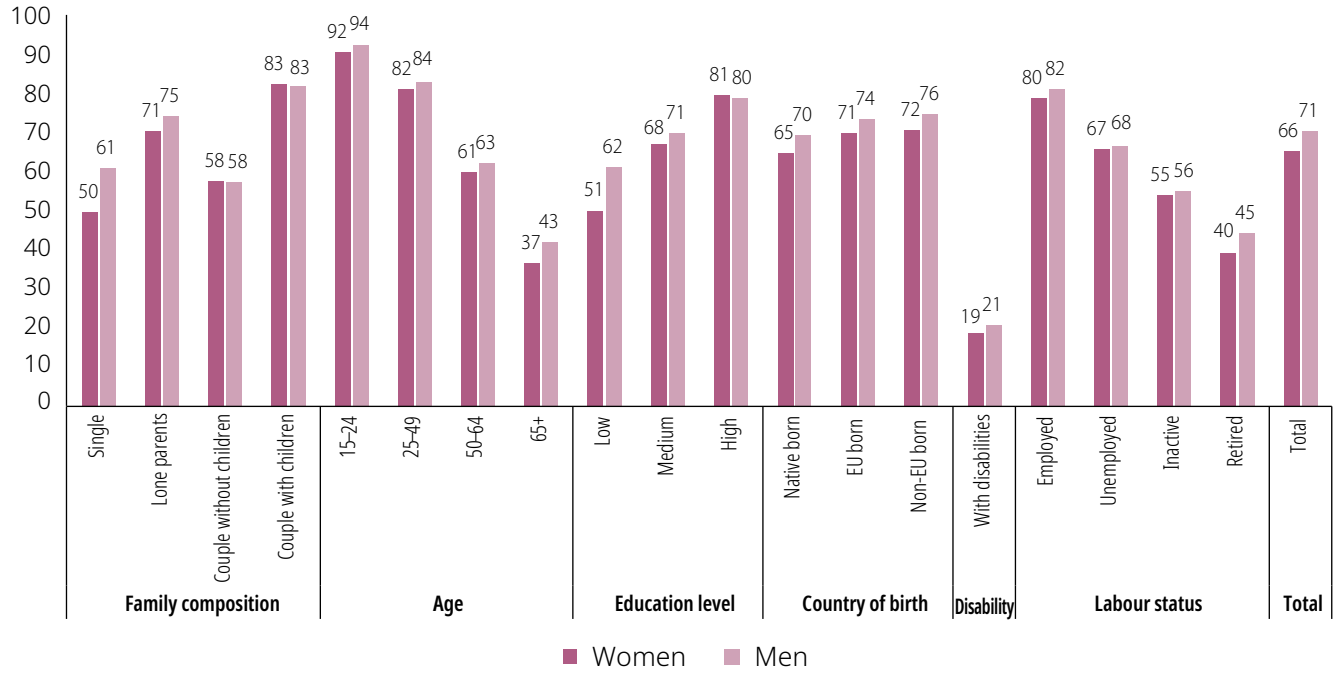


Source: Eurostat, https://ec.europa.eu/eurostat/web/products-datasets/-/hlth_silc_01.

Age, disability and education are important markers in shaping individual health status, with self-reported health levels the lowest for women with disabilities, women over 65 years and retired women (Figure 25).

([63]) Health Behaviour in School-aged Children (HBSC) survey for children aged 11, 13 and 15 years, 2017/2018. Authors' calculations. NB: EU: unweighted average.

Figure 25. Women and men perceiving their health as good or very good by sex, family composition, age, education, country of birth, disability and labour status (%, 16+ years, EU, 2019)



NB: EU-born and non-EU born are based on 21 countries (DE, EE, LV, MT, RO and SI are excluded).
Source: Authors' calculation with microdata, EU-SILC, 2019 (IE, IT, 2018).

Table 19 in Annex 4 presents the share of people across population groups reporting their health as being good or very good from various data sources. It signalises how gender intersects with income levels, living environments (rural, suburban or urban), sexual orientation and migration status to determine a person's likelihood of having good health.

According to WHO, many conditions and factors impacting people's health are not under individual control. These include income, social status, education, physical environment, social support networks, genetics, health services and gender.

Research has highlighted gender-specific effects of three major SDH – education, employment and income levels. Education has long been known to be a crucial life resource for maintaining good health. Research in nine EU countries shows that higher levels of education have positive effects on the health of women and men (Uccheddu et al., 2019), particularly in countries promoting more women's employment. Similarly, an analysis based on EU-SILC data indicates both that the probability of poor self-perceived health generally is higher among women than among men and that the biggest gender differences in self-perceived health are among individuals with relatively low levels of education in countries with the greatest gender employment gaps, that is in southern and eastern European countries (Gumà et al., 2019).

Employment status influences people's health through income, social status and its impact on distress (Marmot et al., 2012).Employment and higher quality of work are linked to bette r health at individual level (Barnay, 2016; Henseke, 2018). Although working has a significant positive impact on the health of women and men, its effects are stronger for men (Hosseinpoor et al., 2012). In the EU, working women and men are more likely than those not in paid work, the unemployed or retirees to rate their health as good or very good (Figure 25).

Lack of paid work is likely to affect women's health disproportionately. For instance, Boerma et al. (2016) found that greater gender gaps in

employment and education lead to greater gender gaps in health assessment, to women's detriment. This is particularly the case in Greece, Spain, Cyprus and Portugal, where women's labour market participation is low (Palència et al., 2014) . Therefore, being in employment may result in lower health gains for women than for men, but being employed still leads to better health outcomes than being unemployed. Gender inequalities in employment and working conditions are also connected to inequalities in health. Precarious employment is considered an SDH (Benach et al., 2014; Siegrist et al., 2016). For example, a review of 27 studies found that temporary work explained between 11 % and 23 % of the variation in poor mental health (Vives Vergara, 2010). Less is known about how gender inequalities in employment and occupational position are related to health and health inequalities. An umbrella review of macroeconomic determinants of health shows that job promotion and improved working conditions can help enhance health and reduce gender-based health inequalities (Naik et al., 2019).

Income is closely linked to individual health – higher income supports good and improved health, while better health enables higher income (Deaton, 2002; Smith, 1999). Income could be causally related to health through a direct effect on the material conditions necessary for biological survival, and indirectly through social participation and ability to control life circumstances that condition health and health risks (Lynch et al., 2004; 2002). Depending on the healthcare system, level of income determines whether healthcare is affordable and accessible because it affects an individual's ability to pay for medical services out of their own pocket (OECD/European Union, 2018). The effect of income on health varies according to gender. A quantitative meta-analysis (Furnée et al., 2011) found significant income-related variation in self-reported poor health between women and men in different countries, even if income or standards of living were comparable.

The extent to which income impacts health status across the EU depends on country-specific contexts. Factors such as pension and wage policies play an important role (Paul Leigh et al., 2019). They are particularly relevant to the health and well-being of older people, especially women, whose income in old age reflects limited economic independence and the cumulative effect of gender inequalities over a lifetime ([64]) (EIGE, 2015, 2016, 2020e, 2020g).

Women are more likely to have health limitations over their lifetime

One in four adults in the EU reports that health problems affect what they can usually do ([65]), ranging from 9 % of people younger than 25 years to 40 % of those aged between 65 and 74 years. As health limitations increase with age and affect women and men differently, any analysis of ill health must consider age, gender and the severity of limitations.

Women suffer greater health limitations than men in all age groups (Figure 26). This is attributed to women being more likely than men to report symptoms of ill health. While normative masculinity is closely associated with physical strength and independence, seeking treatment and discussing symptoms is considered more socially acceptable for women.

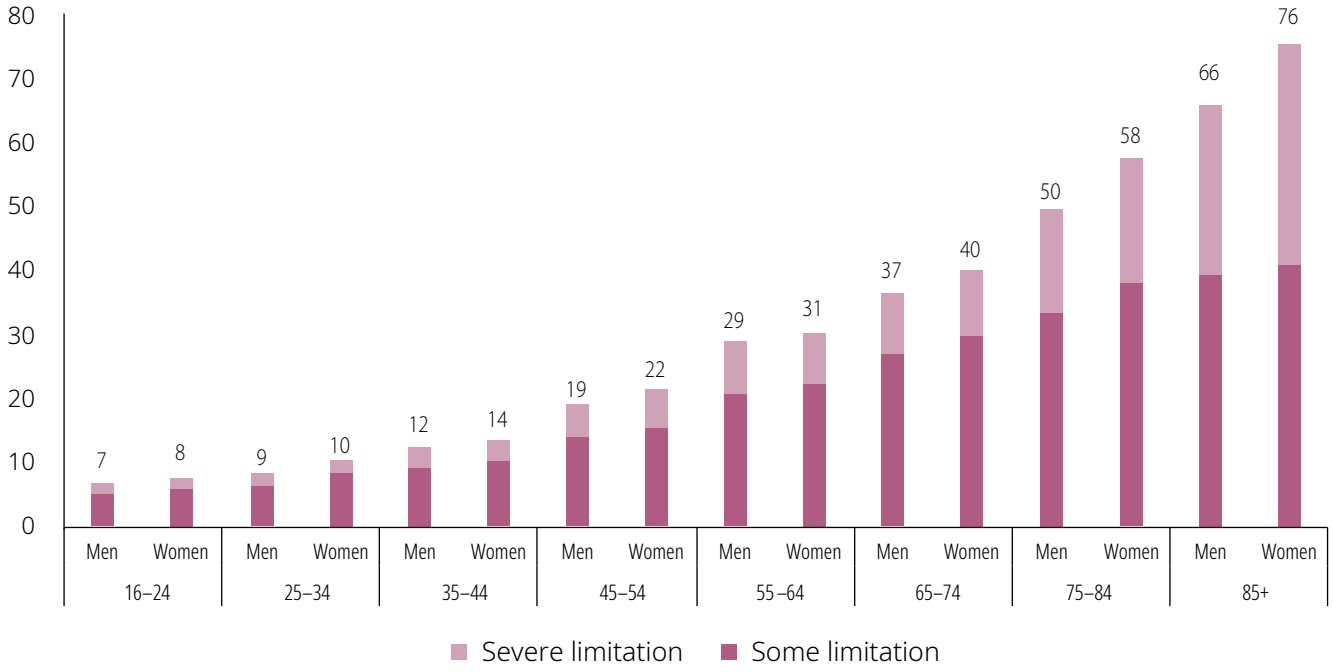
Women are also affected by disabilities and chronic conditions from a younger age and to a greater degree than men (WHO and World Bank, 2011). Reasons include unmet needs for medical examinations, poor working conditions and low socioeconomic status, and gender-based violence (Garcia-Moreno and Watts, 2011; WHO, 2016d).

These factors help explain why gender differences in the extent to which health limitations affect daily activities are higher among older groups, to women's detriment (Ogg and Rašticová, 2020). For example, among those aged

([64]) The financial impact of gender inequalities over the life course is reflected in the gender pension gap. In the EU in 2019, the average pension received by women at age 65 was 30 % lower than that of men. Eurostat, EU-SILC survey, https://ec.europa.eu/eurostat/web/products-datasets/-/ilc_pnp13.

([65]) Eurostat, Health variables of EU-SILC, https://ec.europa.eu/eurostat/web/products-datasets/-/hlth_silc_06, 2019.

Figure 26. Women and men limited in their usual activities because of health problems, by age group and level of difficulty experienced (%, EU, 2019)



NB: Data labels refer to the total percentage of women and men of each group reporting some or severe health limitations.
Source: Eurostat, EU-SILC 2019, https://ec.europa.eu/eurostat/web/products-datasets/-/hlth_silc_06.

55–64 years, the proportion of individuals who report that everyday activities are limited by their health is only 2 p.p. higher among women than among men, at 31 % and 29 %, respectively Among those aged between 75 and 84 years, that difference rises to 8 p.p.: 58 % of women and 50 % of men.

The greater likelihood of women experiencing poor health is supported by data on healthy life years. Women and men in the EU can expect to be in good health until 65 and 64 years of age ([66]), respectively. However, as women tend to live longer, more of their life is spent in poor health – an average of 19 years, compared with 14 years for men ([67]) (Bambra, Albani, et al., 2020; EIGE, 2019c; WHO, 2016d, 2018b). While women appear to have a 'mortality advantage', it is offset by this higher morbidity (Bambra, Albani, et al., 2020; EIGE, 2019c; WHO, 2016d, 2018b), a phenomenon described by some as the 'gender and health' paradox (Bambra, Albani, et al., 2020; Doyal, 1995).

Gender differences across various indicators of self-reported health can also be accentuated by significant gender gaps in health literacy ([68]). Several studies show that women are more likely to have general health knowledge and understanding, including of public health guidelines, common symptoms of specific health problems and their own health status (Baker, 2019). Lower levels of health literacy are associated with lower levels of information-seeking behaviours (Beck et al., 2014; Manierre, 2015; Nölke et al., 2015; Saab et al., 2018) and with men not seeking timely help for cancer symptoms (Baker, 2019; Fish et al., 2019).

([66]) Eurostat, mortality data, https://ec.europa.eu/eurostat/web/products-datasets/-/hlth_hlye, 2019.
([67]) 'Years of ill health' is defined as a difference between 'life expectancy at birth' and 'healthy life years'. Healthy life years and years of ill health add up to expected life expectancy at birth. Eurostat, mortality data, https://ec.europa.eu/eurostat/web/products-datasets/-/hlth_hlye, 2019.
([68]) WHO defines health literacy as 'the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health' and explains that 'health literacy implies the achievement of a level of knowledge, personal skills and confidence to take action to improve personal and community health by changing personal lifestyles and living conditions' (Nutbeam, 1998).

The main causes of premature mortality are gendered

Life expectancy at birth is defined as how long a newborn can expect to live, on average, if current death rates do not change. As a main indicator of human longevity, life expectancy is often used to characterise the health status of a population (Johnson et al., 2020). On average, women in the EU are expected to live until 84 years of age, which is 5.5 years more than men, at 78.5 years. However, this figure varies substantially between countries ([69]) (Franklin et al., 2021; OECD/European Union, 2020).

As mentioned in the domain of health chapter (see Chapter 7), COVID-19 has negatively affected life expectancy in most EU countries, particularly for men.

The gender gap in life expectancy is often attributed to a combination of biology and modifiable factors, such as risky behaviour, smoking and excessive alcohol consumption (Kolip, 2012; Stephens et al., 2017), as well as the different societal roles of women and men (Hoffmann et al., 2018). Men's lower life expectancy reflects their thinking on masculinity and way of life, which determines their exposure to risk, their health-seeking behaviours and how health providers address men and their health needs (WHO Regional Office for Europe, 2018).

Education – one of the most documented social determinants of life expectancy – is used to measure the impact of social and economic status on longevity. Here, too, men are particularly affected. The OECD found that the average difference in life expectancy among 30-year-old men between those without an upper secondary education and those with a tertiary education was 7 years. The impact of education is particularly notable – amounting to a difference of 10 years – in Hungary, Poland and Slovakia (OECD/European Union, 2020). Similarly, studies show that women educated to tertiary level live longer than those with lower qualifications (WHO, 2016d). For example, Roma women have a shorter life expectancy than women in the population at large (EPHA, 2018).

Such gender differences are reflected in data on causes of premature mortality in EU countries. Men are more likely than women to die from causes related to risky health behaviour. According to Global Burden of Disease (GBD) 2019 data ([70]), the rate of premature mortality ([71]) from external causes, such as accidents, suicides, injuries, homicides and other violent deaths, is higher among men (10 %) than among women (5 %).

The main causes of premature death among adults also affect women and men to different degrees (Table 3). For example, while cardiovascular diseases and strokes are the principal causes of death for both women and men, many more men than women die from ischaemic heart disease (+ 31 p.p.). As WHO notes, such diseases are perceived as men's issues, with health systems tending to minimise or overlook risk factors in women (WHO, 2016d).

Among other common causes of premature death for men are liver disease and suicide – ranking sixth and seventh, respectively. Alzheimer's disease and other dementias, as well as hypertensive heart disease, are among the most common causes for women – ranking fifth and ninth, respectively. Sex-specific cancers similarly lead to significant early loss of life among women and men. Breast cancer is the third highest-ranking cause of premature death for women, while prostate cancer ranks eighth for men.

([69]) Life expectancy by age and sex, https://ec.europa.eu/eurostat/web/products-datasets/-/demo_mlexpec, 2019. Data extracted on 8 April 2021.

([70]) The GBD data set is a collection of a wide range of data, including from the national health registries, as well as health-related survey evidence. More information on the list of data sources used can be found online http://ghdx.healthdata.org/gbd-2019.

([71]) Years of life lost because of premature mortality are calculated by multiplying the number of deaths by the standard life expectancy at the age of death.

Table 3. Leading causes of premature mortality among women and men (number of years of life lost, 20+ years, EU, 2019)

Cause	Women	Men	Gender gap (p.p.)
Ischaemic heart disease	5 406 350	7 832 577	31
Stroke	3 613 705	3 315 024	– 9
Tracheal, bronchus and lung cancer	2 114 608	4 545 089	53
Colon and rectum cancer	1 541 334	2 079 668	26
Chronic obstructive pulmonary disease	1 293 433	1 945 706	34
Alzheimer's disease and other dementias	1 918 196	978 477	– 96
Cirrhosis and other chronic liver diseases	832 997	1 839 797	55
Self-harm	496 962	1 801 050	72
Lower respiratory tract infections	1 036 074	1 244 853	17
Pancreatic cancer	932 009	1 090 042	14
Diabetes mellitus	771 538	868 921	11
Chronic kidney disease	760 603	737 302	– 3
Stomach cancer	529 536	894 968	41
Sex-specific cancers			
Prostate cancer		1 500 678	
Breast cancer	2 276 349		
Ovarian cancer	768 439		

Source: Number of years of life lost, 2019, GBD. Authors' calculations.
Note: Ranked by order of total number of years of life lost

Data from the European Cancer Information System shows that in 2020 more men than women were diagnosed with cancer, with men accounting for 54 % of cancer diagnoses in that year (and women 46 %). Most new cases among men are lung, colorectal and prostate cancer. For women, breast cancer is the most prevalent, at 29 %, followed by colorectal cancer at 12 %, and lung cancer at 9 % (OECD/European Union, 2020).

Gender differences in death associated with mental health, such as dementia, suicide and alcohol and drug abuse, are particularly stark. For example, in 2018, the rate of mortality from overdoses among people aged between 15 and 64 years was 22.3 per million, but the rate was almost four times higher among men than among women. Men aged between 35 and 44 years were most affected, with a mortality rate of 53.7 deaths per million. This is more than double the average for all ages, and more than three times the rate of mortality from overdose of women in the same age group, which was 13.9 deaths per million (European Monitoring Centre for Drugs and Drug Addiction, 2020).

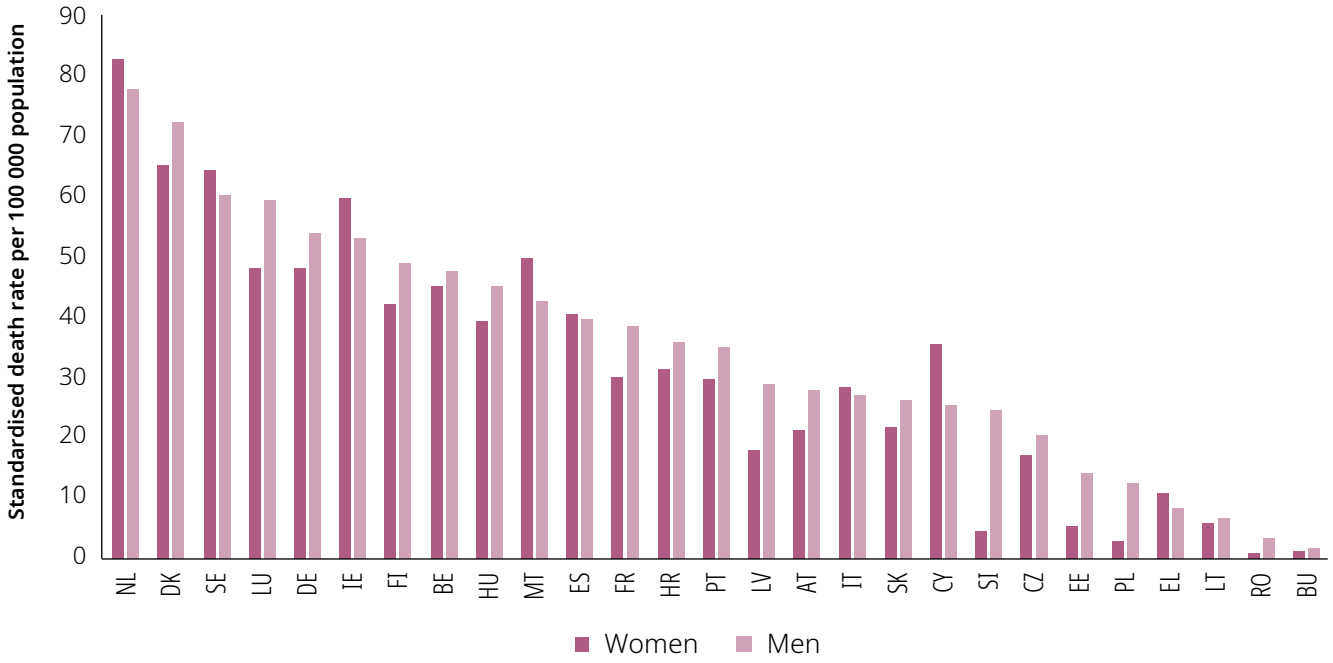
Eurostat's mortality data on suicide and mental and behavioural disorders, including deaths from alcohol and drug abuse, also reveals that more men than women die from these causes (Figure 27) ([72]).

([72]) To account for the yearly variations in death rates, particularly in small countries and due to specific causes, a 4-year average (2014-2017) age-standardised death rate is used.

Only in eight countries – Cyprus, Greece, Ireland, Italy, Malta, Netherlands, Spain and Sweden – do more women than men die of mental and behavioural disorders. This can be attributed to the high prevalence of Alzheimer's disease and other dementias among women. In those countries where mortality from mental and behavioural disorders is higher among men, the difference is mainly due to a large gender gap in deaths from alcohol-related causes.

A systematic review highlights that men are more likely than women to die from suicide, although more young women than young men attempt suicide (Miranda-Mendizabal et al., 2019) ([73]). Gender differences in suicide are large, especially in central and eastern Europe. Here, the age-standardised mortality rate for suicide is five times higher for men than for women. In western Europe, it is 3.3 times higher for men than for women (Naghavi, 2019).

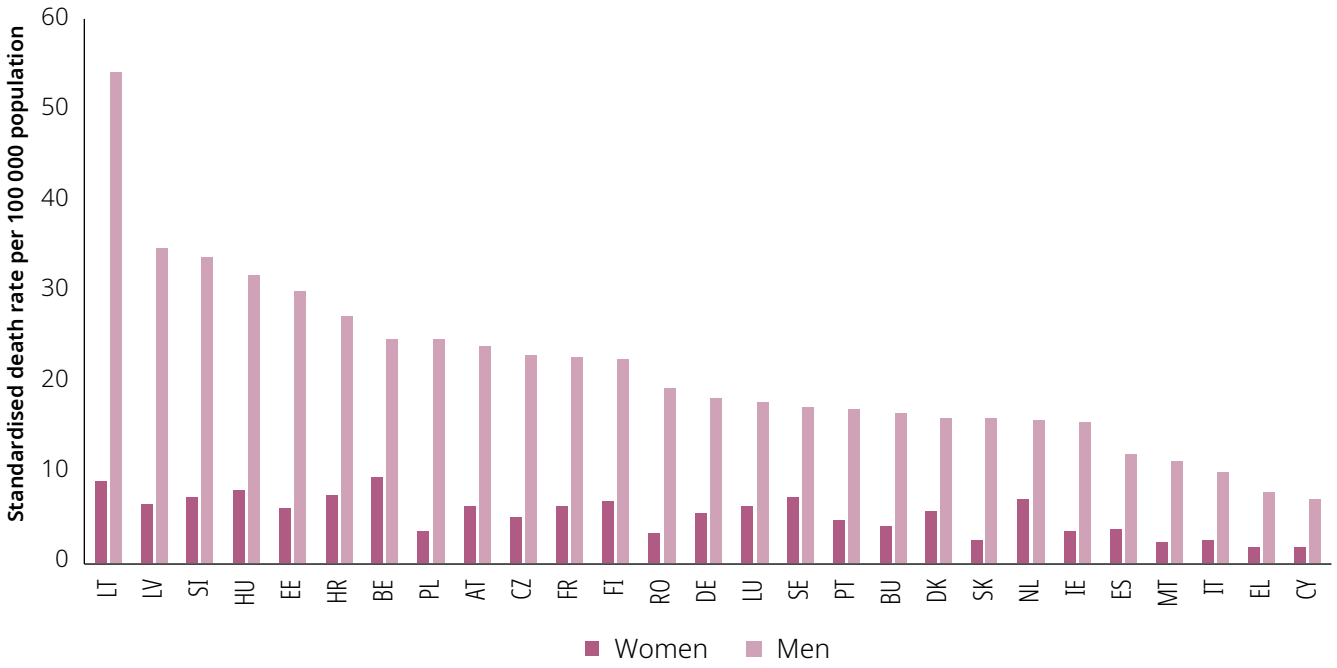
Figure 27. Death rate of women and men due to mental and behavioural disorders, by EU Member State (% per 100 000 population, 2014–2017 average rate)



NB: EU-27 average not available. Mental and behavioural disorders include dementia and mental and behavioural disorders due to use of alcohol, drug dependence and toxicomania, as well as other mental and behavioural disorders.
Source: Eurostat, https://ec.europa.eu/eurostat/web/products-datasets/-/hlth_cd_asdr2.

([73]) A number of different theories have been proposed to explain the higher proportion of non-fatal suicidal behaviour among womenand the preponderance of menwho complete suicides. These include men's choice of more lethal methods for suicide; women's better recall of suicide attempts in social surveys; higher levels of alcohol and drug abuse, and other perceived 'masculine' self-destructive behaviours, among men; and men's reluctance to seek help, and related underdiagnosis of mental health problems, but also poor treatment compliance among men (Mościcki, 1994; Schrijvers et al., 2012).

Figure 28. Death rate of women and men due to intentional self-harm, by EU Member State (% per 100 000 population, 2014–2017 average rate)

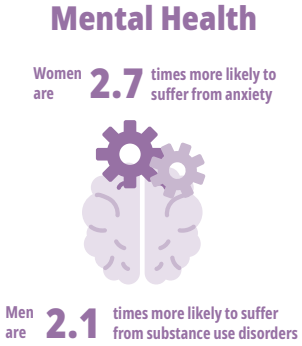


NB: EU-27 average not available.
Source: Eurostat, https://ec.europa.eu/eurostat/web/products-datasets/-/hlth_cd_asdr2.

Similarly, deaths from intentional self-harm are far more prevalent among men than women in all EU countries (Figure 28). The variations in suicide rates between countries are particularly large among men, while differences among women are much smaller. Gender differences in deaths from self-harm are particularly evident in central and eastern Europe.

Women report poorer mental well-being than men

Mental health is defined as the state of well-being in which individuals can realise their own potential, cope with the normal stresses of life, work productively and contribute to their community (WHO, 2018a). Mental health disorders refer to a wide range of conditions affecting mood, thinking, behaviour and relationships with others. With the COVID-19 pandemic posing an unprecedented challenge to collective mental well-being, mental health issues could hamper recovery if they are not addressed.



Understanding how poor mental health affects women and men, and the role that gender norms and relations play in shaping it, can help improve overall health status in the EU. The following sections give an overview of gender differences in mental health over the life course and explore how gender contributes to shaping mental health.

Developed in 1998 by the WHO Regional Office in Europe, the WHO-5 ([74]) measures current

([74]) The WHO-5 is a short, self-reported measure of current mental well-being of the EQLS. The WHO-5 consists of five statements, which respondents rate on a scale from 0 (at no time) to 5 (all of the time) in relation to the preceding 2 weeks. The five statements are (1) I have felt cheerful and in good spirits, (2) I have felt calm and relaxed, (3) I have felt active and rigorous, (4) I woke up feeling fresh and rested and (5) My daily life has been filled with things that interest me. The total raw score, ranging from 0 to 25, is multiplied by 4 to give the final score, with 0 representing the worst imaginable well-being and 100 representing the best imaginable well-being.

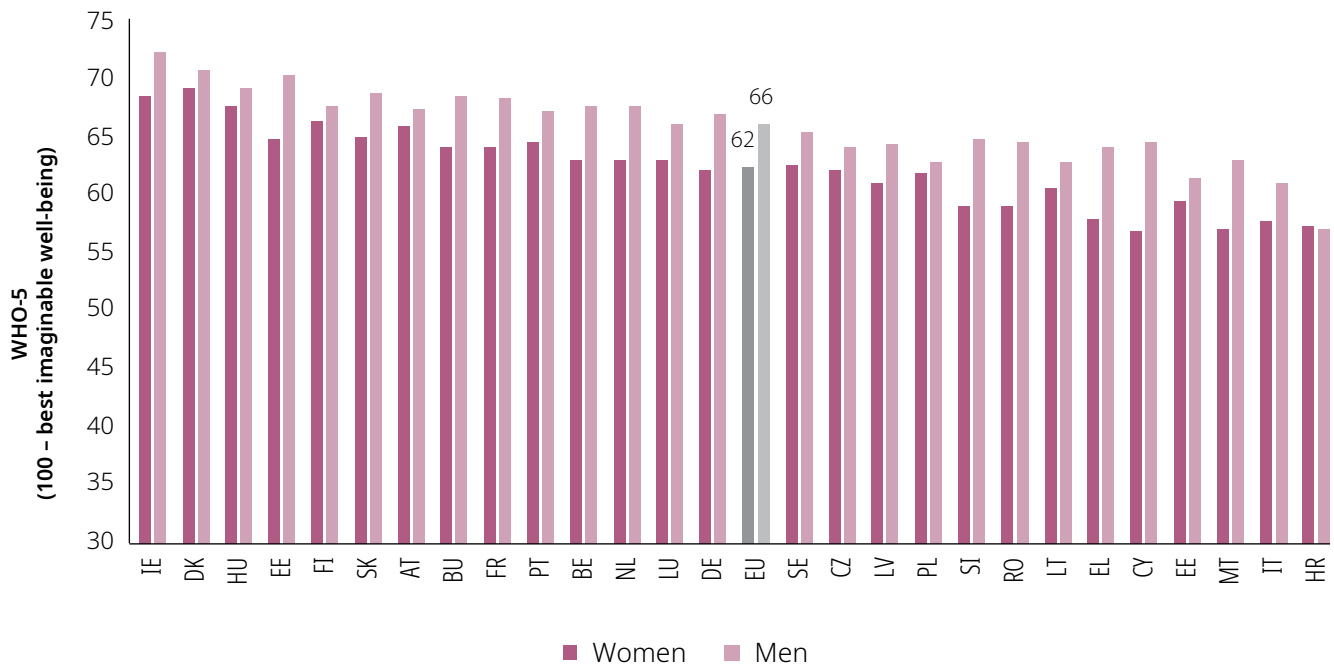
mental well-being. It is considered a valid tool for measuring mental health and screening depression in various populations (Topp et al., 2015; WHO, 1998).

Analysis of the WHO-5 2016 – where a score of 100 represents the best imaginable well-being, while scores of 50 or lower indicate risk of depression – shows that the self-rated mental health index among those over 18 is slightly higher for men than for women.

The average score in Europe is 66 points for men and 62 points for women. Women, as well as showing lower levels of mental well-being (Dreger et al., 2016), are significantly more likely to report feeling unhappy, depressed unable to overcome problems and a loss of self-confidence (Olafsdottir, 2017).

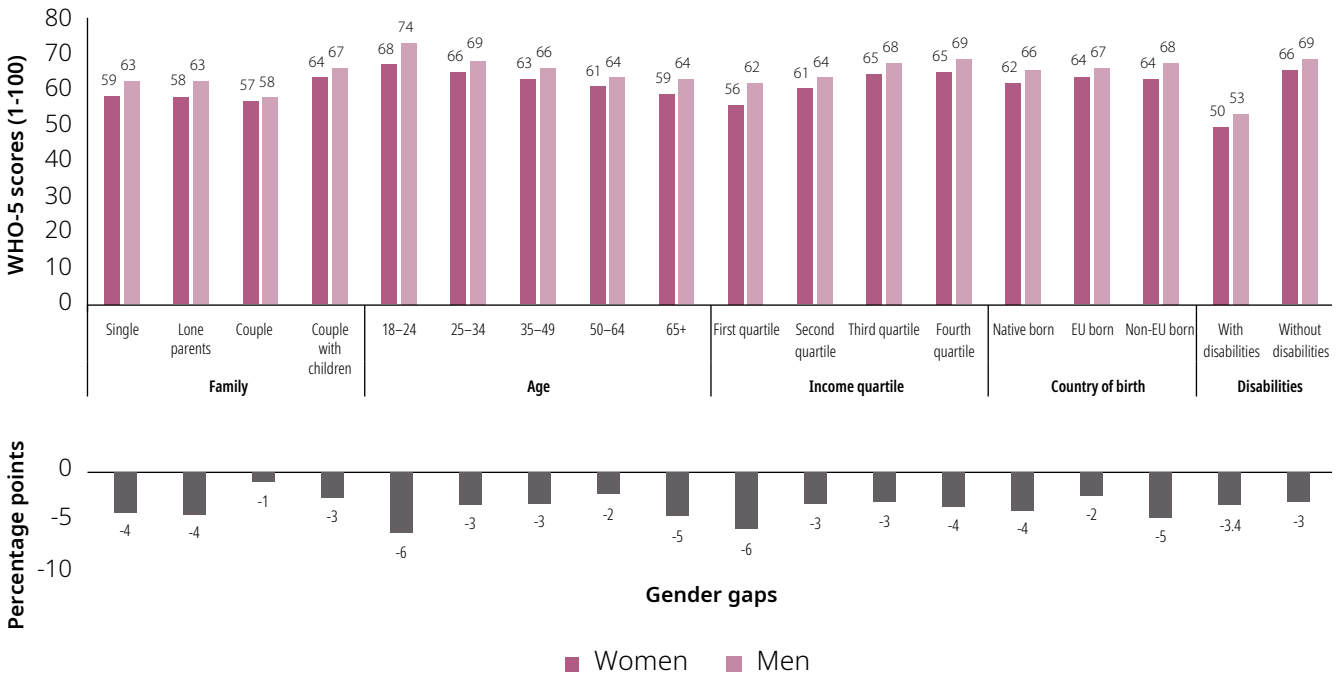
Mental well-being varies across European countries. It is highest for men in Ireland and Denmark, at above 70 points, and lowest in Croatia and Italy, at below 60 points. Although there are clear differences between Member States in self-rated mental well-being, gender differences are small, with an average gap of 4 points (Figure 29).

Figure 29. Self-rated mental well-being of women and men according to the WHO-5, by EU Member State (points out of 100, 18+ years, 2016)



Source: EQLS, 2016. Countries are sorted by their overall WHO-5 scores.

Figure 30. Self-rated mental well-being of women and men according to the WHO-5, by sex, family composition, age, income level, country of birth and disability status (points out of 100, 18+ years, EU, 2016)



Source: Authors' calculations, EQLS, 2016.

Analysis of self-assessed mental well-being across population groups (Figure 30) shows that women report lower levels of mental well-being regardless of family composition, age, income level, country of birth or disability. Further assessment of levels and gender gaps indicates that social determinants of mental health are potentially at play.

Family structure can also impact mental health. (Figure 30). Caregiving is an important factor influencing the physical and mental health of those providing care, who experience accumulated chronic stressors and often neglect their own health (Young et al., 2020).

Research in Europe shows that being a lone mother or father has a substantial effect on depressive symptoms, regardless of gender (Niedzwiedz et al., 2016) . Similar results have been found in other studies, with single parents suffering worse mental health than couples with children (Chiu et al., 2017; Wade et al., 2011). However, single parenthood can affect the health of mothers and fathers differently. One study found mortality from all causes to be higher among lone fathers (Chiu et al., 2018) while another found that lone mothers had worse mental health than other parents (Collings et al., 2014).

While lone parents are generally agreed to be at increased risk of mental health problems, the combined impact of family structure and gender on mental health can depend on the country and its welfare environment (Niedzwiedz et al., 2016; Palència et al., 2017). On average in the EU, lone mothers report poorer mental well-being than lone fathers (Figure 30). As women are far more likely to be lone parents than men, poor mental health and other single-parent challenges affect a larger proportion of mothers than fathers.

Self-assessed mental health declines with age for both women and men, but is lower for women in all age groups. The gender gap for good mental health is highest among young adults aged 18–24 years, with men scoring 74 points and women 68 points. The gap is lower among those aged 25–64 years, rising again in retirement (Figure 30). Girls are also more likely to

self-report lower levels of life satisfaction (Currie, 2016; Inchley et al., 2020). Data from the Health Behaviour in School-aged Children (HBSC) survey reveals that 63 % of boys aged 11–15 years in the EU are satisfied with their life, compared with 56 % of same-age girls ([75]). Similarly, girls of this age are much more likely than boys to report multiple health complaints – 44 % and 29 %, respectively – possibly indicating higher levels of somatisation among girls ([76]).

Women and men with a higher income have better well-being than those with a lower income. Data shows that income increase affects the mental well-being of women slightly more than it does men. The difference in women's mental well-being index score between the lowest and highest income groups is 9 points. For men, it is 7 points. The gender gap is highest in the lowest income quartile, reiterating how women's mental health suffers more when their socioeconomic status is low. The same data set also indicates similar findings for education, although gender differences are lower. There is an 8-point difference in women's mental well-being between those with the lowest and those with the highest levels of education; for men, the difference is 6 points. However, men tend to benefit slightly more in terms of mental well-being when moving from unemployment to employment – by 7 points, compared with 6 points for women. While the findings mirror the analysis of self-reported health, it is important to note that these differences are small and more data is needed to explore these relationships further. Generally, research evidence confirms that social exclusion and material deprivation are the strongest social determinants of poor mental health (Dreger et al., 2014).

Despite limited available data, mental health has clearly and significantly suffered during the pandemic, as discussed in Section 9.2.2.

Gender differences in mental disorders begin early in life

Mental health disorders are defined using international diagnostic criteria, such as the those in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) (American Psychiatric Association, 2020), or the International Classification of Mental and Behavioural Disorders (WHO, 2020e). Large-scale meta-analyses have identified mood complaints, including depression, anxiety and substance use disorders (SUDs), as the most common mental health conditions among adults (Baxter et al., 2013; Steel et al., 2014) .

Depending on how they manifest, mental illnesses are often broadly classified as either internalising or externalising disorders. Internalising disorders are characterised by thoughts and emotions within oneself and include mood disorders and anxieties. Externalising disorders are primarily denoted by actions in the external world, and include SUDs and attention-deficit hyperactivity disorder (ADHD). Across the EU, women have consistently higher rates of internalising disorders, for example depression, anxiety, phobias, and suicidal thoughts and attempts. Men self-report twice as high levels of externalising disorders, such as alcohol abuse, ADHD, and conduct and drug-use disorders (Boyd et al., 2015).

Mental health disorders among children and youth

According to WHO, half of all mental health conditions begin by 14 years of age, but most are undetected and untreated (WHO, 2020c). Mental health disorders are one of the most common sources of disease burden in children and young people, particularly adolescent girls (Baranne and Falissard, 2018). WHO estimates that between 10 % and 20 % of adolescents globally experience mental health conditions,

([75]) Health Behaviours in School-aged Children (HBSC) 2017/2018. Authors' calculations NB: EU: unweighted average.

([76]) Health Behaviours in School-aged children (HBSC) 2017/2018. Authors' calculations NB: EU: unweighted average. Young people were asked how often they had experienced the following symptoms in the last 6 months: headache; stomach ache; backache; feeling low; feeling irritable or bad tempered; feeling nervous; difficulties in getting to sleep; and feeling dizzy. Response options for each symptom ranged from 'about every day' to 'rarely or never'. Findings presented here show the proportions with multiple (two or more) health complaints more than once a week in the last 6 months.

making it critical to investigate causes of poor mental health and to intervene as quickly as possible during childhood and adolescence.

Gender-specific data on pre-school children's mental health is scarce. More evidence on gender differences is available 10-19-year-olds. Boys are generally more affected by autism, particularly Asperger's syndrome, anxiety and conduct disorders, while girls tend to suffer from anxiety, conduct disorders and depression (Baranne and Falissard, 2018).

Among children and adolescents aged 6–17 years and 5–17 years, the prevalence of ADHD and conduct disorders is estimated at around 5 % and 3 %, respectively (Wittchen et al. 2011). Boys are three times more likely to be affected by both ADHD and conduct disorders than girls. The prevalence of common mental health disorders among adolescents, for example depressive and anxiety disorders, is estimated at between 25 % and 31 %, depending on the diagnostic criteria, with girls more affected (S. A. Silva et al., 2020). Regarding overall self-reported mental health, 10 % of boys and 14 % of girls aged 11 years in 28 European countries noted 'feeling low' more than once a week, on average (OECD, 2018). These figures rise significantly with age; gender differences become more pronounced, with 29 % of girls aged 15 years saying they felt low, compared with 13 % of boys the same age.

Mental health disorders among adults

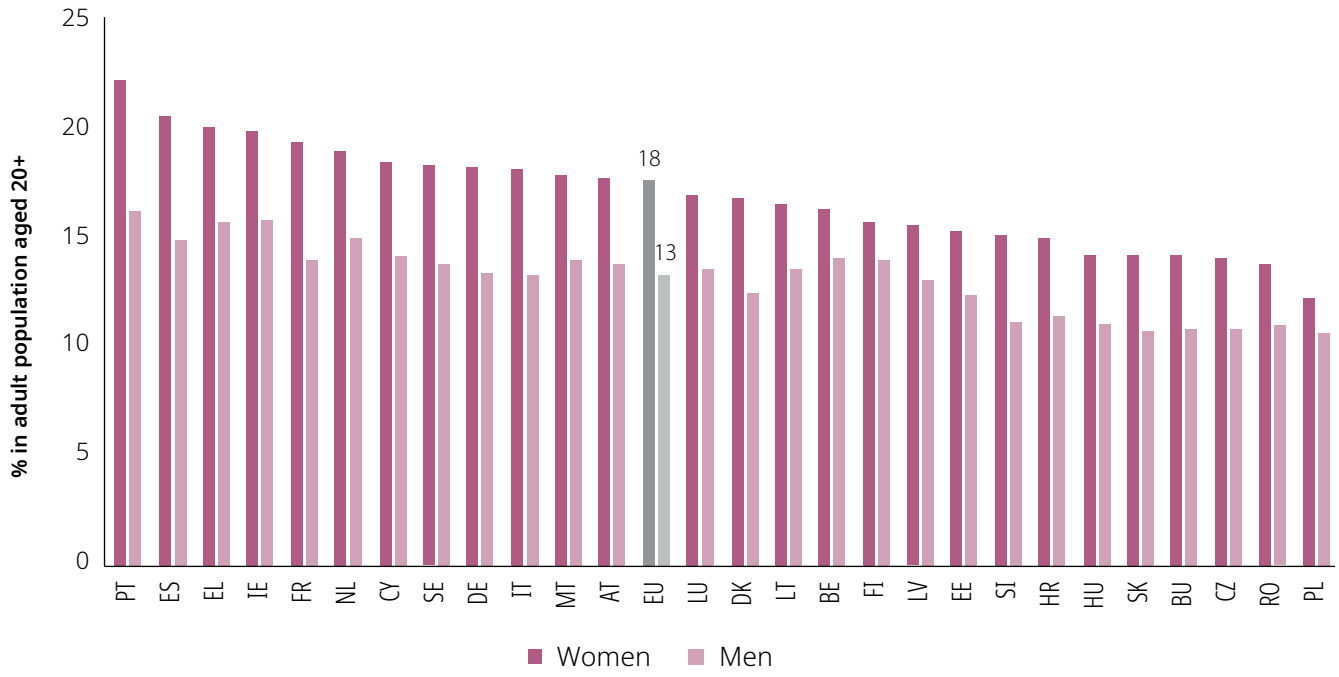
Analysis of GBD ([77]) data shows that in 2019 36.7 million women and 34.1 million men aged over 20 years in the EU suffered from mental disorders ([78]). These figures represent 20 % and 18 % of the total adult population of women and men, respectively.

There are important gender differences in prevalence rates for internalising and externalising mental health disorder, Figure 31, based on GBD data, shows the distribution of internalising mental disorders in women and men across countries. In all EU countries, the proportion of adults with mental disorders, excluding SUDs, is higher among women than among men. Prevalence rates among women range from 20 % or higher in Portugal, Spain and Greece to 12 % in Poland. The difference between countries is lower for men , ranging from 16 % in Portugal, Ireland and Greece to around 11 % in many eastern European countries (Figure 31). The highest prevalence of mental disorders among women and the greatest gender gaps are in western European countries. This does not mean that the mental health burden is lower in eastern Europe. The results are influenced by access to mental healthcare and stigma related to seeking professional help, both of which can vary across countries. As shown in Figure 31, women in northern and central European countries turn to mental healthcare professionals more often than women and men elsewhere.

([77]) GBD data set is a collection of a wide range of data, including from the national health registries, as well as health-related survey evidence, http://ghdx.healthdata.org/gbd-2019.

([78]) Mental disorders include schizophrenia, depressive disorders, bipolar disorders, anxiety, eating disorders, autism spectrum disorders, ADHD, conduct disorder, idiopathic developmental intellectual disability and other mental disorders, as well as SUDs.

Figure 31. Women and men affected by a mental disorder (except SUDs) as a share of the total population, by EU Member State (%, 20+ years, 2019)



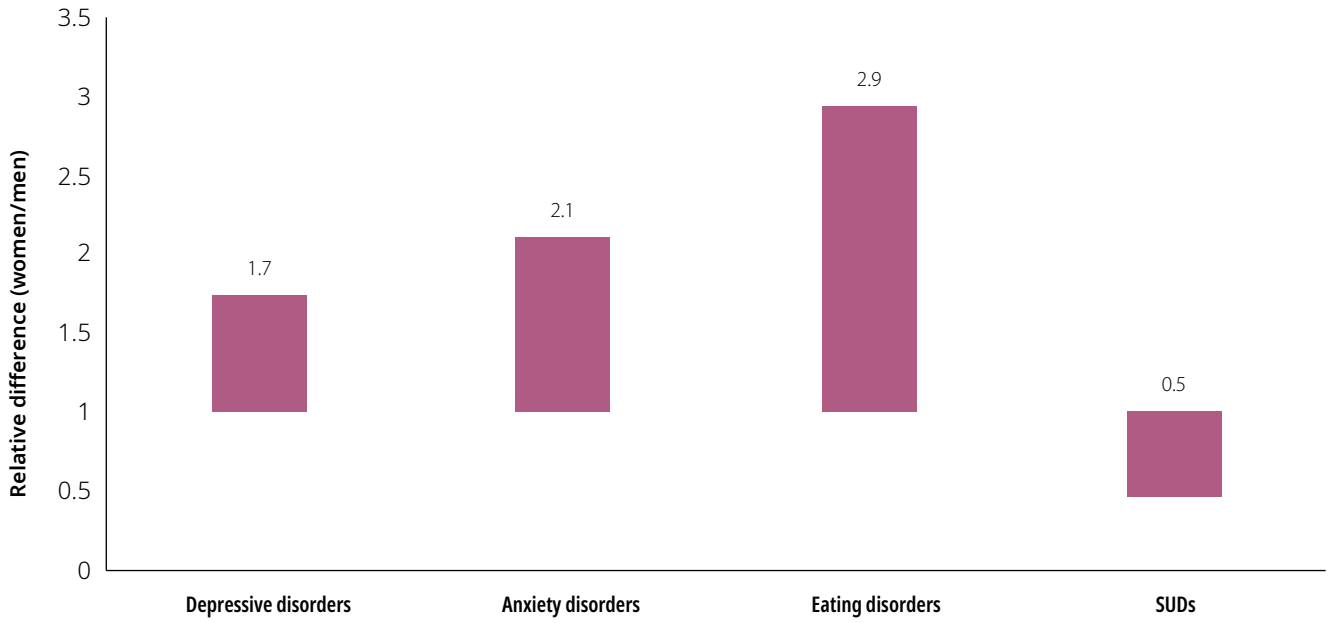
NB: The data includes mental disorders without SUDs.
Source: GBD Study 2019. Authors' calculations.

Older age groups are at risk of specific types of mental disorders, such as dementia, with Alzheimer's disease accounting for between 60 % and 70 % of all dementia cases (Mielke, 2018). An estimated 5 % of people aged 60 years or older in the EU suffer from dementia, and women are about 1.6 times more likely to be affected than men (Wittchen et al., 2011). This gender gap is partly due to life expectancy, as women live longer than men. Dementia is less common in eastern Europe than in the rest of Europe (Wittchen et al., 2011) because of women's comparatively lower life expectancy in eastern Europe. However, it is not yet clear whether women have a higher risk of dementia than men after accounting for differences in life expectancy. While some risk factors are more common among women, such as depression and lower educational levels, others are more prevalent among men, including sleep apnoea (Mielke, 2018). This means that it is possible that the gender gap in dementia is partly determined by sex differences, and not only by gender inequalities.

Gender differences in mental disorders

As mentioned above, mental illness tends to manifest differently in women and men, with the distinction between internalising and externalising disorders particularly relevant.

Figure 32. Relative differences in prevalence of mental disorders among women and men by type (%, 20+ years, EU, 2019)



Source: GBD study 2019. Results, authors' calculations.

GBD data reveals that the prevalence of depression in the EU is 1.7 times higher in women than in men (Figure 32), while anxiety disorders are twice more prevalent among women. Gender differences in eating disorders are even higher, with almost three times more adult women than men suffering from this illness ([79]). The gender gap is reversed in cases of SUDs, which are 2.1 times more prevalent among men. This is consistent with earlier findings on internalising mental health disorders being more common among women and SUDs being more common among men.

Depression is the most widespread mental illness in the EU (Wittchen et al., 2011). Some scholars estimate it to be about twice as prevalent among women as among men (Kuehner, 2017; Van de Velde et al., 2013; Wittchen et al., 2011; Yu, 2018). For women, one in 10 of all healthy life years lost is lost because of depression. For men, it is roughly one in 20.

Men are more likely to suffer from alcohol, opioid and cannabis dependence, with men-to-women ratios of 3.3:1, 1.4:1 and 2.5:1, respectively. Alcohol use disorders make up the greatest mental health disease burden among men (Wittchen et al., 2011). However, some recent research suggests that the gender gap in SUDs may be narrowing, especially among adolescents (Thibaut, 2018).

Gender-specific mental health disorders have different impacts on health status. Overall, poor mental health contributes to the overall burden of disease, including NCDs ([80]).

While the percentage of healthy life years lost ([81]) that is attributable to mental disorders is almost the same for women and men aged over 20 years in the EU – 9 % and 8 %, respectively – the proportion of healthy life years lost as a result of SUDs is higher among men. On aver-

([79]) Across the EU-27, more than 900 000 adult women (aged over 20 years) suffered from eating disorders in 2019, which is three times higher than for men (317 000) (GBD 2019 data).

([80]) Mental health is considered an important factor in NCDs, with a meta-analysis by WHO showing that psychosocial factors are affecting NCDs in Europe and, particularly, that 'Psychosocial distress may also have a direct effect on NCDs such as coronary heart disease independent of these other factors' (Pikhart and Pikhartova, 2015).

([81]) 'Lost healthy life years' refers to the number of years lost as a result of premature deaths and years lived with disability, based on life expectancy.

age, 37 % of all healthy years lost through SUDs are lost from alcohol or drug abuse. Figures are highest in the Baltic countries, Denmark and Poland, at more than 50 %. In contrast, SUDs account for only 13 % of all healthy years of life lost among EU women overall. This share differs across EU countries. It ranges from 24–25 % in Estonia and Poland, to less than 10 % in southern European countries and the Netherlands. This is consistent with the analysis of men's premature mortality being disproportionately impacted by alcohol and substance abuse (Table 3).

Gender norms and relations impact mental health

Research in various parts of the world connects the level of gender inequalities in society with their impact on individual women's mental health. Using measures for women's political participation, economic independence, employment and SRHR to assess levels of gender equality, Chen et al. (2005) found that low gender equality scores were associated with higher levels of depressive symptoms in women. The link was particularly notable among certain groups of women – younger, unmarried and non-white. Similar findings in the EU by Van de Velde et al. (2013) showed that macro-level gender equality supported good mental health for women and men. Some groups were affected more than others by certain aspects of gender equality. Research in various parts of the world connects the level of gender inequalities in society with their impact on individual women's mental health. Using measures for women's political participation, economic independence, employment and SRHR to assess levels of gender equality, Chen et al. (2005) found that low scores were associated with higher levels of depressive symptoms. The link was particularly notable among certain groups of women – younger, unmarried and non-white. Similar findings in the EU by Van de Velde et al. (2013) showed that macro-level gender equality supported good mental health for women and men. Some groups were affected more than others and by certain aspects of gender equality.

Other research in Europe also argues that the gender gap in mental health over the life course is affected by a country's gender equality levels, measured by the Global Gender Gap Index. For example, the mental health of older women in gender-unequal countries is worse than in more gender-equal countries (Bracke et al., 2020). This could suggest that the effects of disadvantage, such as being a woman in a gender-unequal country, accumulate over a lifetime and result in more pronounced health inequalities. This is consistent with previous research linking rigid gender norms with poor levels of cognition in old age (Bonsang et al., 2017).

Gender-based violence ([82])

Violence and power imbalances adversely affect the mental health of women and men victims (Bhui, 2018). For example, exposure to interpersonal violence heightens the risk of suicide among youth and young adults (Miranda-Mendizabal et al., 2019). Since women are more likely to face gender-based violence and power imbalances, they are also more likely to suffer from mental health problems (Oram et al., 2017). Violence is, therefore, an important contributor to gender differences in poor mental health.

The definition of gender-based violence varies, including through each country's legal framework and the scope of action (FRA, 2014). Gender-based violence also takes many forms: domestic violence, intimate partner violence, sexual violence, forced and early marriage,

([82]) Literature on the links between mental health and other types of gender-based violence is scarce. Studies suggest that women victims of human trafficking often suffer high levels of depression, anxiety, post-traumatic stress, psychotic disorders and SUDs (Oram et al., 2015, 2016; Ottisova et al. 2016). The risk of suffering mental health problems is increased by physical and sexual violence, and the is related to the duration and the severity of the trafficking experience. Mental health problems may be present in the long term, even after the victim has escaped from the trafficker, and can be reinforced by poor social support (Abas et al., 2013; Kiss et al., 2015). Studies suggest that women subjected to FGM, in addition to experiencing physical health problems, are also more likely to have mental health problems such as anxiety, depression, somatisation, post-traumatic stress and low self-esteem (Berg et al., 2010; Knipscheer et al., 2015).

'honour' crimes, FGM and human trafficking. However, intimate partner and sexual violence are its most common forms worldwide (Sian Oram et al., 2017). In the EU, physical and sexual violence by a current or former partner or spouse is the most prevalent (FRA, 2014) form of gender-based violence. More than one in five women (22 %) has suffered it. Different forms of gender-based violence consistently lead to a range of mental illnesses globally, including anxiety, depression, suicide, post-traumatic stress and substance abuse (Escribà-Agüir et al., 2010; Ferrari et al., 2016; Riedl et al., 2019). FRA's most recent Fundamental Rights Survey shows that incidents of a sexual nature, in particular, have a profound long-term psychological impact on victims – 50 % of women victims feel anxious, 49 % feel vulnerable, 39 % lose confidence and 36 % are depressed. Other effects include 35 % of women victims having difficulties sleeping and 33 % experiencing panic attacks (FRA, 2021).

Research on victims of **intimate partner violence** – physical, psychological and sexual – reveals the impact of abuse on the development of mental health problems. Among these are trauma and stressor-related disorders, eating and addiction disorders, insomnia, depression and suicidal tendencies (Campbell et al., 2002; Halim et al., 2018; Sarkar, 2008). Victims of intimate partner violence have a threefold increased risk of a depressive disorder and a fourfold increased risk of developing an anxiety disorder. However, post-traumatic stress disorder (PTSD) is the most common mental health problem among women victims of intimate partner violence, with risk increasing sevenfold (Chandan et al., 2019; Ferrari et al., 2016; Shen and Kusunoki, 2019). The probability of psychotropic drug use, as well as psychological distress, increases with the duration of violence over a lifetime (Bonomi et al., 2006; Ruiz-Pérez and Plazaola-Castaño, 2005). Although women are more likely to be victims of intimate partner violence, a major contributor to the mental health gender gap, men suffering such violence are similarly impacted (Sian Oram et al., 2017).

Women who have recently experienced severe episodes of violence generally experience higher levels of distress (Hegarty et al., 2013); these levels decrease in time, independently of whether or not women are offered treatment (Coker et al., 2012; Sullivan and Bybee, 1999). Some victims still experience high levels of psychological distress and trauma-related symptoms years later (Riedl et al., 2019), demonstrating the enduring effects of intimate partner violence on mental health (Campbell et al., 2002).

Health services should consider symptoms of mental illness as a potential indicator of past or current intimate partner violence or non-partner domestic violence (Ferrari et al., 2016). Several 'risk factors' also need to be included in any analysis of the relationship between intimate partner violence and mental health – gender, socioeconomic status, age, social and family network, previous mental health problems and abuse during childhood (Abramsky et al., 2011; Finkelhor et al., 2007; Hughes et al., 2017; Jewkes, 2002). Mental health services, therefore, need to be aware of interpersonal violence experienced and perpetrated by women and men, and to provide gender-sensitive and cross-cutting services to address it (Sian Oram et al., 2017).

Hate-motivated violence against the LGBTI community has significant and lasting consequences for individual victims. Psychological problems and a fear of going out are the two most frequently mentioned impacts of physical and sexual attacks on health and well-being – reported by 49 % and 30 %, respectively (FRA, 2020b). Trans and intersex victims of physical and sexual attacks experience a higher rate of psychological problems, including depression or anxiety (FRA, 2020b). LGBTI people are two to three times more likely to report an enduring psychological or emotional problem – suicidal thoughts and attempts, substance misuse and deliberate self-harm – than the general population (European Commission, 2017). For example, a meta-analysis revealed that lesbian and bisexual women are nearly 1.82 times more likely to attempt suicide than heterosexual women (M. King et al., 2008).

Violence and harassment at work can also result in poor mental health (Eurofound, 2015).

Sexual harassment in the workplace is an often neglected form of gender-based violence, receiving inadequate organisational responses. More than one in three women are victims of it (O'Neil et al., 2018). They are likely to suffer psychological problems such as depression, anxiety and PTSD (Sojo et al., 2016). Even after the removal of the threat, victims are likely to show psychological distress years afterwards (Nielsen and Einarsen, 2012), as sexual harassment acts as a chronic stressor.

New forms of gender-based violence have emerged with digitalisation. **Cyber-violence against women** is rising and spreading, abetted by the anonymity afforded to aggressors, enabling them to perpetrate violence with relative impunity (Cuenca-Piqueras et al., 2020). Younger women, the main users of social media, are disproportionately affected (WHO, 2020f). Cyber-violence encompasses cyberstalking, hacking, impersonation, cyberbullying, sexual harassment and image-based sexual abuse (Faith and Fraser, 2018). Each of these can take myriad forms. For example, image-based sexual abuse incudes revenge porn, upskirting (taking secret, sexually intrusive photographs) and sexualised Photoshopping as well as sextortion and voyeurism (McGlynn et al., 2017). Increased internet activity during the COVID-19 pandemic has been accompanied by a sharp rise in cyber-violence (EIGE, 2020g; WHO, 2020f), which lowers victims' self-esteem and exacerbates their distress when interacting with others online. Victims of cyber-violence can experience concentration problems, stress, anxiety, depression and panic attacks as a result, and can feel helpless, pessimistic about the future and unable to control their own lives (European Parliament, 2021).

Work stressors

The working environment for those in paid jobs often causes chronic stress and may lead to burnout and depressive symptoms. Workers suffering from prolonged stress can simultaneously develop serious physical health problems such as cardiovascular disease or musculoskeletal conditions ([83]). With entrenched gender segregation in the labour market, women's over-representation in precarious work and the continued difficult articulation between paid and unpaid work, work-related stressors are likely to have different impacts on women and men. For example, women constitute 70 % of the global health workforce and are highly visible on the frontlines of the COVID-19 pandemic. Their working hours, shift assignments and great exposure to infection create extremely high levels of distress and risk burnout (WHO, 2020c). The effects of the COVID-19 pandemic on the mental health of workers, especially those deemed 'essential workers', are likely to be profound and are analysed in Section 9.2.2.

In Europe, severe forms of burnout are rather infrequent, at below 5 %, based on diagnostic criteria, while more moderate and mostly self-assessed forms of burnout are reported by between 15 % and 25 % of respondents in different cross-cutting studies(Eurofound, 2018b). The same Eurofound study found that women are more likely than men to be affected by burnout in Belgium, Czechia, Germany and the Netherlands. In other countries, for example Austria, Finland and Slovenia, there appears to be no significant gender gap. However, women and men may experience burnout differently. For example, women tend to feel more emotionally and physically exhausted and overextended at work, whereas men become more depersonalised, which can manifest in them distancing themselves psychologically from clients and co-workers (Purvanova and Muros, 2010). Contrary to expectation, occupation does not moderate gender-specific patterns of burnout.

A substantial proportion of the European working population – 22 % of women and 19 % of men – report depressive symptoms, and it is suggested that work-related risk factors for depressive symptoms are gender specific (Ardito et al., 2014) . Among women, high psychological and intermediate emotional demands significantly enhance the risk of depressive symptoms.

([83]) Comprehensive information on psychosocial risks and stress at work is available on the EU-OSHA website, https://osha.europa.eu/en/themes/psychosocial-risks-and-stress.

Conversely, high levels of decision authority and support from managers, intermediate support from colleagues, a positive social climate, and job rewards and security are protective. Among men, the relative risk of depressive symptoms is significantly raised by exposure to intermediate psychological demands and high pressure to hide emotions. However, a variety of work, opportunity for skills use and development, support from colleagues and managers, and job rewards and security greatly reduce the risk.

Work–life balance tensions

Work–life balance and conflict are other important aspects affecting the mental health of the working population (Eurofound, 2017, 2018b). Both the work-to-family conflict, namely spending extra time at work and reducing time with family, and family-to-work conflict, namely domestic obligations affecting work hours, are strongly correlated with burnout (Purvanova and Muros, 2010). A meta-analysis demonstrates that women are more likely to experience family-to-work conflict, while men more often face work-to-family conflict (Byron, 2005) . OECD statistics on time in paid and unpaid work show that men spend more time in paid work ([84]). Women, in contrast, spend more time in unpaid work, but also spend more time in total on work, paid and unpaid combined.

EIGE (2021d) has highlighted the continued burden of unpaid care on women, whether or not they are employed. It has also shown that women in precarious jobs face higher time demands than women in stable work. However, the demands of unpaid care are rarely analysed as a social determinant of mental health. Of 1 522 papers covered in a recent gender-sensitive literature review of the impact of precarious jobs on mental health, none considered the distribution of domestic work (Valero et al., 2020).

Gender disparities in unpaid care widened during the COVID-19 pandemic. The closure of schools, childcare and other services put women with care responsibilities under particular strain (EIGE, 2021d). For lone mothers, the loss of childcare support and related economic fallouts, such as income loss, have been especially consequential in terms of physical, economic and mental health (Bauer et al., 2021).

Traditional norms of masculinity

Traditional gender roles place expectations on men to be the sole breadwinner in the family. Gender equality progress and profound changes in the labour market may have given greater prominence to dual-earning family models, with men encouraged to embrace more caring masculinities and roles (EIGE, 2019c), but the conventional vision of the male provider can affect men's sense of self-esteem (Gough and Novikova, 2020).

Reducing the burden of mental disorders on individuals and societies, including suicide mortality, requires greater encouragement of those in distress to seek help. Men are less likely to seek help for mental health than women ([85]). Young men are among the least likely to ask for help from friends or medical professionals for mental health problems (Biddle et al., 2004; Oliver et al., 2005).

Lower levels of health-seeking behaviour are shown to be related to social construction and cultural representations of masculinities (Baker, 2019; Brown et al., 2019; Gough and Novikova, 2020). Men's conformity to traditional masculinity norms can affect their health behaviour in multiple ways. These include an inability to recognise depressive symptoms and displaying atypical symptoms such as violence, anger and substance abuse, as well as reluctance to seek professional help except as a last resort and a reluctance to use therapies if considered unacceptable, for example medication (Seidler et al., 2016). WHO argues that men who adhere to traditional masculinity norms, including

([84]) OECD Time Use Database, https://stats.oecd.org/index.aspx?queryid=54757.

([85]) Analysis of the European Health Interview Survey (EHIS) data indicates that women turn to mental healthcare professionals more often than men (based on self-reported consultation of a mental healthcare professional, including a psychologist, psychotherapist or a psychiatrist). In the EU-27, 4 % of men and 7 % of women report having sought the help of a mental healthcare professional.

self-reliance, emotional control, anti-femininity and toughness, are more likely to avoid talking about and seeking help for mental health issues (Gough and Novikova, 2020). Such norms and attitudes are often reinforced at work, particularly in male-dominated sectors, where displays of weakness are discouraged, competition between peers is encouraged and violence is sometimes condoned.

Common factors affecting help-seeking behaviour include a preference to handle the problem by oneself, little perceived need and low mental health literacy (Andrade et al., 2014; Schnyder et al., 2017). Stigma surrounding assistance, causing internal shame and embarrassment, hinders people across all population groups from asking for help. It may disproportionately affect minority groups, young people, men, and those working in the military and health (Clement et al., 2015). As highlighted in Section 9.1.2, fear of disclosure and cultural norms and stigma around mental health explain why men, and some more than others, are less likely to seek help (Gough and Novikova, 2020; Han et al., 2018; Magaard et al., 2017).

Body image drives poor mental health, especially in youth

Analysis of the 2017–2018 WHO HBSC survey shows that girls report poorer mental health than boys. Nearly one in two girls – 47 % – report mental health difficulties at least once a week, compared with 34 % of boys. Some reasons for higher rates of mental health problems among girls and young women may be related to permanent concerns over physical appearance and body dissatisfaction, including weight. WHO notes that eating disorders commonly emerge during adolescence and young adulthood, and they mostly affect girls (WHO, 2020a). While boys are more likely to be overweight or obese, girls more often report perceiving their body to be too fat and being on weight-reducing diets. Gender differences increase with age (Inchley et al., 2016; Inchley et al., 2020). The share of adolescents reporting poor mental health grows significantly in tandem with greater dissatisfaction over body image ([86]). In contrast, actual body mass index or objectively being obese does not have a strong effect on mental health. Therefore, whether or not a person is overweight is irrelevant; rather, it is perceived overweight that is linked to increased risks of depressive symptoms and suicidality. This link has been observed irrespective of study location and the age or gender of participants (Haynes et al., 2019).

As highlighted in EIGE (2019b), adolescent girls' concern over physical appearance correlates highly with their social media use. The 'beauty myth', by which girls and women are subjected to unachievable standards of beauty, balancing low self-esteem and self-confidence with competition with other women, is reinforced in online spaces (EIGE, 2019b). Comparisons with peers and professional models on social media (Carey et al., 2014) have been associated with body image concerns among adolescent girls, with social media playing an intermediary role (Tiggemann and Slater, 2013, 2014).

9.1.2. Health and risk behaviours are clearly gendered

WHO defines health behaviour as 'any activity undertaken by an individual, regardless of actual or perceived health status, for the purpose of promoting, protecting or maintaining health, whether or not such behaviour is objectively effective towards that end' (Nutbeam, 1998). Health behaviour and health status are interlinked, since the activities shaping the first influence the outcomes of the second. Health behaviours have different characteristics and aims. While health-promoting behaviours are purposefully espoused to protect and maintain health status, risk behaviours are adopted despite their harmful consequences (Nutbeam, 1998). The Gender Equality Index monitors both types of health behaviour. Indicators for health-protecting behaviour include diet and

([86]) HBSC study, 2013–2014, authors' calculations. NB: Data is missing for Cyprus and Lithuania.

exercise, while health risk behaviour covers activities such as heavy drinking and smoking ([87]).

Gender is an important social determinant of health, shaping and reproducing how women and men engage in health behaviour. Research often frames women as as engaging in health-promoting behaviour, whereas men are portrayed as taking more risks (Courtenay, 2000), a pattern visible in the EU. However, **on average, the EU population does too little physical activity and consumes insufficient fruit and vegetables regardless of gender**, despite WHO recommendations.

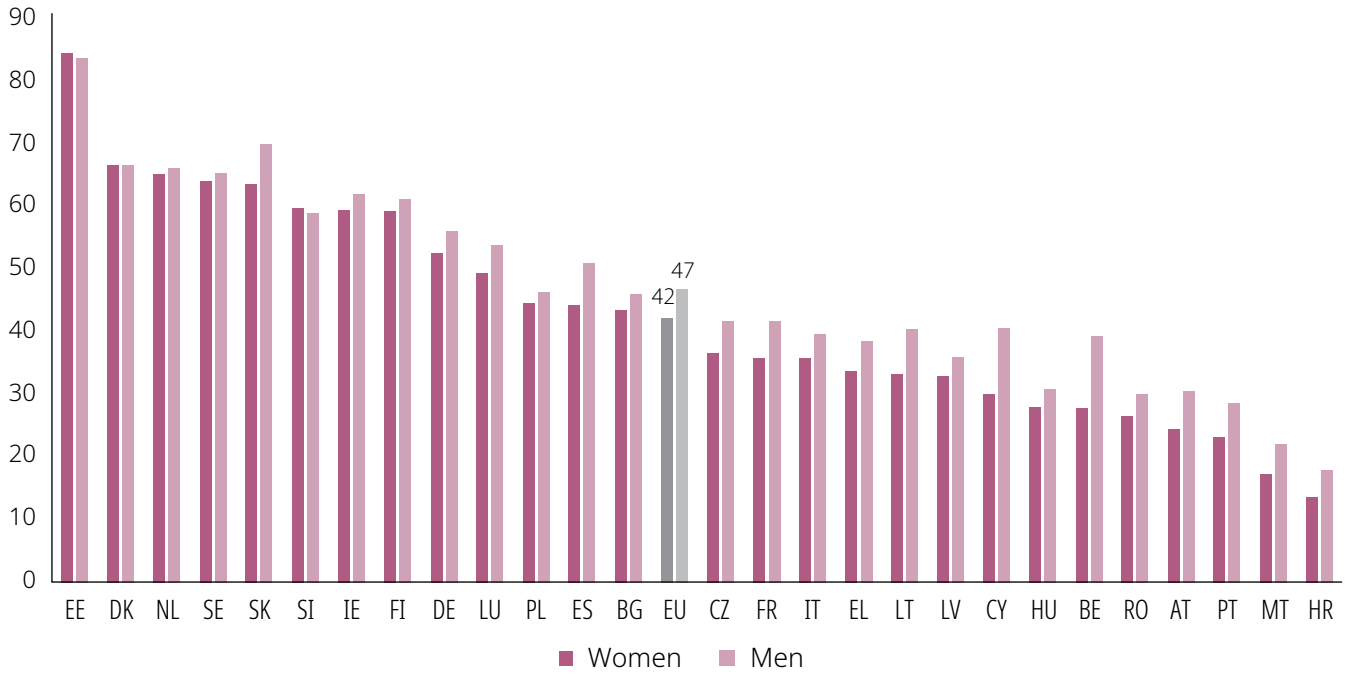
Women are less physically active but eat more healthily

Physical activity is an important component of healthy behaviour recommended for all ages and in stages of the life cycle, including during pregnancy and post partum. The health benefits of exercise range from better cognitive and mental health to improved cardiovascular activity and, ultimately, lower all-cause mortality rates. The WHO recommends that all adults aged between 18 and 64 years engage in at least 150–300 minutes of moderate-intensity aerobic activity or between 75 and –150 minutes of vigorous-intensity aerobic exercise every week (WHO, 2020h).

On average, approximately more than half the EU adult population is missing the target of 3 hours a week (Figure 33). The gender gap in physical activity across the EU is 5 p.p. in men's favour. Estonia is the only Member State where slightly more women than men engage in physical activity, and it is also the country with the highest proportion (85 %) of people exercising ([88]). Belgium has the largest gap (11.7 p.p.) in weekly exercise between women and men, while Denmark is the only Member State without a gender gap. Throughout life (16–75+ years), gender gaps in physical activity remain the lowest, at 1 p.p., between the ages of 50 and 64 years. The biggest gender gaps are among young adults (16–24 years) and elderly people (75+ years). In both cases, the gender gap is 10 p.p. to women's detriment ([89]).

([87]) It is important to note that the Index consults the share of the population that is not engaging in risk-taking health behaviour to have consistent measurements reflecting health-promoting behaviour. Therefore, a higher Index score for health behaviour indicates that a higher share of the population engages in physical activity and healthy diets, and drinks and smokes less.
([88]) Values for Estonia are estimates. The reliability of the data is limited.
([89]) EIGE calculations based on Eurostat, https://ec.europa.eu/eurostat/web/products-datasets/-/ilc_hch07.

Figure 33. Women and men performing physical activity outside working time for at least 180 minutes per week, by sex and EU Member State (%, 16+ years, 2017)



Source: Eurostat, https://ec.europa.eu/eurostat/web/products-datasets/-/ilc_hch07.
Notes
EU: Eurostat estimation, EE, LT, SK: low reliability

In the EU, gender gaps in physical activity emerge before adulthood. WHO underlines the importance of exercise for children and adolescents, recommending even higher amounts of daily activity because of ongoing physical and cognitive development during this life stage (WHO Regional Office for Europe, 2020a). HBSC survey data shows that children's level of activity tends to decline between the ages of 11 and 15 years, especially among girls (WHO, 2016a, WHO Regional Office for Europe, 2017), with parental income key to determining children's access to sports (Richter et al., 2009). Among 11-, 13- and 15-year-olds, boys more often than girls report daily moderate to vigorous physical activity of at least 60 minutes. The EU gender gap in this instance is 7 p.p. The largest gender gaps are noted in Spain, at 14 p.p., and Austria, Finland and Ireland – all at 11 p.p.

Gaps are even more pronounced in the share of girls and boys engaging in vigorous physical activity at least four times a week. Here the EU gender gap doubles to 15 p.p., again to the detriment of girls. France and Luxembourg have the highest gaps, of 23 p.p. ([90]). Exercise in adolescence is particularly important because regular physical activity, such as school-based high-impact exercise protocols, can improve bone mass and prevent osteoporosis. This condition affects half of all women in old age, but only a fifth of men (Xu et al., 2016). Adolescence is also when physical activity habits lasting into adulthood are established (Currie, 2016).

Physical and social activity have been proven to be positively associated with better health (Roychowdhury, 2020). However, women and men have different patterns of social activities

([90]) HBSC survey 2017/2018, authors' calculations. NB: EU: unweighted average.

and different amounts and uses of leisure time (EIGE, 2020g) ([91]). The diminishing boundaries between professional and personal time created by digitalisation have seen paid work increasingly encroaching on leisure time, especially for women in precarious employment (EIGE, 2020g; European Parliament, 2016a; Wajcman, 2015).

Research suggests that less physically active women tend to report more barriers to exercise (E. S. Edwards and Sackett, 2016). Since women generally do most of the childcare and housework, they have less leisure time available for physical activities than do men (The Lancet Public Health, 2019). Environmental and socio-economic factors also determine women's and men's engagement in physical activities. A Eurofound study on social insecurities and resilience suggests that women and men have different risk perceptions of outdoor surroundings after dark. Women living in the poorest urban settings feel the most insecure in their neighbourhood (Eurofound, 2018a). For them, physical activity outside is a safety risk, discouraging them from exercising, including walking or running.

Although it is too soon to know the long lasting effects of the COVID-19 pandemic on activity levels, there are already indications of gendered changes in physical activity. Lockdown measures at the start of the pandemic led to men, particularly younger men, doing less physical activity. Research in Croatia (Sekulic et al., 2020) and Italy (Giustino et al., 2020) suggests that this is because young men rely more on outdoor and team sports, which were more severely restricted by social distancing orders than the home-based, individual exercise women more often participate in. A systematic review found that people who exercised regularly before the pandemic increased their physical activity during lockdown, while those who did not were even more sedentary (Khan et al., 2021).

Healthy diets are key to prevent or delay NCDs such as diabetes, hypertension, cancer and osteoporosis (WHO, 2003). This is particularly important during the COVID-19 pandemic, as NCDs put individuals at greater risk of severe health outcomes and death in the case of infection. Men's higher mortality rate during the pandemic is partly due to their higher levels of NCDs (see Section 9.2.2.).

For adults, healthy eating involves at least 400 g (or five portions) of fruit and non-starchy vegetables as daily target (WHO, 2020d). Although the exact breakdown, preparation method and weight amount differ across Member States, all have implemented WHO guidelines and recommend eating at least five portions of fruit and vegetables daily in their national dietary guidelines (European Commission, 2021f).

([91]) As highlighted in EIGE (2020g), data from the time domain shows that, among working adults, rates of regular participation in sport, cultural and leisure activities outside the home are extremely low in some countries, especially among women. The share of working women engaging in regular social activities outside the home varies widely, being lowest in in Romania (6 %), Portugal and Cyprus (10 % each) and Bulgaria and Greece (11 % each) and highest in Denmark (53 %), the Netherlands (56 %) and Finland (60 %).

Figure 34. Women and men consuming at least five portions of fruits and vegetables daily, by EU Member State (%, 15–64 years, 2014)

Source: Eurostat, https://ec.europa.eu/eurostat/web/products-datasets/-/hlth_ehis_fv3e.

Data from the European Health Interview Survey (EHIS) (2014) shows that barely 1 in 10 adults meet these recommendations, and large gender gaps exist in healthy eating across the EU. On average, the share of women who consume the recommended five daily portions of fruit and vegetables is almost twice that for men (Figure 34). The share of women meeting the daily target is lowest in eastern and south-eastern Member States, and highest in Ireland and Denmark. Ireland also has the most men meeting WHO recommendations, with more recent data on living conditions in Europe confirming this ([92]). Although Ireland, Denmark and the Netherlands have more men eating the required daily amounts of fruit and vegetables, substantial gender gaps remain when compared with women. Overall, men are more likely to have poor diets and to engage in dietary risk behaviour. This is particularly so among men over 50 years. The highest rates of loss of healthy life years among men attributable to poor diet are in eastern Europe, but men in western Europe also show distinct patterns of unhealthy eating behaviour, with diets low in fruits, nuts and vegetables (WHO Regional Office for Europe, 2018).

Gender differences in healthy dietary behaviour exist across the age spectrum. For example, the Healthy Lifestyle by Nutrition in Adolescence (HELENA) study examines healthy eating behaviours among adolescents in 10 Member States. Girls have a greater variety of healthy diet patterns, greater availability of fruit at home and more awareness of what it means to eat healthily than boys (González-Gil et al., 2019). In addition, the authors noted that healthy diet patterns are determined by the food choices parents provide, regardless of gender. Both these observations – the gender gap in fruit consumption and parental influence on adolescents' healthy eating behaviour – are also made in a WHO report examining the health behaviour of school-aged children (Inchley et al., 2016). The report also shows that income and family affluence are a driving factor for healthy eating behaviour. Adolescents living in more affluent households are more likely to share meals with family members and have more access to fruit. Adolescents from

([92]) EU-SILC, https://ec.europa.eu/eurostat/web/products-datasets/-/ilc_hch11, 2017.

low-affluence households, especially girls, reported a higher consumption of sugared drinks. These findings underline the need for healthy foods, such as fruit and vegetables, to be affordable, available and accessible to all ages, and for their consumption to not be feminised.

A systematic review of dietary behaviour during the COVID-19 pandemic concluded that gender and low income are determinants of weight gain (Khan et al., 2021). These factors play a particularly influential role in the health behaviour of lone mothers, who are likely to spend a disproportionate amount of their income on healthy food for their children, neglecting their own health by going without food or making cheap, unhealthy, choices, often leading to weight gain (Martin and Lippert, 2012). As of 2015, Finland was the only country to provide free school meals for all pupils and students at all levels, from pre-primary to upper secondary (Polish Eurydice Unit, 2016). While all Member States provide some school meal discounts for low-income families, school closures during the COVID-19 pandemic led to food insecurity for school-aged children and adolescents from less affluent backgrounds (Nicola et al., 2020).

Dietary behavioural change during the pandemic has been noted in women, but not necessarily in men. In a study of three Member States (DK, DE and SI), Janssen et al. (2021) noted that women increased their consumption of fruit and vegetables during the first month of the lockdown in 2020, in contrast to men. The authors attribute the growing gap in fruit and vegetable consumption to wider gendered patterns in health, since women are more likely to control their healthy eating behaviour and prevent or mitigate a possible COVID-19 infection.

Men are more likely to smoke and drink

Sociocultural norms and gendered attitudes shape willingness to engage in health-promoting or risky behaviours. Harmful perceptions of masculinity limit boys and men in their self-care and create barriers to healthy living and well-being. Acceptable norms for women and men, in terms of health behaviour, structure men's health in two ways. First, societal gender norms discourage men from participating in health-promoting behaviour, usually seen as feminine, including using sunscreen (Courtenay, 2000), being a vegetarian (Bogueva et al., 2020) or getting psychological counselling (Seidler et al., 2016). Second, social acceptance of certain risky health behaviours. including unprotected sex, excessive use of harmful substances, extreme sports, violence, smoking and excessive alcohol consumption, is greater when such practices are carried out by men (Baker, 2019; Courtenay, 2000).

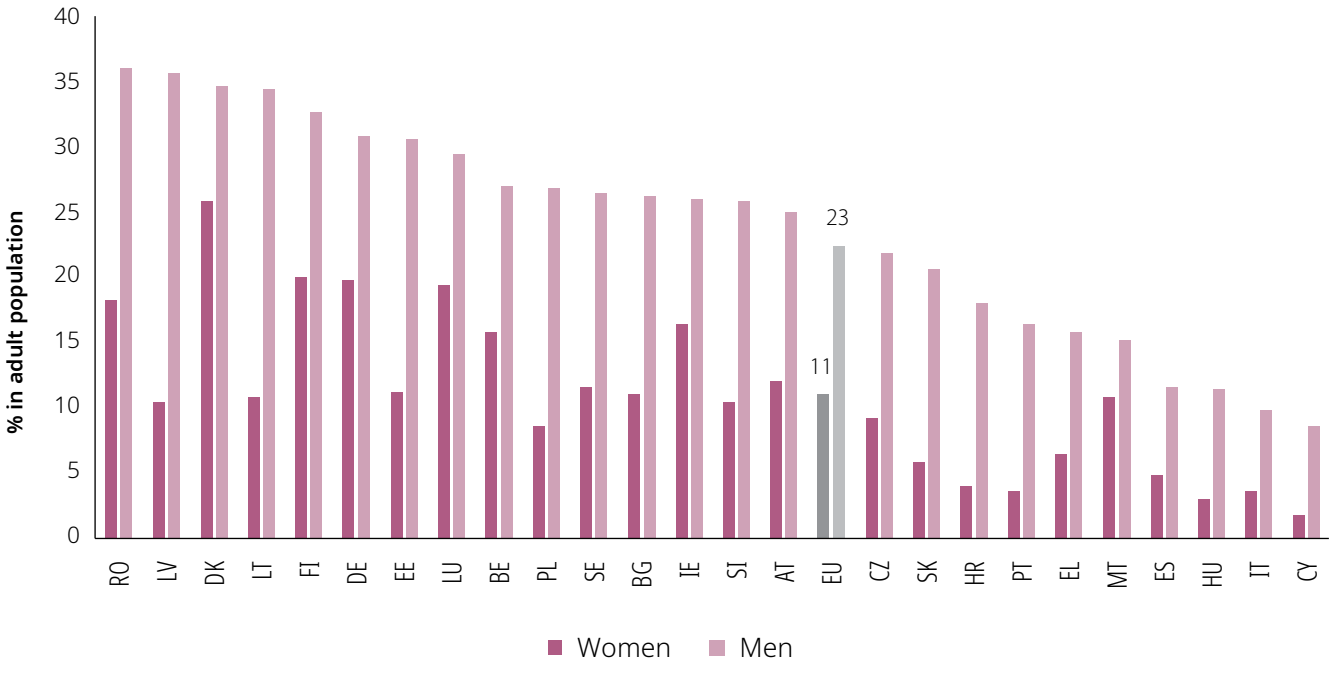
Between 2003 and 2005, smoking and hazardous drinking were responsible for substantial proportions of the mortality gender gap in 30 European countries. Smoking-related deaths accounted for 40–60 % of this gender gap in all surveyed countries; alcohol-related mortality accounted for 20–30 % of the gap in eastern Europe and 10–20 % elsewhere in Europe (G. McCartney et al., 2011). Although 15-year-old girls are slightly more likely to smoke than boys of the same age – 19 % compared with 17 % – the trend among adult is reversed (OECD/European Union, 2020).

In 2014, more men than women smoked daily in 26 Member States, with Sweden the only exception (Eurostat, 2020). Nationally, daily smoking figures ranged from 7.5 % in Sweden to 37.3 % in Cyprus for men, and from 8.3 % in Romania to 22 % in Austria for women. Several studies have identified factors linked to smoking and adverse health outcomes for women, including biological, genetic and hormonal factors, socioeconomic determinants, occupational exposure, job stress, personal lifestyle and passive smoking, or a combination of these factors (Syamlal et al., 2014). In addition, women find it harder to stop smoking than men. This is especially true for younger women with lower income and education levels, who are also more likely to continue smoking during pregnancy (WHO Regional Office for Europe, 2021a). The same report found that only 11 % of warning images on tobacco packaging feature women, implying a gender gap in female representation in health prevention measures.

WHO Europe has declared the growing use of electronic cigarettes, especially among adolescents, as alarming for public health. Although there is no complete data set for the EU-27, countries with a high prevalence of adolescents using e-cigarettes are Poland (23.4 %), Latvia (18 %) and Italy (17.5 %) (WHO Regional Office for Europe, 2020b). As with tobacco smoking, gendered patterns are visible in e-cigarette use. A systematic review covering the WHO Europe region found a higher prevalence of e-cigarette use among men, adolescents and young adults, tobacco cigarette smokers and former smokers (Kapan et al., 2020). Though further research is needed, a study on 14 to 17 year-olds in seven Member States found that boys are more likely than girls to use only e-cigarettes (Kinnunen et al., 2021). The same study also shows that more boys than girls smoke both tobacco and e-cigarettes.

Alcohol consumption is considered one of four key contributors to NCDs, for example diabetes, cancer, cardiovascular diseases and epilepsy. Harmful drinking is a risky health behaviour, with gendered implications. Drunkenness can lead to gender-based violence, hinder effective contraceptive use and cause adverse pregnancy outcomes such as fetal alcohol syndrome (WHO, 2019d). According to a WHO Europe report, Europe has the highest alcohol consumption worldwide, irrespective of gender (WHO Regional Office for Europe, 2018). However, there is a pronounced gender difference in average heavy episodic or binge drinking ([93]). Men engage in this behaviour twice as often as women (Figure 35). The lowest shares of men binge drinking at least once a month are in southern and Mediterranean Member States, at less than one in five, while more than a third of men drink excessively in Latvia and Lithuania.

Figure 35. Women and men engaging in heavy episodic drinking at least once a month, by EU Member State (%, 18–64 years, 2014)



Source: Eurostat, https://ec.europa.eu/eurostat/web/products-datasets/-/hlth_ehis_al3e. No data available for FR and NL.

([93]) Heavy episodic drinking is defined as 60 g or more of pure alcohol on at least once per month (WHO, 2019d).

Alcohol consumption patterns differ when considering various socioeconomic factors. According to the OECD (2015), men with lower incomes do more heavy drinking than those with higher incomes. For women, this pattern is reversed. Drinking to relieve distress is noted predominantly in men, and far less so in women. Distress in men increases harmful drinking, including alcohol dependence, binge and hazardous drinking, and intoxication (de Goeij et al., 2015).

Research on 50 to 64 year-olds in 15 EU Member States and Switzerland shows that the prevalence of hazardous drinking is significantly higher among men than among women in most countries. Likewise, the risk of becoming a hazardous drinker is 1.69 times higher for men than for women (Bosque-Prous et al., 2015). Lower values on the gender empowerment measure ([94]) 'economic and political participation, and power over economic resources' and higher unemployment rates are linked to greater gender differences in such drinking. The authors suggest that this can be attributed to gendered patterns, as unemployed men drink more and unemployed women drink less, widening the overall gap (Bosque-Prous et al., 2015). Countries with the greatest gender differences in hazardous drinking are those with the greatest gender inequalities in daily life, while smaller gender differences seem to be related to higher consumption among women (Bosque-Prous et al., 2015). The authors note that women's higher alcohol consumption in more gender-equal countries could be related to more progressive gender norms, making it easier for women to be targeted in alcohol adverts and for their risky drinking behaviour to be more acceptable.

A systematic review of alcohol consumption during economic crises over a 25-year period also reveals gendered differences. Emotional stress leads men to drink more whereas financial limitations result in women drinking less (De Goeij et al., 2015). In Poland, a study on health behavioural changes during the COVID-19 pandemic found that overall alcohol consumption has increased among men. Women are drinking the same amount as before, but are drinking different types of alcohol (Sidor and Rzymski, 2020). Robust evidence is still scarce and mostly based on national research

9.1.3. Gender and intersecting inequalities in access to health services

Timely access to good-quality, affordable healthcare (both preventive and curative) plays a critical role in maintaining good health. It is considered an important social determinant of health (WHO, 2019e). In the EU context, access to health services has been acknowledged as a right and recognised as a key principle of the European Pillar of Social Rights. In a survey carried out by EIGE, respondents ranked nine public services in order of the extent to which they enabled their participation in different everyday life activities ([95]). The respondents, women and men alike, ranked health services as the most important type of public service and those that have the most transformative potential towards advancing gender equality in society. They create opportunities for people to be involved in education, employment and leisure (EIGE, 2020d).

Despite the EU standing out among industrialised regions for the health coverage of its population (OECD, 2019), universal access to health services is not yet achieved, and there are great variations in the level of access across the EU (Burns et al., 2019). Ethnic minority groups and migrant populations are seen to be over-represented among the population without, or with inadequate, health coverage (OECD, 2019). This section analyses which population groups are lagging behind in terms of access to health services and explores some of the reasons behind this.

([94]) The gender empowerment measure has since been integrated into the United Nations Development Programme's Gender Inequality Index, http://hdr.undp.org/en/content/gender-inequality-index-gii.

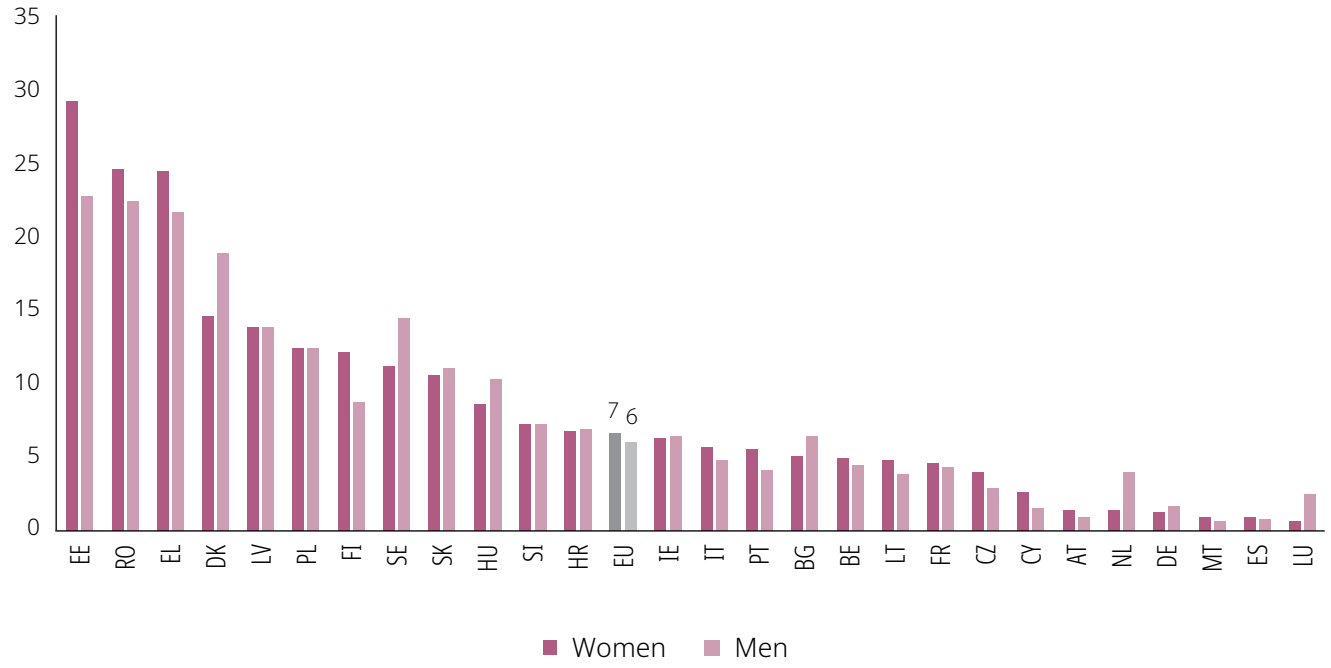
([95]) In general, health services were perceived to enable a person's participation in activities such as employment, domestic work, leisure and education. Health services and medical centres enable a variety of activities, but to different degrees for women and men. A majority of women perceived health services and medical centres to be very important for participating in education, carrying out domestic and care work, and participating in employment; the proportion of men with this perception was smaller

Gender intersects with other social positions to hamper access to healthcare

Gender inequalities and gender norms intersect with socioeconomic, geographic and cultural factors and create structural barriers when accessing healthcare (WHO, 2019a). As highlighted in the domain of health chapter (Figure 22), several population groups, such as lone parents, older people, migrants and people with disabilities, and women in particular, stand out as highly vulnerable to unmet healthcare needs. Gender is an important determinant of healthcare access and uptake. Gender socialisation tends to deter men from seeking diagnosis and treatment, resulting in men being less likely than women to visit medical practitioners. A study in the United Kingdom found that men were 8 % less likely to consult a doctor than women, even when excluding consultations for reproductive reasons (Wang et al., 2013). The fact that women's greater familiarity with the health and social services system is often attributed to the fact that they dedicate more of their time to childcare and long-term care.

Globally, people with disabilities have unequal access to healthcare services, and therefore have more unmet healthcare needs than the general population (WHO and World Bank, 2011). At the EU level, 7 % of women and 6 % of men with disabilities report unmet needs for medical services, but these figures are much higher in Estonia (29 % of women and 23 % of men), Romania (25 % of women and 23 % of men) and Greece (25 % of women and 22 % of men) (Figure 36). Gender gaps are modest in the majority of countries, with the exception of Estonia (6 p.p.). In Denmark, Sweden, Hungary, Bulgaria, the Netherlands and Luxembourg, men with disabilities are more prone than women to having their medical needs unmet.

Figure 36. Unmet needs for medical services for women and men with disabilities, by EU Member State (%, 16+ years, 2019)



Source: Author's calculation with microdata, EU-SILC, 2019 (IE, IT, 2018).

Older adults with disabilities and those living in rural areas experience difficulties in accessing appropriate transport to get to their medical healthcare providers (Gibson and O'Connor, 2010). Physical or structural barriers make it difficult for women with disabilities, especially when they live in rural areas, to access healthcare services, and as a result they may be dissuaded from attending screening for cervical or breast cancer (Ramjan et al., 2016). Furthermore, people with disabilities may have poor access to health promotion and disease prevention initiatives. This results in women with disabilities being less likely to receive screening for breast and cervical cancer than women without disabilities, and men with disabilities are less likely to be screened for prostate cancer (WHO and World Bank, 2011). The recently adopted 2021–2030 strategy on the rights of persons with disabilities includes access to healthcare ([96]). The European Commission is also planning some guidance on access to healthcare based on inclusive, accessible, person-centred healthcare and free and informed consent, in line with the objectives of the UN Convention on the Rights of Persons with Disabilities.

Beyond medical services, access to long-term care services is critical to autonomous living and the well-being of people with disabilities and health limitations, especially in the context of the EU's ageing population (EIGE, 2020f, 2021d). As shown by EIGE (2020f), barriers to accessing professional home-based care ae affect women disproportionately, as they are over-represented among the population most in need. In the EU, about 29 % of households reported unmet need for professional home care services in 2016 (EIGE, 2019d). Households were slightly more likely to report unmet needs (30 %) if a woman completed the survey than if a man did so (28 %). Women are more likely than men to report an unmet need for professional home care services in all but five Member States (LU, NL, AT, PT and SE) and the United Kingdom. The Member States with the highest unmet needs for professional home care services were Portugal (reported by 85 % of women and 86 % of men), Greece and Cyprus.

Nearly a quarter of women and men live in households that rely on informal care, which may either be insufficient or not be the most suitable / preferred arrangement for either the carer or the one cared for.

Access to palliative care or end-of-life care is also very uneven across the EU. Because palliative care revolves around pain relief and contributes to easing the physical and emotional suffering of patients and families, it is considered fundamental to human dignity (Council of Europe, 2018). The Council of Europe has highlighted the need to factor in rising needs for palliative care services as a corollary of ageing and an increase in the burden of disability. It raised particular concerns over 'the lack of access to appropriate pain relief leading to situations in which patients suffer for months and even years and experience avoidable painful deaths'. Limited palliative care services have profound gendered impacts, with women bearing the brunt of lack of services not only as patients (women being more likely to suffer from health limitations, especially in older age groups, as shown in Figure 26) but also as informal carers whose own well-being and financial independence is put at risk by the burden of care (EIGE, 2019c, 2020e; Eurofound, 2020; Gott et al., 2020).

Reasons for unmet needs and underutilisation of medical services

This section will touch on three main sets of factors inhibiting access to medical services, namely the cost associated with them, experiences of discrimination and issues related to cultural sensitivity and a lack of gender sensitivity.

While unmet needs for medical services is a self-reported measure and, as such, could reflect certain biases, exploring reasons why individuals are not accessing the medical services

([96]) Union of equality: strategy on the rights of persons with disabilities 2021–2030 (easy-to-read version) – Employment, Social Affairs and Inclusion – European Commission, https://ec.europa.eu/commission/presscorner/detail/en/ip_21_810.

they need can point to certain important determinants and inequalities and how they affect certain groups in particular.

Cost

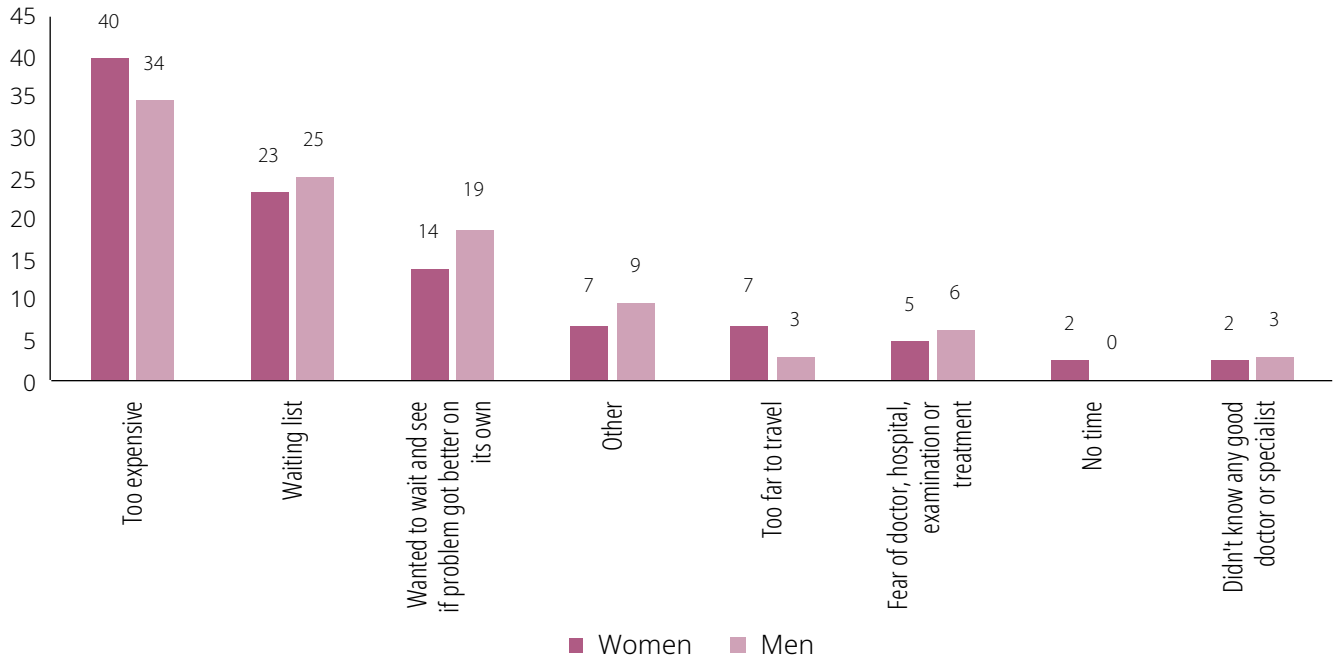
According to EU-SILC data, about one quarter of individuals who reported unmet medical needs gave cost as a reason for being unable to access care ('Could not afford to (too expensive)'). The other most common reasons for unmet medical care needs were 'Wanted to wait and see if problem got better on its own', lack of time ('Could not take time because of work, care for children or for others') and waiting times. In the case of dental care, the proportion of unmet needs due to financial reasons is far higher: half of the respondents gave this as an explanation. Women were a little more likely than men to mention cost as the main reason for not consulting, for either medical or dental care (Chaupain-Guillot and Guillot, 2015). Likewise, the cost of healthcare is a reason why women in financially unstable situations avoid care services, for example those who experience homelessness (Kneck et al., 2021).

As highlighted in Section 7.2., on the domain of health, women aged over 65 are slightly more likely than women overall to experience unmet needs for medical services ([97]). The share of women and men aged 65+ experiencing unmet needs is highest in Estonia (22 % of women and 15 % of men), Romania and Greece (18 % of men and 13 % of women) ([98]). Difficulties in accessing healthcare in old age are related to the fact that women are at higher risk of poverty or social exclusion than men when they reach old age (EIGE, 2020g), which reflects the accumulation of economic inequality over the life course. This is of particular importance since women are more likely than men to experience health limitations in old age (Ogg and Rašticová, 2020). Among people aged 65 and older, the leading reasons for unmet medical needs are affordability, especially among women, followed by being on a waiting list. Men are more likely than women to delay medical examination in the hope that the health issue will resolve itself (Figure 37).

([97]) At the EU level, 4 % of women over 65 and 3 % of men of the same age report unmet needs for medical services, compared with 3 % of women and men in the overall adult population.

([98]) Authors' calculation with microdata, EU-SILC, 2019 (IE, IT, 2018).

Figure 37. Reasons for unmet needs for medical examinations among women and men (%, 65+ years, EU, 2019)

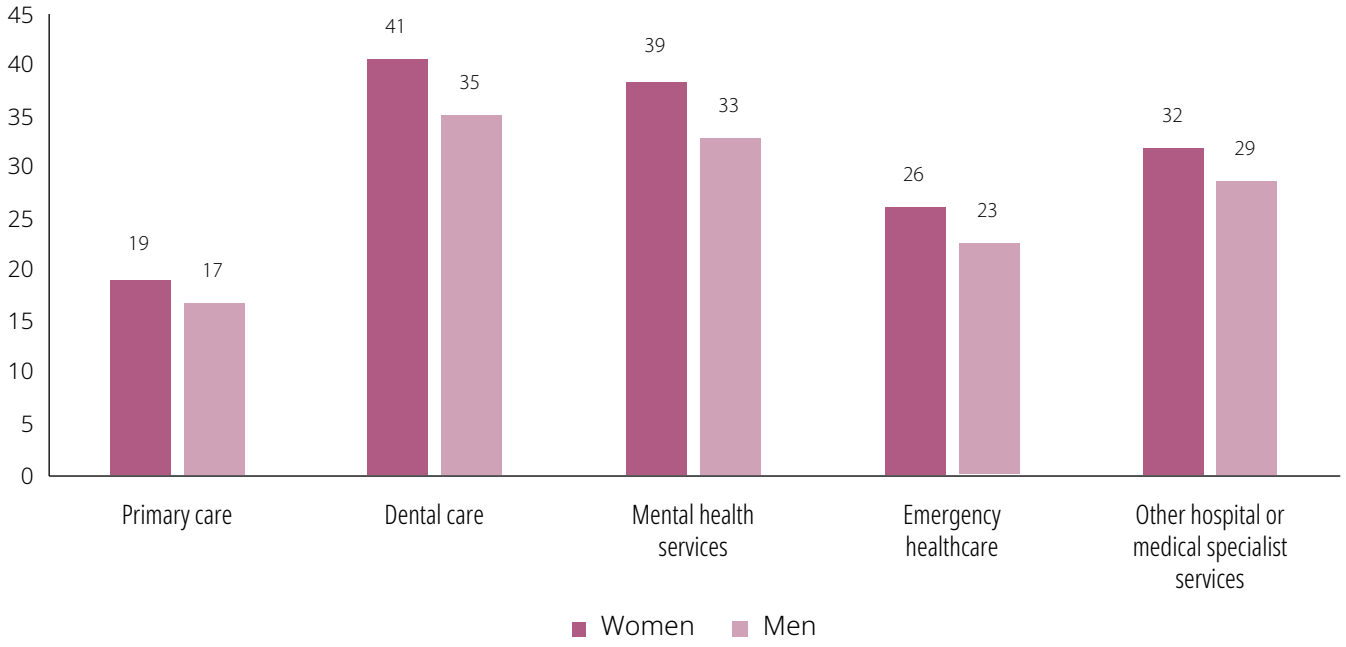


Source: Authors' calculations based on Eurostat, https://ec.europa.eu/eurostat/web/products-datasets/-/hlth_silc_14.

Cost of medical services as a barrier to access is more frequently mentioned by people aged 65 and over than in the adult population as a whole (40 % of women and 34 % of men aged 65 and over, compared with 33 % of women and 29 % of men of the total adult population).

This is not to say that other population groups are not experiencing difficulties in affording healthcare. Data shows that large segments of the EU population would find it difficult to pay for unexpected dental care (41 % of women and 35 % of men), mental health services (39 % of women and 33 % of men) and other hospital or medical specialist services (32 % of women and 29 % of men) (Figure 38).

Figure 38. Difficulties in paying for unexpected medical expenses by sex and type of medical service (rather difficult or very difficult, %, 18+ years, EU, 2016)



NB: Respondents were asked, for each type of medical service, 'How easy or difficult would it be for you to cover expenses for each of the following services, if you needed to use it tomorrow?'. Answers selected: 'Rather difficult' and 'Very difficult'.
Source: EQLS, 2016.

The financial impact of health expenses, especially on a low-income population, can be captured by two indicators, namely 'catastrophic health spending', a situation in which households spend a high proportion of their resources on healthcare via out-of-pocket payments, and 'impoverishing health spending', in which a household either falls below the poverty line as a result of health expenses or is further impoverished by them (OECD, 2019). While 'impoverishing health spending' affects up to 6 % of households, catastrophic health spending is more common across the EU, affecting from around 1 % of households in Slovenia, Czechia and Ireland to 15 % in Lithuania (WHO, 2019b). Across the EU, households at the bottom of the income ladder, a group among which women and lone mothers are over-represented, were considerably more likely to be affected.

Discrimination and other systemic barriers

Accessing health services involves social interactions between patients and health workers in which societal power relations shape patients' experiences (WHO Regional Office for Europe, 2016b). WHO's 2019 global monitoring report on primary healthcare sheds light on how gender norms and power influence access to health services. The report found that gender norms and power relations influence women's access to health services and timely diagnosis, while harmful notions of masculinity increase men's risk-taking and reduce their willingness to use health services (WHO, 2019f).

Age, wealth, marital status, ethnicity, religion, caste, disability, education level, homelessness and migration status can lead to stigma and discrimination, which influence access to and use of health services (WHO, 2019a).

A survey by FRA found that 16 % of respondents felt discriminated against by healthcare or social services staff because of being LGBTI in the preceding 12 months ([99]). Trans and intersex people were the most affected, with 34 % of respondents reporting feeling discriminated against in a health context, followed by lesbian women (16 %), bisexual women (14 %), gay men (11 %) and bisexual men (10 %). Members of the LGBTI community are still, at times, refused healthcare services or experience discrimination, and many feel unable to be open with healthcare professionals about their sexual and/or gender identity, or about being intersex. In the EU-28, 46 % of LGBTI respondents reported that none of their medical providers was aware of their LGBTI status. However, this figure varied greatly by country, from 28 % in Denmark to 82 % in Lithuania ([100]). Discriminative behaviours experienced by LGBTQI individuals include stigma, denial or refusal of healthcare, and verbal or physical abuse. Knowledge and educational levels, beliefs and religion affect healthcare providers' attitudes towards LGBTQI patients and can lead to homophobic behaviour (Ayhan et al., 2020). Heterosexism, transphobia and homophobia are barriers to healthcare service access; these phenomena are systemic factors, not just individual practices, and may cause LGBTQI people to avoid treatment altogether (Smalley, 2018).

A body of literature explores the gap in the health and health needs of non-EU migrants, which may differ greatly from those of the general European population (Fair et al., 2020, Keygnaert et al., 2015, 2014a, 2014b). Compared with the general EU population, non-EU migrant women have less access to family planning and contraception and less access to SRH services (Abubakar et al., 2018; Fair et al., 2020).

Migrant women may face specific access barriers exacerbated by the intersection of gender, socioeconomic status and migration status. Such barriers may include less access to health information, cultural and religious beliefs, fear for their social, labour and administrative situation, housing and pressing economic needs and a deficient or a non-existent network of social and family support (Sánchez-López and Limiñana-Gras, 2017). Migrant girls may use health services less frequently than boys, depending on the study setting and ethnic group; however, further gender-based analyses of immigrant children's healthcare use are needed, since the reasons behind the differences are largely unstudied (Pulver et al., 2016). Many studies have focused on how healthcare practices based on Western cultural concepts influence migrant and refugee women in mental healthcare services, but not many studies have examined how social support, gender, and institutional and organisational structures present barriers to women's health-seeking behaviour (O'Mahony and Donnelly, 2010). Cultural barriers are seen to exacerbate other barriers to access, especially when it comes to mental health services for certain marginalised groups such as refugees or asylum seekers (Satinsky et al., 2019).

The COVID-19 pandemic has further exacerbated barriers to access to healthcare services in the EU either because of deferment and deprioritisation of certain medical procedures or because of fear of infection. In particular, the Eurofound COVID-19 e-survey (2021c) found that 21 % of respondents had missed a medical examination or treatment during the pandemic. This proportion has remained stable at EU level since the onset of the pandemic and was highest in Latvia, Hungary and Portugal. In spring 2021, 18 % of respondents were experiencing a health issue for which they could not get treatment (Eurofound, 2021c).

([99]) Source: Authors' calculations for EU-27 based on FRA, EU-LGBTI II 2019 in the 12 months before the survey. Respondents were asked the question 'In the past 12 months have you ever felt discriminated against due to being LGBTI by healthcare or social services personnel (e.g. a receptionist, nurse or doctor, a social worker)?'.

([100]) Respondents were asked 'To how many medical staff/healthcare providers are you open about being LGBTI?' Source: FRA, EU-LGBTI II Survey, 2020.

9.2. Health dimensions in focus

The following section on SRHR highlights some of the specific barriers that certain groups of women and men face when attempting to access information and services.

9.2.1. Rights, access and outcomes – sexual and reproductive health in focus

'Good sexual and reproductive health is a state of complete physical, mental and social well-being in all matters relating to the reproductive system. It implies that people are able to have a satisfying and safe sex life, the capability to reproduce, and the freedom to decide if, when, and how often to do so' (UNFPA, 2021).

The 1994 International Conference on Population and Development (ICPD) framed SRH as a basic human right. Building on landmark agreements of the ICPD in Cairo and the Fourth World Conference on Women in Beijing (1995), governments and advocates have worked to realise and expand international commitments on SRH. Since then, the protection and promotion of SRH without any discrimination, while tackling gender inequalities on this issue, have been on UN agendas and included in the SDGs.

Gender inequalities significantly impact SRH outcomes. They are shaped and structured in accordance with gender norms and unequal power relations in society, and may strip women and men of their ability to control their SRHR. However, biological sex determines the extent to which an individual can access SRH. Women, in particular, are subjected to sexual and reproductive control and limited in their bodily autonomy (UNFPA, 2021). Inequalities based on age, (dis)ability, race, ethnicity, migration status and sexual orientation, as well as gender, influence access to SRH. This section looks specifically at family planning and birth control, sexually transmitted infections (STIs) and STDs, and abortion and pregnancies. It also explores SRH developments during the COVID-19 pandemic. Gender-based violence is considered a contributing factor to poor SRH, and specific findings are included where relevant.

Gender-sensitive approaches to sexual and reproductive health are key to public health

Women and men have different SRH needs, and gender-specific approaches to SRHR highlight sex-specific diseases, for example breast or prostate cancer. Unique challenges in this area constrain the health of both women and men.

Women may experience a range of gynaecological conditions influencing their SRH. Issues relating to the female reproductive cycle – from menstruation to menopause – including painful periods and endometriosis, are particularly common. Other SRH problems faced by women and girls are uterine fibroids, interstitial cystitis, polycystic ovary syndrome, infertility of various causes, limited access to abortion, and the impacts of sexualised violence. Unplanned pregnancies, complications around pregnancy and childbirth, unsafe abortions, gender-based violence, STIs, STDs and reproductive cancers threaten the well-being not only of women, but also of men and families (Starrs et al., 2018).

Men's reproductive health issues include male factor infertility, androgen deficiency, undescended testis, testis mass, scrotal disorders, phimosis, congenital chordee, Peyronie's disease, premature ejaculation and sexual dysfunction, as well as concerns over contraception, HIV infection and STIs (Wessells, 2021).

Since the 1994 ICPD, governments have been advised to encourage and enable men to take responsibility for their sexual and reproductive behaviour. Hawkes and Hart (2000) note the importance of recognising from the outset that men's reproductive concerns are unrelated to those of their female partners, and to acknowledge that 'men' around the world are not a homogeneous group with the same needs and worries. Just like women, men are characterised not only by their sex and gender, but also by their age, ethnicity, sexuality, educational status, income and occupation, geographical location, their position within a family, and their access to information and ability to use it.

Wessells (2021), while pointing out that urological disease burden among men becomes sig-

nificant only after the age of 45 years, suggests that identifying men's health risks and engaging them in their own health promotion should begin decades earlier. However, men have different priorities over their lifespan, and manage health risks differently from women. Often reluctant to seek medical attention even when symptoms are noticeable, men typically wait until a problem can no longer be ignored before contacting a healthcare professional (Pell, 2021).

Framing certain SRH conditions as affecting only one sex can be detrimental to health outcomes and reinforce gendered inequalities in health. WHO (2011) considers health interventions as gender transformative when they recognise gender differences and challenge and change the status quo of harmful gender norms, roles and relations.

Sex-based approaches to reproductive health focus on cervical and breast cancer, as these are also among the most common cancers among women. However, women-only cancers are not a concern for girls and women only. For example, cervical cancer is caused by human papillomavirus (HPV) ([101]), which also causes tongue and tonsil cancer, both of which can affect everyone, regardless of gender or sexual identity. Although the prevalence of high-risk HPV types is higher in women, and women are overall more likely than men to develop cancer as a result of HPV infection (Wendland et al., 2020), tongue and tonsil cancers are more common in men (Näsman et al., 2020).

Gender-transformative strategies for SRH interventions include offering HPV vaccinations to boys and men, and Italy was the first EU Member State to do so (Audisio et al., 2016). Vaccinating boys as well as girls not only protects both sexes from tonsil and tongue cancer but also reduces the circulating pool of virus in the male population, thus reducing the risk of transmission to women during sexual intercourse and the risk of cervical cancer. In addition, HPV vaccination for all, to prevent poor SRH, has proven to be cost-effective, and is explicitly recommended for all Member States (ECDC, 2020b). However, according to data provided by WHO in 2019, only 14 Member States include boys in the primary group for HPV vaccinations, and in only 10 of these is HPV vaccination for boys funded (Bonanni et al., 2020).

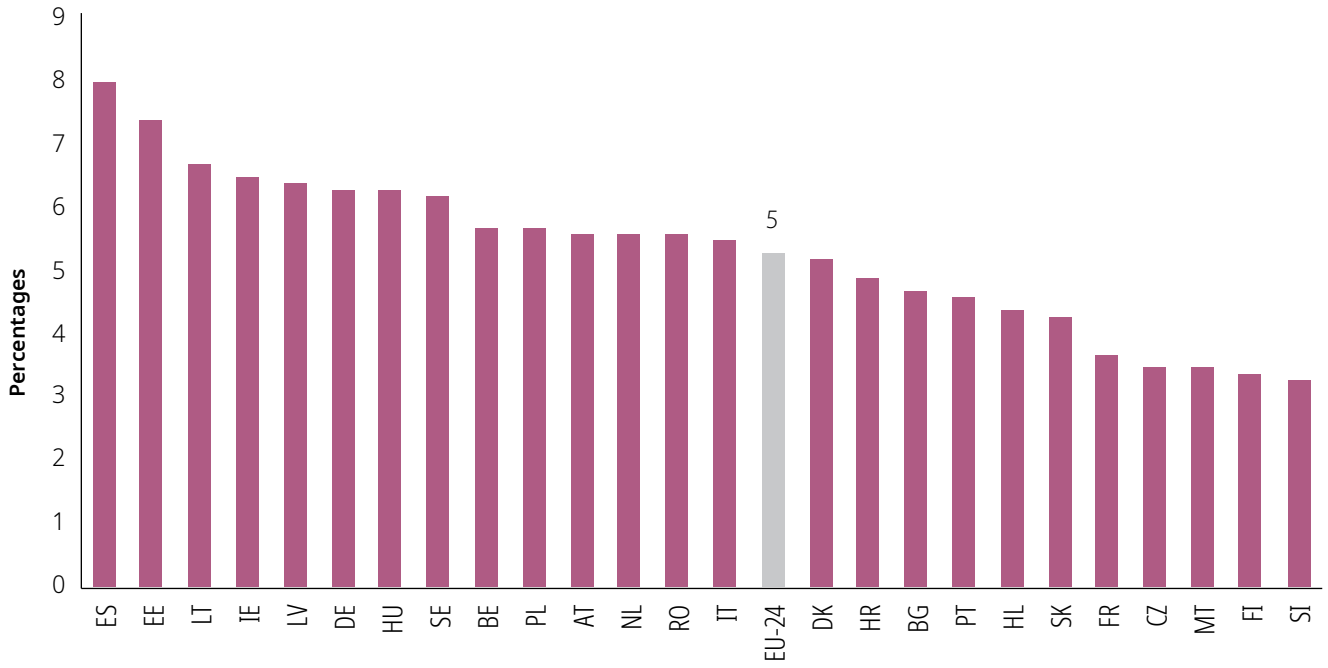
Gender-biased reproductive health often overlooks men

Counselling, access to information and services, and birth control methods used to avoid unintended pregnancy enable people to make informed choices in their sex lives. Starrs et al. (2018) state that modern contraception was arguably the most revolutionary intervention in SRH in the 20th century, facilitating the delinking of sex and reproduction and enabling couples and individuals to choose the number and timing of their children.

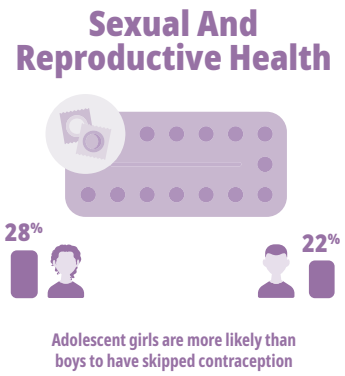
On average, almost 95 % of family planning needs are met among women in the EU, but differences remain between Member States. In Slovenia, only 3 % of women and girls report having unmet needs for family planning, but in Spain this figure is more than double that (8 %) (Figure 39).

([101]) HPV – a sexually transmitted infectious disease, the main cause of cervical cancer and genital warts (ECDC, 2020).

Figure 39. Women reporting unmet need for family planning, any method, by EU Member State (%, 15–49 years, 2017)



Note: Percentage of women of reproductive age (15 -49 years) who want to stop or delay childbearing but are not using a method of contraception.
Source: UN database, family planning indicators, https://www.un.org/development/desa/pd/data/family-planning-indicators, 2017.



Studies from Europe and worldwide show that family planning and birth control methods largely remain women's responsibility, with men frequently kept out of the contraceptive decision-making process (de Irala et al., 2011; Dereuddre et al., 2017). Although contraceptive options include methods for men, and some require their participation, family planning programming has predominantly focused on women. Contraceptive options and methods follow a gender-binary approach in their design, since they concern male condoms and female hormonal contraception, for example the pill or injections. Female condoms have existed for decades, but are either less known or perceived as too expensive in comparison with the male version (Peters et al., 2010). Similarly, male hormonal contraception is still under development, with clinical trials previously being interrupted because of side effects such as dizziness, depression and changes in weight (Yuen et al., 2020).

In their literature review covering Europe, Canada and the United States, Gold et al. (2021) found that ambivalence towards pregnancy, miscommunication between sex partners and/or between patients and healthcare professionals increase women's inconsistent contraceptive use. Research on men's contraceptive behaviour is still limited, but findings from France suggest that miscommunication with partners also seems to contribute to unplanned pregnancies. Half of male survey respondents who had not used contraception, leading to an unplanned pregnancy, said they thought their female partners were using birth control (Kågesten et al., 2015).

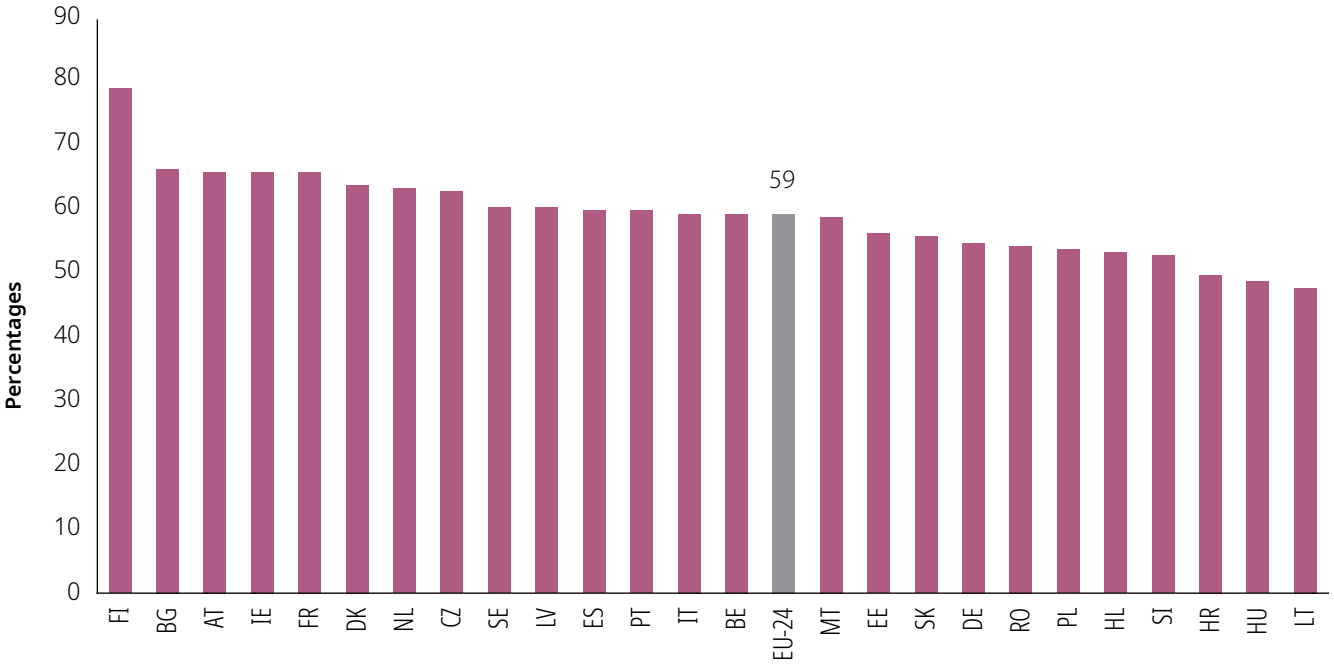
Contraception availability and accessibility are not the only criteria for uptake. Reliable supply and low-cost interventions are other crucial factors for SRH outcomes. In Romania, Roma women have access to and know about contraceptives, for example the pill, injections and intrauterine devices, but they cannot necessarily

afford them long term. Free SRH programmes are often discontinued or are not affordable because of transportation costs or corrupt health staff demanding bribes from Roma women (Kühlbrandt, 2019).

Overall, the UN estimates that 59 % of women in the EU can cover their contraception needs, with Finland outperforming all other Member States (Figure 40). However, data on contraceptive prevalence is lacking for men and for those defining their gender identity differently.

Male condoms and female hormonal contraception are the most prevalent birth control methods used by adolescents in the EU. On average, 65 % of 15-year-old girls and boys report using male condoms during their last intercourse, with the pill used by 28 % (WHO Regional Office for Europe, 2020a). A quarter of adolescents do not use either during intercourse, while more than a third in Croatia, Lithuania, Malta and Slovakia report not using any contraceptives (Inchley et al., 2020). Contraceptive access, availability, affordability and accountability vary greatly between Member States. According to the latest European Contraception Atlas (2020) ([102]), only seven Member States have comprehensive contraception policies (BE, DE, FR, LU, NL, PT and SE). Eastern European Member States (CZ, LT, HU, PL and SK) are the worst performing, although only in Poland has access to contraception been further restricted in the last 4 years. However, it should be noted that limited access to contraception is not associated with increased fertility rates: the 10 countries with the lowest access to contraception have lower fertility rates than the 10 countries with the highest contraception access.

Figure 40. Estimated prevalence of contraceptive use of any method among women, by EU Member State (%, 15–49 years, 2020)



Note: Percentage of women of reproductive age (15-49 years) who are currently using any method of contraception
Citation: United Nations, Department of Economic and Social Affairs, Population Division (2021). Model-based Estimates and Projections of Family Planning Indicators 2021, custom data acquired via website
Source: UN database, 2020.

([102]) The European Contraception Atlas, https://www.epfweb.org/european-contraception-atlas, has been produced since 2017 by the European Parliamentary Forum for Sexual and Reproductive Rights, a network of Members of Parliament throughout Europe who are committed to protecting sexual and reproductive rights. The Atlas stratifies 46 European countries by traffic light colours according to their access to contraceptive supplies, family planning counselling and online information.

Women and men both vital to stop sexually transmitted illnesses

Not only do contraceptive methods help prevent pregnancies, but barrier methods such as condoms also make sex safer by limiting the spread of STDs and STIs. The most common STI in the EU is chlamydia, in many cases a symptomless infection in both women and men. Safer sex habits and testing are, therefore, essential tools to stop chlamydia from spreading. Infection rates are highest among women younger than 24 years (ECDC, 2020a), but social stigma can result in young women often avoiding chlamydia testing (Balfe et al., 2010). However, understanding men's risk-taking behaviour can play an important role in preventing the spread of chlamydia. A study of young Swedish men tested for STDs revealed a variety of sexual risk behaviours and reasons why different subgroups did not use condoms. Migrant men reported more unprotected sex and more sexual partners overall, while men who have sex with men reported greater exposure to coercion to have unprotected sex (Helsing et al., 2021). Therefore, chlamydia prevention cannot solely rely on testing and safer sex practices. External factors, such as gender-based violence and gendered social stigma, also need to be taken into consideration in prevention policies.

According to WHO (2016c) and ECDC (2019) data, gonorrhoea is increasingly resistant to conventional antibiotics in Europe. Although this heightens the health risk for all people, gender implications need attention. While infertility is a serious consequence of an untreated gonorrhoeal infection for women and men, it is also associated with adverse pregnancy outcomes. Mother-to-child transmission of gonorrhoea can cause blindness in the newborn (WHO, 2016b). Since gonorrhoea is mostly asymptomatic, especially in women, women partners of those diagnosed should be screened. Prevention efforts should also include the supply of male and female condoms (Ndowa et al., 2012).

Cross-cutting research creates nuanced and context-specific evidence to improve SRHR policies, taking global, regional and local diversity into account. In the case of HIV, for example, such research would help policymakers move beyond individual focus to consider the multilevel root causes of HIV infections, such as biased and/or gender-blind healthcare systems, not enough funding for or ill-equipped prevention programs, etc. Co-factors such as drug use, poverty, low health literacy, and the relationship between different factors shaping health inequalities (Hankivsky, 2012).

Gender inequalities in relation to HIV determine access to prevention and treatment outcomes, especially for women and girls. Factors such as younger age, pregnancy, gender-based violence, limited access to transportation and financial resources, and lack of bodily autonomy expose women and girls to HIV risk (Ghanotakis et al., 2012; UNFPA, 2021). Primary health services should not only respond to the effects of HIV, but should also begin to address the underlying gendered problems of HIV so that interventions are better attuned to different population groups. HIV prevention, for example, mostly targets men who have sex with men, despite the fact that 30–40 % of new cases are in heterosexual men infected by women (Weber and Castellow, 2012).

While sex between men is the main driver of HIV transmission in the EU, heterosexual HIV transmission is the second most common mode overall. In nine Member States – Estonia, France, Italy, Latvia, Luxembourg, Portugal, Romania, Finland and Sweden – it accounts for most new infections (ECDC/WHO, 2019). This underlines the need for women and men of all sexual orientations to be included in HIV awareness campaigns. The same holds true for other interventions and policies concerning STIs and STDs. The ECDC continuously advocates for gender, age, HIV status and other characteristics to be recorded to obtain better-quality data to help tackle STIs and STDs in the EU (ECDC, 2021).

Abortion, pregnancy and maternal care disparities across the European Union

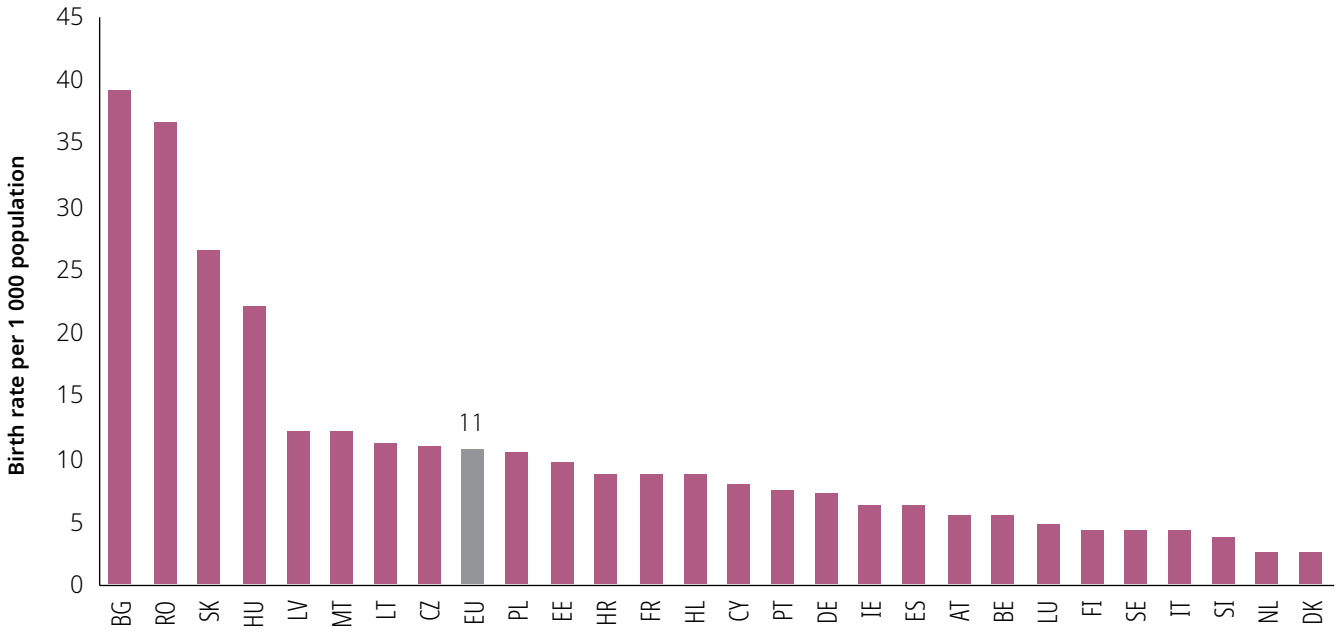
Estimates suggest that almost half (48 %) of pregnancies worldwide are unplanned (Bearak et al., 2020). This shows that abortion services and care are essential components of public health, to ensure high-quality SRH for women and girls (WHO, 2012). The physical and mental health of women and girls who have an abor-

tion requires more than just that the procedure is medically safe. Abortion can be considered safe only when it is performed without the risk of criminal or legal sanction, stigmatisation, stress or isolation (Starrs et al., 2018). Laws and policies on accessing abortion services, with reproductive health consequences for those using them, vary greatly across Europe. Although barriers to legal abortions differ across the EU, all Member States except one allow it under certain conditions. In Malta, all abortions are banned (IPPF, 2019).

Eleven Member States – Belgium, Germany, Ireland, Spain, Italy, Latvia, Luxembourg, Hungary, the Netherlands, Portugal and Slovakia – have a mandatory waiting period. Belgium, Germany, Italy, Lithuania, Hungary, the Netherlands and Slovakia mandate pre-abortion counselling. The only countries not requiring third-party consent, for example parental consent, for abortion in underaged children, are Belgium, Ireland, the Netherlands, Portugal and Finland (IPPF, 2019). Legal provisions can change in both directions: more liberal abortion policies were recently adopted in Ireland (UNFPA, 2021), while Poland tightened its already restrictive abortion legislation in 2020. Overall, eastern European Member States have the most unwanted pregnancies and 66% of unintended pregnancies end in abortion here (Bearak et al., 2020). They also rank low on the Contraception Atlas (2020), suggesting inadequate SRHR policies. According to the most recent WHO data available (2015–17) ([103]), the fewest abortions in the EU are in Member States with the most restrictive abortion laws – Ireland ([104]), Malta and Poland.

Lastly, many abortions are carried out unregistered, either by medical staff or outside the healthcare system altogether, which can explain that in the UN European region, between 2010 and 2014, 11 % of all abortions were deemed unsafe (Ganatra et al., 2017). The same study also found that countries with highly restrictive abortion laws and policies had a higher share of unsafe abortions than countries with less restrictive laws.

Figure 41. Adolescent birth rate by EU Member State (per 1 000 population, 15–19 years, 2018)



Source: SDG 3.7.2., UN, https://unstats.un.org/sdgs/unsdg, 2018.

([103]) WHO, European Health Information Gateway, https://gateway.euro.who.int/en/hfa-explorer/#cyDZ8PKNUc, 2018.
([104]) Recent changes in abortion legislation in Ireland (2018) are not reflected in the data yet.

Sexuality education is essential to prevent unplanned pregnancies in adolescence. Young people are in need of comprehensive sexuality education to understand and enact their rights to health, well-being and dignity. Access to rights-based sexuality and relationship education varies between Member States (EIGE, 2020a). The German Federal Centre for Health Education (BZgA) ([105]) developed sexuality education standards for Europe in 2010 as a framework for policymakers, education and health authorities, and specialists (WHO Regional Office for Europe and BZgA, 2010). An assessment carried out in 2018 (BZgA and IPPF EN, 2018) found that the implementation of sexuality education differed widely between and within EU countries. While sexuality education is mandatory in most Member States (except Bulgaria, Italy, Cyprus, Lithuania, Poland and Romania), exemptions can be granted based on faith and moral grounds (EIGE, 2020a). Inadequate sexuality education, along with other factors, such as lack of access to contraceptives, can contribute to higher birth rates among adolescents. In the EU, birth rates in this group are highest in the eastern European Member States, with rates in Bulgaria, Hungary, Romania and Slovakia more than double the EU average (Figure 41). In these countries, sexuality education is optional, with students also start learning about sexual health issues later in their school life in comparison to their peers in other Member States. (Picken, 2020).

Maternal care inequalities persist, especially for migrants

Although maternal and child mortality has been steadily decreasing in the EU, pregnancy still carries health risks (WHO, 2017). Some health conditions occur only during or after pregnancy and require assessment from a gender-informed perspective. Researchers and practitioners alike have long overlooked several pre- and postnatal health conditions, with care in these areas requiring improvement. For example, hyperemesis gravidarum, or chronic morning sickness, affects an estimated 2–4 % of pregnancies and is potentially deadly (McCarthy et al., 2014). Yet it is often unrecognised by healthcare professionals and classified as something imagined or exaggerated by women suffering it (Jansen et al., 2020). Likewise, violence in childbirth, known as obstetric violence, poses a risk to maternal health in the EU ([106]).

UNICEF data shows that the maternal mortality ratio (per 100 000 live births) in the 27 Member States in 2017 ranged from 2 in Italy and Poland to 19 in Latvia and Romania. Maternal mortality and care inequalities are higher among marginalised and vulnerable communities such as migrants, refugees, asylum seekers, women with disabilities, prisoners and victims of trafficking. Access to maternal healthcare services and midwifery in the EU is affected by the interplay between health systems, laws, policies, socioeconomic factors and attitudes of healthcare professionals and users.

In the EU, only 11 Member States – Belgium, Germany, Estonia, Greece, Spain, France, Italy, the Netherlands, Portugal, Romania and Sweden – have laws regulating free or subsidised maternal care for undocumented migrants (Center For Reproductive Rights, 2020). However, implementation of legal frameworks is not necessarily automatic. Greece, Spain and Italy, which receive more than half of all migrant arrivals in the Mediterranean, have unfavourable maternal health outcomes for documented and undocumented migrants, despite existing policies granting access to care (Grotti et al., 2018). Undocumented pregnant migrants in Germany, Croatia, Slovenia and Sweden fear deportation if they seek medical assistance, as healthcare staff in these countries are required to report their patients' immigration status (Make Mothers Matter, forthcoming 2022). But it is not only undocumented migrants who can experience limited access to maternal care. Foreign workers' visa status also determines their access to SRHR. In some Member States, women who work as au pairs must

([105]) The BZgA has been designated a WHO collaborating centre for sexual and reproductive health since 2003. The BZgA has a close cooperation with the IPPF EN.

([106]) For further information, Section 3.2.2 of the report Gender Equality and Health in the EU offers a detailed overview of obstetric violence in the EU, https://op.europa.eu/en/publication-detail/-/publication/5b59409f-56e4-11eb-b59f-01aa75ed71a1.

be unmarried and without children as a precondition for obtaining a visa. Au pairs who become pregnant are effectively stripped of their residency permit and, consequently, their right to healthcare (PICUM, 2016).

Roma women also have less favourable access to maternal care than the majority population in their EU Member States (Franklin et al., 2021). This is particularly worrying, as some Member States with high maternal mortality rates have large Roma populations (FRA, 2016). Other racial inequalities in maternal mortality are well documented in the United Kingdom, where black mothers are at least four times as likely, and Asian mothers twice as likely, to die during childbirth as their white peers (MBRRACE-UK, 2020).

9.2.2. The COVID-19 pandemic aggravates and brings forth health inequalities

In the early summer of 2021, most EU countries were simultaneously battling a third wave of COVID-19 and aggressively rolling out large-scale vaccination programmes. Various levels of restrictions were in place and progressively being lifted. At the time of writing, the EU had reported more than 33 million cases and at least 730 000 direct COVID-19-related deaths ([107]). France, Germany, Italy, Spain and Poland have had the highest number of cases – from nearly 3 million in Poland to more than 5.7 million in France ([108]). If, overall, about 7 % of the EU population has been infected, the highest shares of cases by population are in less populated countries – Czechia, Slovakia, Slovenia and Luxembourg – with rates ranging from 11 % in Luxembourg to 16 % in Czechia ([109]). The shock of such a staggering loss of life in little more than a year and the ramifications of many people suffering long-term effects from COVID-19 will be felt for years to come.

The pandemic's impact has been very unequal across the EU and over time. Western and southern European Member States were more affected than central European countries during the first wave in spring 2020. In contrast, the second and third pandemic waves have seen central and eastern European countries such as the Baltic states, Czechia, Poland and Romania more affected (OECD/European Union, 2020).

The pandemic has impacted different groups of people differently, and to different degrees, depending on a varitey of factors including the level of exposure to the virus and prior health status. many authors, such as Bambra et al. (2020b), have pointed out, differences in COVID-19 infection rates and mortality have highlighted pre-existing socioeconomic inequalities and the unequal burden of chronic disease across the population. Some authors have described the current situation as a 'syndemic' – in which the interaction of a pandemic and a NCD, each exacerbating the effect of the other, against the backdrop of significant social and economic disparity, has led to adverse outcomes for large segments of the population (Bambra et al., 2020b; Horton, 2020).

This section presents data gathered during the pandemic on mortality, morbidity, and vaccine uptake and hesitancy. Analysis is also provided on three specific gendered impacts of the pandemic on health: poor mental health, a rise in gender-based violence and the provision of SRH services in a crisis.

COVID-19 deadlier for men, 'long COVID' more likely for women

There are considerable variations in how data is provided across countries. For example, the number of people tested differs greatly between countries. Some countries test individuals more than once and provide data on the number of tests, some countries provide data on the number of individuals tested, and other countries test only people who are severely ill or hospitalised (Rozenberg et al., 2020). In addition, data on testing, prevalence and mortality is not

([107]) ECDC COVID-19 surveillance update, https://www.ecdc.europa.eu/en/cases-2019-ncov-eueea, accessed 7 July 2021.
([108]) ECDC COVID-19 surveillance update, https://www.ecdc.europa.eu/en/cases-2019-ncov-eueea, accessed 7 July 2021.
([109]) Authors' elaboration based on ECDC daily data, https://www.ecdc.europa.eu/en/cases-2019-ncov-eueea, accessed as of 19 May 2021, based on 2020 data for population.

always separated by sex, with evidence showing no progress, or even a decline, in the number of countries reporting sex-disaggregated data over time ([110]). According to the Global Health 50/50 initiative, which tracks sex-disaggregated data on COVID-19 from 119 countries, the most frequently reported data relates to confirmed cases (68 % of countries) and deaths (55 % of countries) (Global Health 50/50, 2020).

Early in the pandemic, women were more likely to get tested than men, as priority was given to healthcare and residential care workers – both groups mostly composed of women. At the time of writing, data on COVID-19 cases disaggregated by sex and age is unavailable for all Member States, hindering a comprehensive gender analysis of the pandemic's toll.

Men are more likely to have severe outcomes

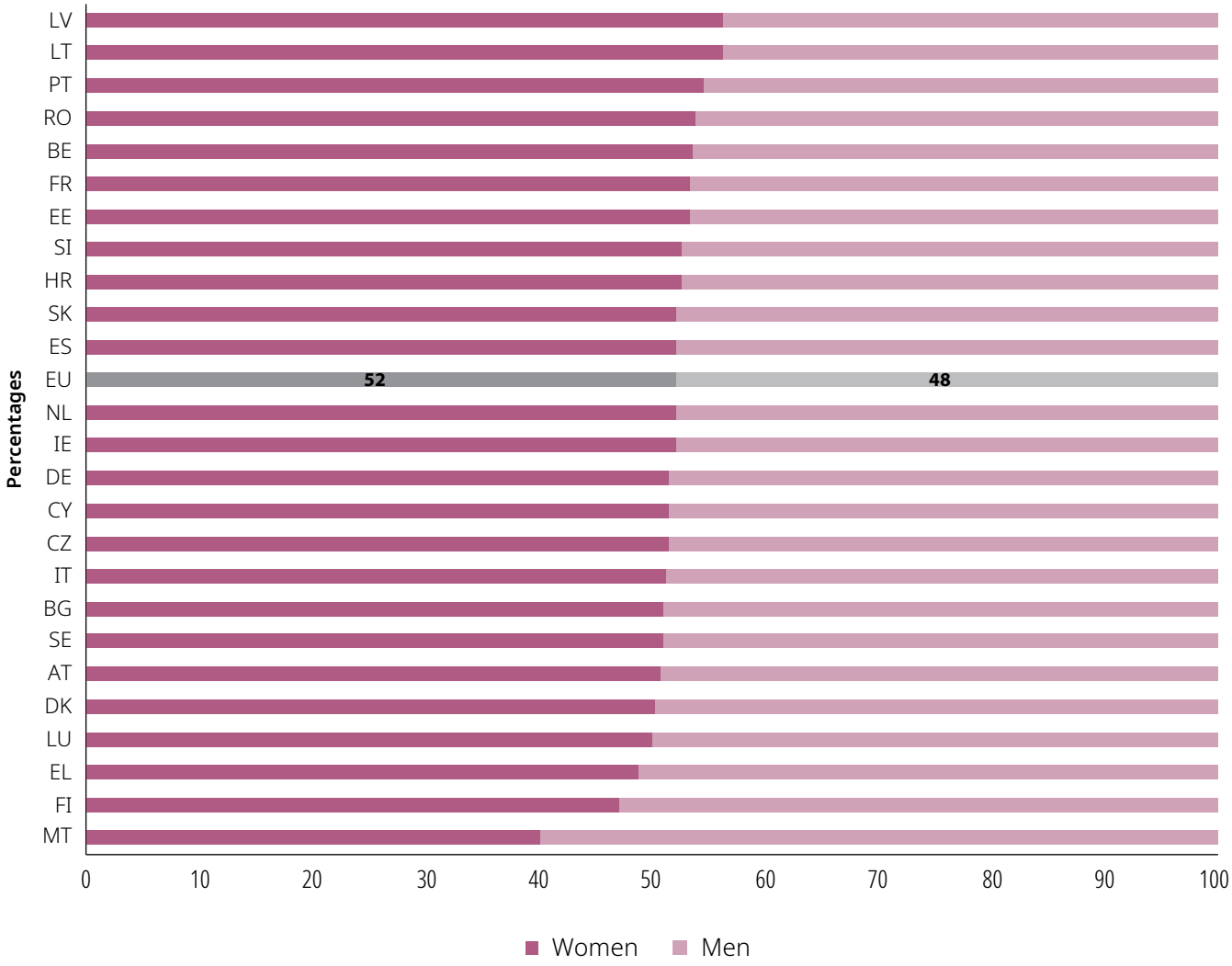
Early in the pandemic, overall infection rates appeared to be similar among women and men across EU countries (Rozenberg et al., 2020). Likewise, at the time of writing, women accounted for just over half of all cases in EU countries for which data is available (52 %) (Figure 42). In only three Member States (Greece, Malta and Finland) were COVID-19 rates higher among men.

When age is taken to account, large gender differences are revealed in the number of cases. A study of 10 European countries, including seven EU Member States ([111]), found that, among those of working age (i.e. up until about the age of 60), infections in women far outnumber those among men; at older ages, infection is more common in men. The highest rates of infection among men are among those aged between 70 and 79 years. Higher rates of infection among women have been linked to their presence in caring professions, especially healthcare (Tomáš Sobotka et al., 2020). This is consistent with reports that poor working conditions, including a lack of appropriate occupational health and safety measures and precarious employment, contribute to high infection levels in women-dominated frontline sectors (OECD, 2020b; Pelling, 2021; Shallcross et al., 2021).

([110]) The COVID-19 Sex-disaggregated Data Tracker: April update report, Global Health 50/50, https://globalhealth5050.org/wp-content/uploads/April-2021-Data-tracker-update.pdf.

([111]) Belgium, Czechia, Denmark, Germany, Italy, Norway, Portugal, Spain.

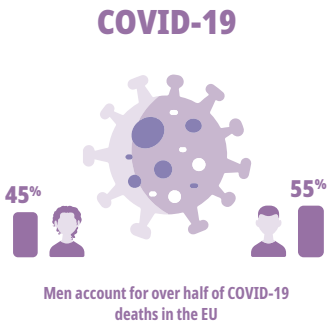
Figure 42. Cases of COVID-19 in the EU by sex and Member State (%, June 2021)



Source: The Sex, Gender and COVID-19 Project, Global Health 50/50, the African Population and Health Research Center and the International Center for Research on Women. EU: authors' elaboration (BG, CY, HR, MT data was not available). Updated on 21 June 2021. Data extracted on 25 June 2021.

Evidence shows that men are more likely than women to become severely ill or die from COVID-19 complications ([112]), with gender differences often quite large (Parra-Bracamonte et al., 2020; Rozenberg et al., 2020). In spring 2020, the mortality rate related to COVID-19 infections was significantly higher among European men than among European women (Pérez-López et al., 2020). The rates of all-cause mortality within 30 days of COVID-19 diagnosis and of intensive care unit admission were also higher among men (Kragholm et al., 2020).

Across the world, the Global Health 50/50 data for April 2021 shows clear gender differences in health outcomes. Although women are more likely to be tested – women account for 57 % of COVID-19 tests overall – women and men are similarly affected. Of confirmed cases, women accounted for 51 % and men for

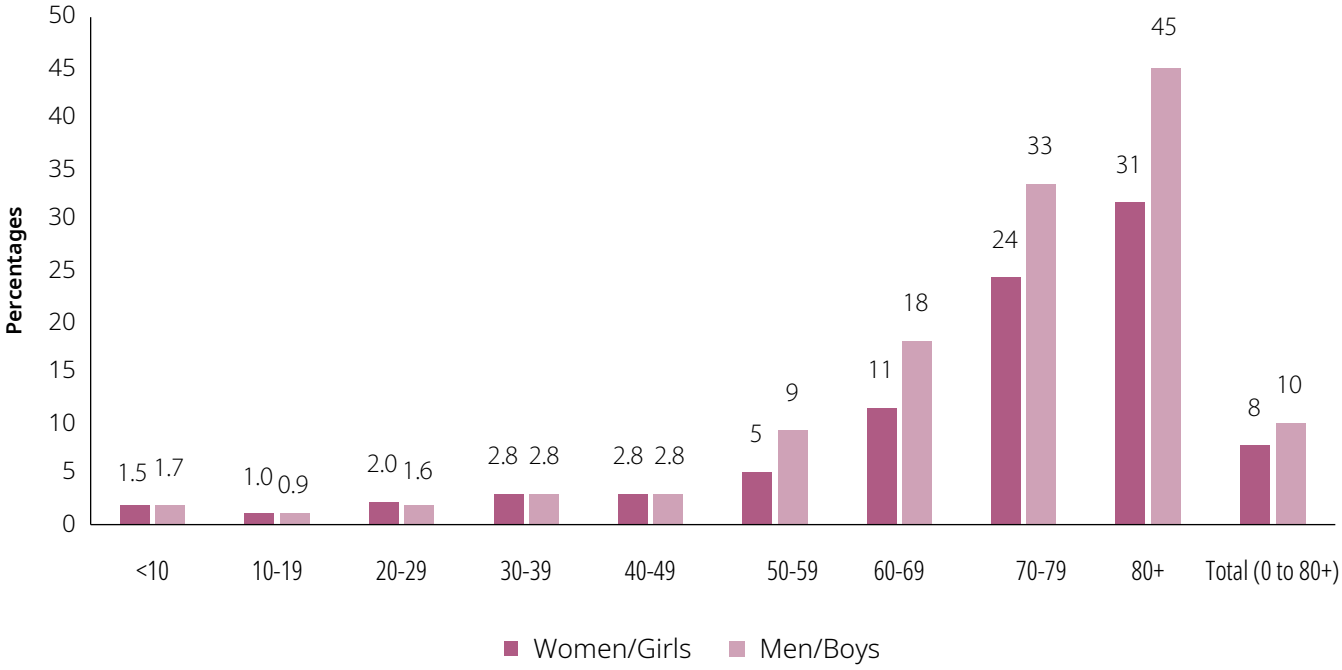


([112]) This is in line with research on other infectious diseases, which has found that mortality from infectious sepsis is 70 % higher in men than in women. Men are also more likely than women to die from severe acute respiratory syndrome (SARS) and Middle East respiratory syndrome (MERS) (21.9 % vs 13.2 %) (Rozenberg et al., 2020).

49 % globally ([113]). However, men are more likely to be hospitalised and to be admitted to an intensive care unit, accounting for 53 % of hospitalised patients and 64 % of those requiring intensive care.

Data from the ECDC for 10 EU Member States reflects similar trends, that is that men are at higher risks of severe disease (as measured by the need to hospitalise) and death from COVID-19, with gender differences increasing with age (Figure 43). Overall, 8 % of women and 10 % of men infected with COVID-19 were hospitalised as a result; however, among those aged 70–79 years who contracted COVID-19, 24 % of women and 33 % of men were hospitalised. For those aged 80 years or older, the rate of hospitalisation reached 31 % for women and 45 % for men.

Figure 43. Hospitalisation rates by age and sex out of all cases until week 23, 2021 (%, 10 EU Member States)

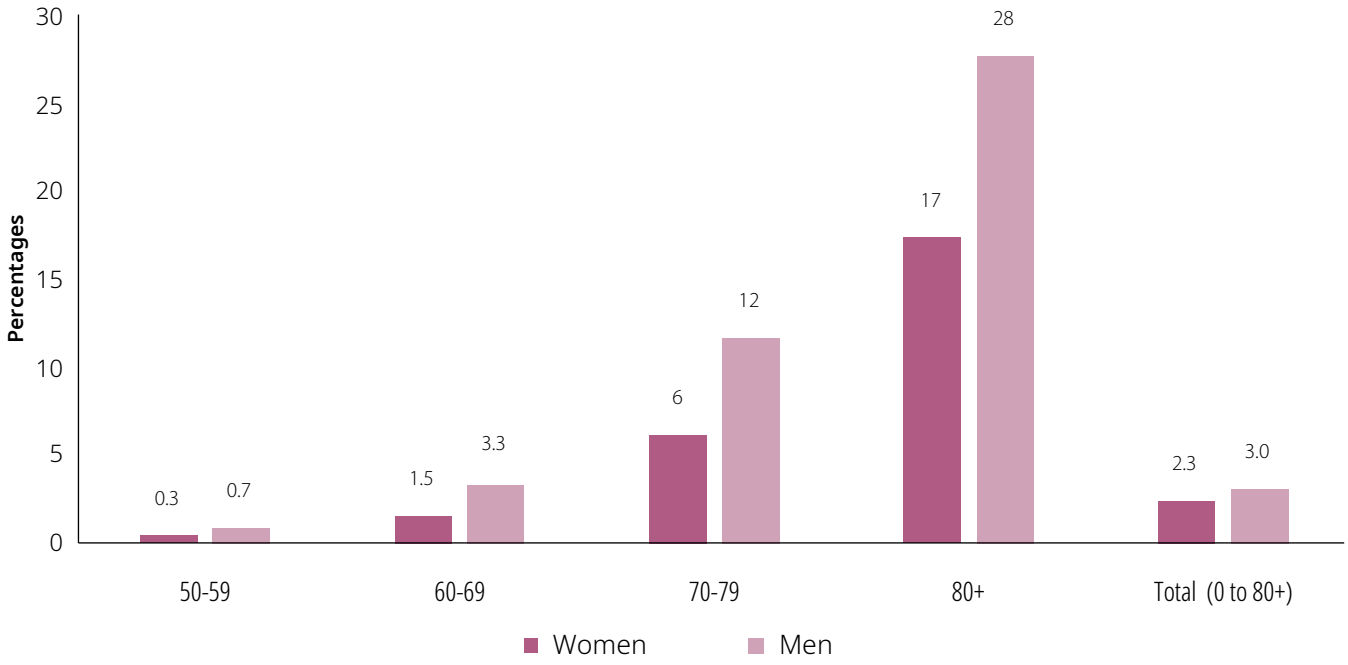


Source: ECDC, data for 10 EU Member States (CZ, DE, IT, CY, LU, MT, AT, PL, SK, FI and SE). Data extracted on 17 June 2021.

Similarly, data on fatality from COVID-19 shows that, in the 10 EU Member States reporting data disaggregated by age and sex, about 2 % of women and girls who tested positive for COVID-19 died from the disease, compared with 3 % of boys and men. Disaggregating by age group shows that overall fatality rates, as well as gender differences, are considerably higher among patients aged 70–79 years (6 % of women and 12 % of men) and among patients aged 80 years and older (17 % of women and 28 % of men dying) (Figure 44).

([113]) The COVID-19 Sex-disaggregated Data Tracker: April update report, Global Health 50/50, https://global-health-summit.europa.eu/rome-declaration_en.

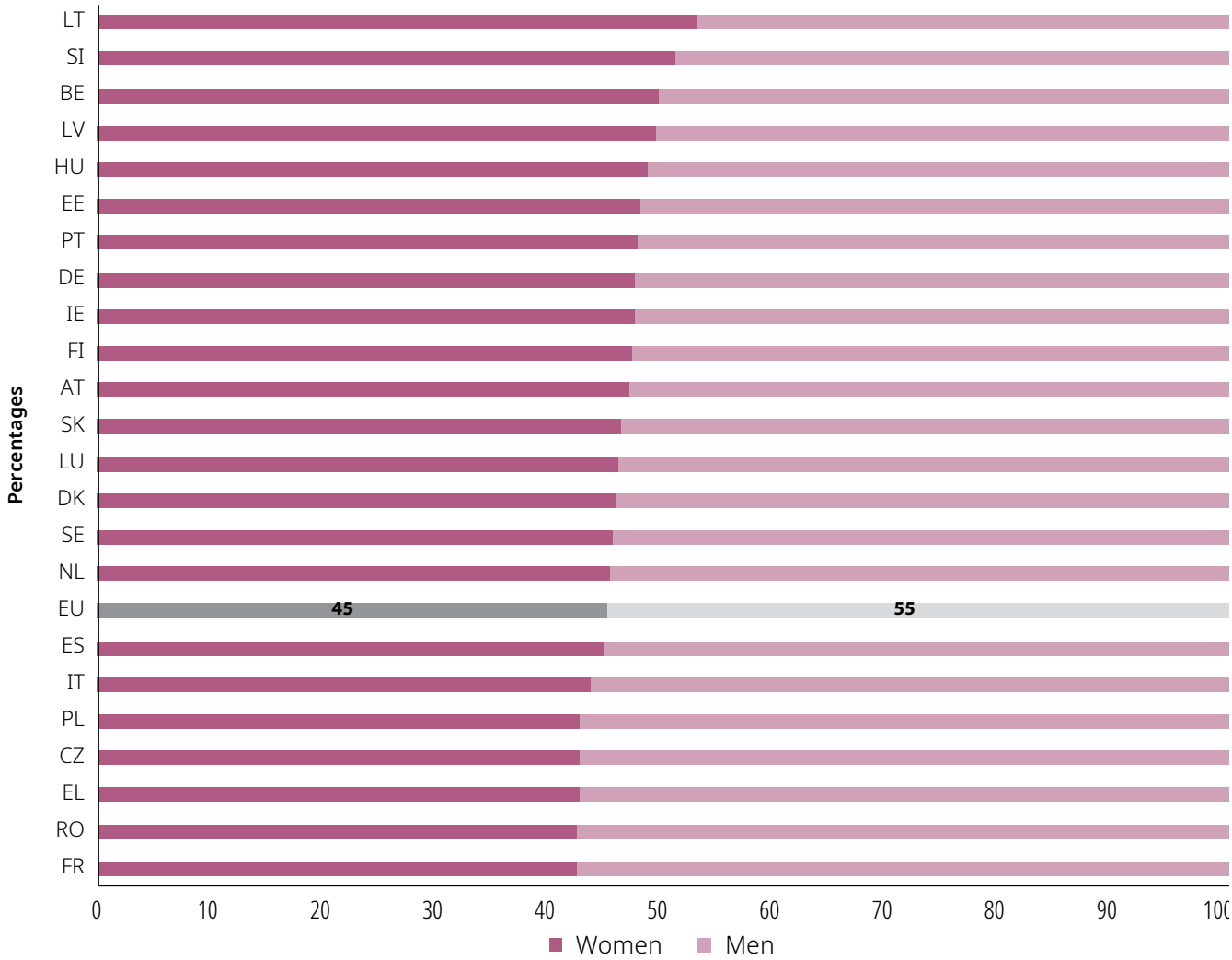
Figure 44. Fatality rates by age and sex out of all cases until week 23, 2021 (%, 10 EU Member States)



Source: ECDC, data for 10 EU Member States (CZ, DE, IT, CY, LU, MT, AT, PL, SK, FI and SE). Data extracted on 17 June 2021.

Overall in the EU, men account for 55 % of COVID-19 deaths. Their increased risk of dying is reflected in almost all EU countries for which data is available, with the exception of Lithuania and Slovenia (Figure 45).

Figure 45. Deaths of COVID-19 in the EU, by sex and Member State (%, April 2021)



Source: The Sex, Gender and COVID-19 Project, Global Health 50/50, the African Population and Health Research Center and the International Center for Research on Women. EU: authors' elaboration (BG, CY, HR, MT data was not available). Updated on 21 June 2021. Data extracted on 25 June 2021.

Figure 44 presents for each group the case fatality rate, that is the number of deaths divided by the number of COVID-19 cases confirmed by testing. It indicates the severity of infection among different population groups. However, it can be misleading, as values for both the number of cases and the number of deaths are likely to be underestimated, for example because of insufficient testing. It has been recommended that fatality rates (Figure 44) and data on COVID-19 deaths (Figure 45) be read in conjunction with excess mortality to best capture the toll (Hantrais, 2021; Islam et al., 2021).

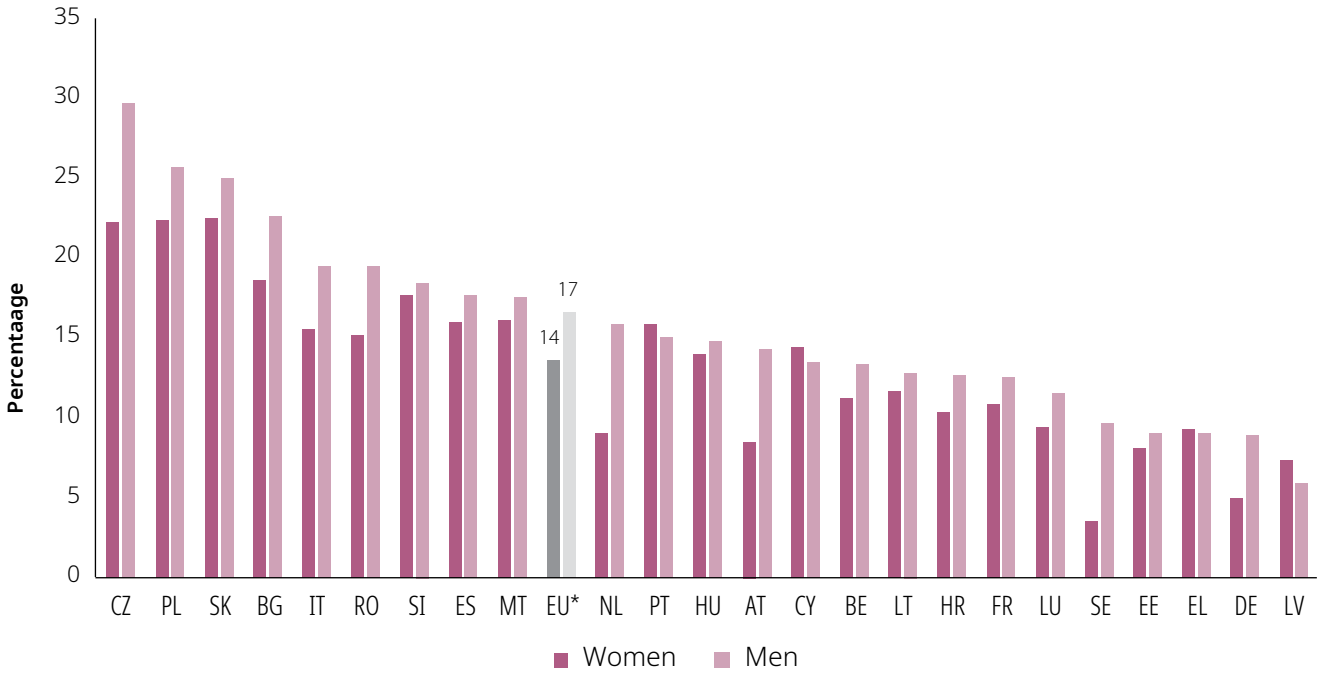
In the EU, men's mortality in 2020/2021 was, on average, 17 % higher than in an average week in previous years, and 14 % higher for women (Figure 46). The excess mortality among men in 2020/2021 was highest in Czechia, Poland and Slovakia, at 30 %, 26 % and 25 %, respectively. The same three countries accounted for the highest excess mortality among women in the EU: 22 %, 22% and 23 %, respectively (Figure 46).

These findings confirms WHO data showing that analyses of numbers of registered COVID-19 deaths underestimate the full toll of the pandemic ([114]). A similar analysis of 29 high-income countries concluded that estimated excess mortality substantially exceeded the number of reported deaths from COVID-19 in many countries. The highest excess death rates (per 100 000) for men were in Hungary, Italy, Lithuania, Poland and Spain; the highest rates for women were in Belgium, Hungary, Lithuania, Slovenia and Spain (Islam et al., 2021).

The COVID-19 pandemic has been particularly devastating for nursing home residents. Miralles et al. (2021) found that the highest COVID-19 mortality rates in nursing homes in six EU countries ranged from 26 % to 66 %.

Gender differences in severe COVID-19 infections and associated mortality are often attributed to comorbidities, behavioural habits and biology, including differences in immune systems (Kragholm et al., 2020; Rozenberg et al., 2020). Health behaviours such as smoking, and comorbidities such as cardiovascular disease, hypertension and diabetes, which are more common among men, are linked to increased COVID-19 mortality rates. This may explain some gender differences (Franklin et al., 2021; OECD, 2020a; Rozenberg et al., 2020). Evidence shows that women are more likely than men to follow hand hygiene practices (Baker, 2019), to adhere to social distancing and other public health recommendations, such as mask wearing (Capraro and Barcelo, 2020; Galasso et al., 2020), and to seek preventive care (Sharma et al., 2020), all of which can reduce infection rates and improve health outcomes.

Figure 46. Excess mortality in 2020–2021, compared with 2016–2019, by sex and EU Member State (%, latest data available in 2021)



NB: Excess mortality is the number of additional deaths in a week (average of 2020–2021) compared with a baseline period and is expressed as a percentage. The baseline is given by average weekly deaths in 2016–2019. The higher the value, the more additional deaths have occurred, compared with the baseline. (1) Last week in 2021 for which data is available. EU calculated using week 4, available for all Member States. *Includes only 26 Member States (IE data was not available). Data is provided in Annex 4, Table 20.
Source: Authors' calculations, based on Eurostat, Deaths by week and sex, https://ec.europa.eu/eurostat/web/products-datasets/-/demo_r_mwk_ts, extracted on 27 April 2021 (2021, provisional data).

([114]) The true death toll of COVID-19: Estimating global excess mortality, https://www.who.int/data/stories/the-true-death-toll-of-covid-19-estimating-global-excess-mortality.

Beyond sex and age, understanding the full impact of the pandemic requires analysis of the other groups who have been most affected.

Gender intersects with occupation, age, and migration status to increase vulnerability to infection

The COVID-19 outbreak has led to an unprecedented shift in remote working to help slow spread of the virus (ILO, 2020). However, teleworking has not been equally accessible to all workers. Key gender differences exist between those who are able to follow 'stay at home' orders and those whose physical presence is still required at work (EIGE, 2021c). Most governments in the EU established lists of occupations deemed 'critical', 'essential' or 'key' (EIGE, 2021c). In most cases, they involved roles considered necessary for national socioeconomic functioning and which could not be carried out remotely. These jobs are mostly in health and care, victim support services, law enforcement, education, agro-industry, supermarkets, pharmacies and banks.

Women are over-represented among essential workers. Eurostat data shows that women account for 88 % of personal care workers, 84 % of cleaners and helpers, 73 % of education workers and 72 % of health professionals in EU countries ([115]). Fasani and Mazza (2020) estimated that migrant workers constitute 13 % of all key workers and are also over-represented in some low-skill essential jobs, for example personal care workers, drivers, transport and storage labourers, and food-processing workers. As highlighted by the International Organization for Migration, some EU countries with the highest COVID-19 numbers on 1 March 2021 also have some of the highest numbers of foreign-born workers in healthcare – Czechia, Germany, Spain, France and Italy ([116]).

Workers on the frontline of the pandemic response are likely to have more contact with the general public, including those who are possibly infected (OECD, 2020b; Pelling, 2021; Shallcross et al., 2021). This both increases their risk of infection and magnifies the physical and psychological pressure they experience (King et al., 2020). An index of social distancing risks identified accommodation, food services, wholesale and retail trade, and social and personal services as the sectors whose workers face the greatest risk of COVID-19 exposure as a result of regular interpersonal communication, teamwork and customer service tasks (Pouliakas and Branka, 2020). It also estimated that vulnerable workforce groups, such as women, older employees, foreigners and those with a lower level of education, are disproportionately exposed to infection risk at work. Also at increased risk are those working longer hours, on multiple sites or in micro-sized workplaces (Pouliakas and Branka, 2020).

In Germany, Italy, Spain and the United States, around 70 % of confirmed infections among health workers have occurred in women (Rozenberg et al., 2020). Globally, women accounted for an estimated 72 % of COVID-19 cases among healthcare workers, as of April 2021 ([117]). Preliminary EU-OSHA data reveals a stark increase in psychosocial risks in the health and social care sectors. Workforce shortages, partly due to healthcare staff being off sick or in self-isolation, have led to busy schedules, long working days, failure to take time off work and constant struggles with work–life balance (EU-OSHA, forthcoming 2022). These findings support the hypothesis of higher levels of infection and psychosocial risks among working-age women being linked to occupational risks (Tomáš Sobotka et al., 2020).

Migrant workers, especially women, are particularly vulnerable to COVID-19 infection because of their over-representation in care and domes-

([115]) EIGE, COVID-19 web page, https://eige.europa.eu/covid-19-and-gender-equality/essential-workers. Data from EU-LFS, 2018.
([116]) International Organization for Migration, Migration Data Portal 'Migration data relevant for the COVID-19 pandemic', https://migrationdataportal.org/themes/migration-data-relevant-covid-19-pandemic, accessed 19 May 2021.
([117]) The COVID-19 Sex-disaggregated Data Tracker: April update report, https://globalhealth5050.org/wp-content/uploads/April-2021-Data-tracker-update.pdf, Global Health 50/50.

tic work and lower socioeconomic status. Structural inequalities affecting ethnic minorities and people of low socioeconomic status aggravate infection risk already experienced at work through crowded housing and long commuting times, making physical distancing and self-isolation difficult (Bhala et al., 2020).

Women are more likely to have 'long COVID'

Emerging evidence points to significant numbers of people with COVID-19 continuing to have symptoms weeks or even months after contracting the virus (Dennis et al., 2020). The intensity of symptoms does not always mirror the severity of the initial infection. Symptoms can linger, appear for the first time or become worse (Gousseff et al., 2020). Although the prevalence and risk factors remain unclear, this syndrome, termed 'long COVID' or 'post-COVID-19 syndrome', can affect multiple organs and lead to long-lasting health issues such as diabetes (Nalbandian et al., 2021).

More than 1 year into the pandemic, estimates of the prevalence of long COVID are emerging, with some studies finding that the phenomenon could affect half of COVID-19 survivors after 14 weeks (Moreno-Pérez et al., 2021), with three quarters of COVID-19 patients showing at least one ongoing symptom after 6 months (Huang et al., 2021). Long COVID has been referred to as a major public health crisis in waiting. Figures from the UK Office for National Statistics show that 1 million people have self-symptoms 4 weeks after first being infected, and nearly 400 000 people still report symptoms after a year (Ayoubkhani, 2021). Women of working age, people with disabilities, those living in deprived areas and people working in care professions are most likely to be affected with long COVID (Ayoubkhani, 2021). Most respondents report that symptoms adversely impact their day-to-day activities.

A study in the United Kingdom found that women younger than 50 years are five times less likely than men and older women to report feeling fully recovered from infection. They are twice as likely as men of the same age to report greater fatigue, seven times more likely to be breathless and generally more likely to have increased difficulties or new disabilities. More than half of COVID-19 patients report not being fully recovered 7 months after having the first symptoms, with younger women most affected. Long-term outcomes are more frequent among individuals who were previously healthy (Sigfrid et al., 2021).

Another study in the United Kingdom has highlighted that the majority of hospitalised patients are not fully recovered after 5 months, with white middle-aged women among those experiencing more than nine persistent symptoms ([118]).

Patients' associations point to a lack of recognition by health and social protection systems of some severe health limitations associated with long COVID, particularly when it concerns classifying long COVID as an occupational disease.

Vaccine uptake and hesitancy

In the EU, vaccination roll-outs organised by national governments have prioritised health professionals and age groups most at risk of severe outcomes. Studies from various countries show broad public support for such approaches (Duch et al., 2021; Persad et al., 2021), possibly acknowledging healthcare workers' essential role in the pandemic response. High vaccination rates are considered essential to end the pandemic. So too is vaccine uptake among high-priority groups (Zintel et al., 2021).

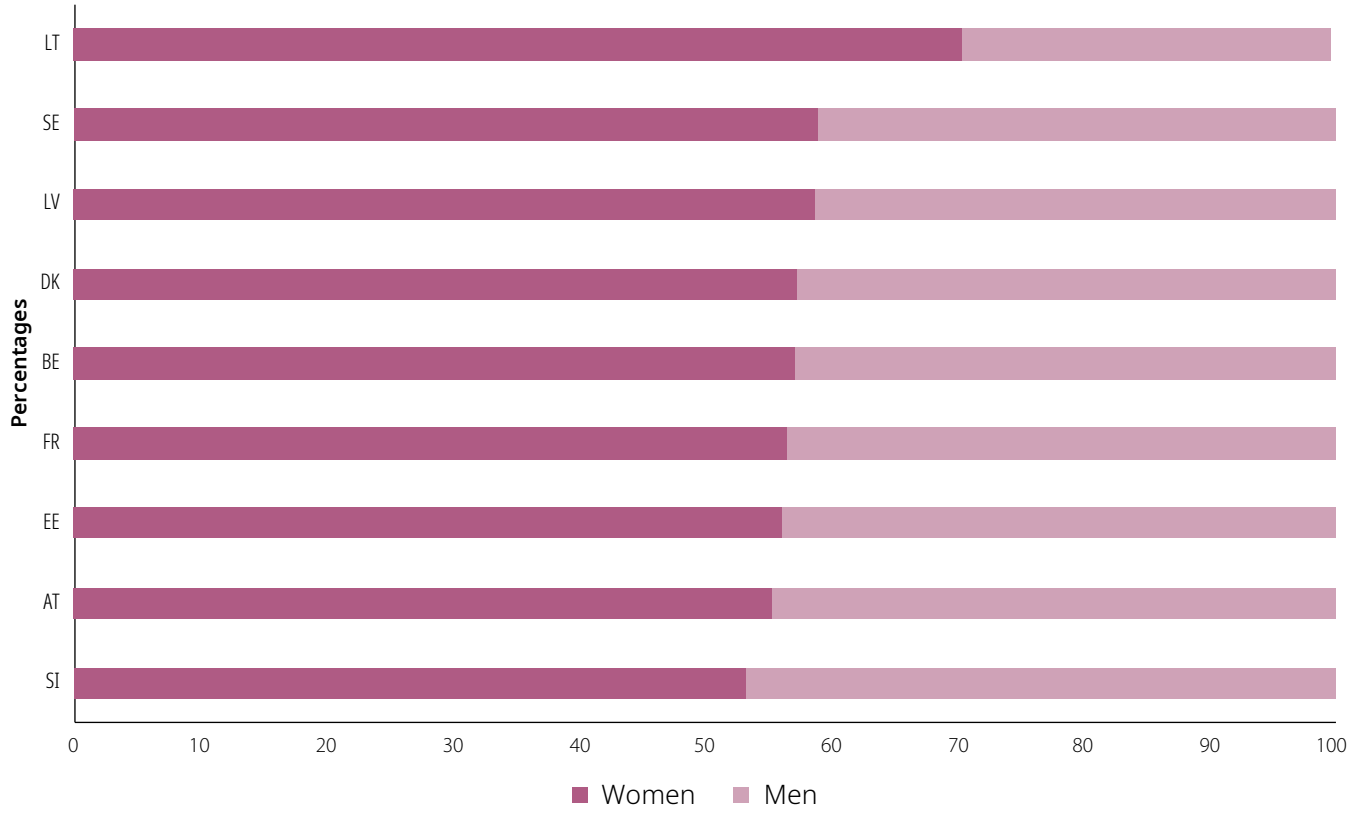
As mentioned previously, women and men have been affected differently by the infection – if only to a degree – depending on age, comorbidities and occupational exposure. While infections among women of working age outnumber those among men, many more men have died from COVID-19.

([118]) Each participant reported an average of nine persistent symptoms such as muscle pain, fatigue, impaired sleep quality and short-term memory loss.

A systematic review of gender differences in vaccination intentions conducted in January 2021 pointed to men being much more likely than women to report that they wanted a vaccination (Zintel et al., 2021). In contrast, the February/March 2021 Eurofound COVID-19 e-survey reported 29 % of male respondents as vaccine hesitant, compared with 25 % of female respondents (Eurofound, 2021c). Results by country show a significant east–west divide. Vaccination intentions were above 60 % in most western European Member States. Among eastern European countries, the rate was much lower – ranging from 59 % in Romania to 33 % in Bulgaria. These figures reveal significant vaccine hesitancy in the EU, particularly in sparsely populated areas, among the self-employed or unemployed, among those with an illness or disability and among those using social media as their main information sources or who spend a lot of time on social media (Eurofound, 2021c). A Eurobarometer survey from May 2021 confirms the east–west divide in vaccine hesitancy: the proportion of respondents who reported that they would not like to be vaccinated ranged from 23 % in Bulgaria to just 4 % in Spain and Portugal. However, the gender gap is small: overall in the EU with 9 % of women said that they would never want to receive a vaccine, while 8 % of men responded the same (European Commission, 2021e).

In terms of actual uptake in the EU, in June 2021, women were more likely than men to be fully vaccinated in all Member States for which data was available (Figure 47), accounting for 70 % in Lithuania, 59 % in Sweden and Latvia, 57 % in Belgium, Denmark and France, 56 % in Estonia, 55 % in Austria and 53 % in Slovenia.

Figure 47. Share of adults fully vaccinated against COVID-19, by sex and EU Member State (%, June 2021)



Source: The Sex, Gender and COVID-19 Project, Global Health 50/50, the African Population and Health Research Center and the International Center for Research on Women. EU: authors' elaboration (BG, CY, HR, MT data was not available). Updated on 21 June 2021. Data extracted on 25 June 2021.

A pandemic in hand with a mental health crisis

As the Index domain chapters show, the full effects of the COVID-19 pandemic may still be unfolding, but preliminary findings point to profoundly unequal social and economic consequences across the EU. Social isolation, fear of infection for oneself and loved ones, grief and financial distress are enormous stressors. Evidence of the impact of these consequences on mental well-being is emerging, with multiple accounts of different population groups showing increased signs of distress such as PTSD, suicidality, eating disorders and burnout. These manifestations are likely to exacerbate pre-existing levels of poor mental health and its gender-specific impacts, as discussed in Section 9.1.1. This section mainly focuses on the mental health of the general public and of healthcare professionals.

Mental well-being levels are at their lowest since pandemic outbreak

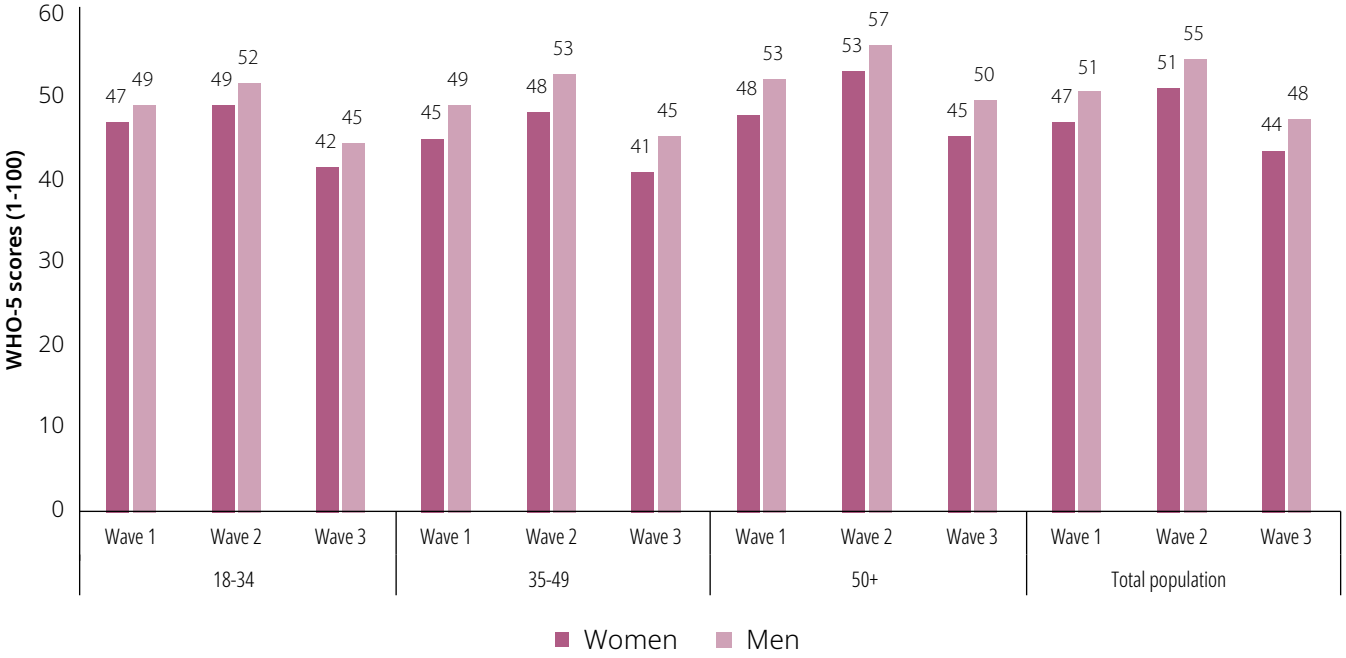
Pandemic lockdown measures have led to a rise in loneliness, recognised as a major public health concern globally. Groups at most risk before and during the pandemic are near identical – young adults, women, people with lower education or income, the unemployed, people living alone and urban residents (Bu et al., 2020).

Lockdowns and other social distancing measures are known to have had a significant impact on opportunities for physical activity, as discussed in Section 9.1.2. A study on social distancing among UK adults found that those who were physically active had better overall mental health, that is they had fewer depressive and anxiety symptoms and more positive mental well-being (Jacob et al., 2020). In Italy, total physical activity has significantly decreased during the pandemic in all age groups, especially among men. This fall in total physical activity has had a profoundly negative impact on psychological health and well-being (Maugeri et al., 2020).

A recent Eurofound survey on COVID-19 effects measured the level of mental well-being across three pandemic waves – April 2020, July 2020 and February/March 2021 (Eurofound, 2021c). Mental well-being, as measured using the WHO-5, was significantly lower than in 2016 in both women and men and across all age groups (Figure 29 and Figure 30). While the results are not directly comparable because of different methodological approaches, they do indicate a worrying deterioration of mental well-being in the EU, with large segments of the population at risk of depression (Figure 48).

On average, mental well-being across the EU-27 fell between e-survey rounds 2 and 3 in summer 2020 and spring 2021, despite having improved earlier in the pandemic. Women consistently had lower mental well-being across the three pandemic waves (Figure 48), with the lowest levels during the third wave being in women aged 18–34 years (42 points) and 35–49 years (41 points). This could be due both to social isolation and to the increased unpaid workload from school closures or movement restrictions (EIGE, 2021c). As highlighted in the domain of time, people with care responsibilities, especially lone parents, have faced acute tensions from balancing the demands of paid and unpaid work when support services and social networks have been profoundly disrupted.

Figure 48. Self-reported mental well-being index by age group in April/May 2020 (first wave), June/July 2020 (second wave) and February/March 2021 (third wave), according to the WHO-5 (points out of 100, EU)



Source: Eurofound (2020), Living, working and COVID-19 data, https://www.eurofound.europa.eu/data/covid-19, Dublin
NB: The data shows the mean for respondents in the EU-27 when asked. WHO-5 is WHO's mental well-being index, with a scale of 0–100. People with a WHO-5 score of 50 or lower are considered at risk of depression.

People aged 50 years or older had better mental well-being scores in round 3 of the e-survey than younger people. However, this older group also saw a large drop in average mental well-being from summer 2020 to spring 2021.

Eurofound (2021c) highlights an overall increase in negative feelings in spring 2021, including tension, anxiety, loneliness and depression, across most social groups in the EU. Among both young men and women, there was a 13-p.p. increase. The greatest jump in loneliness was recorded among women older than 50 years – an increase of 13 p.p. compared with summer 2020 findings. For young women, the findings also reveal an increase in pre-existing levels of anxiety and depressive disorders (see Section 9.1.1.), including a spike in hospital referrals for eating disorders (Solmi et al., 2021). Almeida et al. (2020) discovered that pregnant women and women who are experiencing postpartum or miscarriage are more likely to endure mental health problems during the pandemic. Such alarming accounts of mental well-being, especially among young people, may result in more people resorting to unhealthy coping mechanisms, including substance abuse, which is already common among young men. Studies also warn that the mental health consequences of the crisis are likely to be felt for a long time, peaking only after the pandemic has subsided (Costanza et al., 2020; European Commission, 2021h; Meherali et al., 2021; Standish, 2021).

Care workers face acute distress

Evidence is mounting on the profound mental health toll of the pandemic on frontline workers, particularly in the care sector. Scholars note that health workers are already at higher risk of poor mental health in normal times. That risk increased with COVID-19 and the stress of poor pandemic preparedness of health systems (Mortier et al., 2021), trauma from having to prioritise care and seeing patients suffer or die (Greenberg et al., 2020), insufficient rest and overwork, and the fear of infection or infecting others.

Psychological symptoms include high rates of stress, depression, anxiety and insomnia. Healthcare workers and those directly engaged with affected patients report PTSD and psychological distress (Kisely et al., 2020). Systematic reviews show that frontline healthcare workers and those with pre-existing mental health issues are at higher risk of poor mental health than others (Bekele and Hajure, 2021).

In Spain, where the health system was under enormous strain during the first wave, data from a 30-day period shows that about 8 % of hospital workers – mostly men – had suicidal thoughts and behaviours (Mortier et al., 2021). Evidence from France shows that half of the staff in the social care sector, facing the death of residents, experienced post-traumatic stress (EU-OSHA, forthcoming 2022).

The high level of distress experienced by health workers increased because of staff attrition in the medical field, especially in female-dominated professions. Women make up the majority of medical staff in low-level positions, such as nurses, and occupational segregation is a key reason why women nurses leave the profession (WHO, 2019c). With significant exposure to infected patients, fewer social support systems and different coping mechanisms, women are at greater risk than men of developing PTSD as a result of the pandemic (Carmassi et al., 2020).

According to the International Council of Nurses (ICN), there was already a global shortage of nursing staff before the COVID-19 pandemic, amounting to a deficit of 6 million worldwide. The pandemic exacerbates the attrition of nursing staff. Women nurses report occupational hazards, such as ill-fitting personal protective equipment (PPE), more often than men (Regenold and Vindrola-Padros, 2021). According to EU-OSHA, 'almost half of carers did not have adequate PPE in April 2020 and one in five care workers … considered quitting over the lack of PPE' (European Commission, 2021h). Surveys in Sweden show that 7 % of nurses considered leaving the profession altogether (ICN Policy Brief, 2021). In Denmark, a survey among nurses working in regions and municipalities found that 88 % of respondents were considering looking for a new job, with 37 % wanting a job outside the nursing profession (DSR, 2020). The ICN argues that the pandemic-induced health crisis is worsening the gender inequalities, gender-based violence and social stigmatisation that nurses experience generally (ICN, 2021).

An epidemic of gender-based violence

Governments in 142 countries around the world imposed lockdown measures in early 2020 (Hale and Webster, 2020), which contributed to the global surge in intimate partner violence (Graham-Harrison et al., 2020; WHO, 2020b), causing a 'shadow pandemic' (UN Women, 2020). Forced cohabitation and economic and labour instability are stressors known to be associated with an increase in intimate partner violence (Buller et al., 2018; Buttell and Ferreira, 2020; Jarnecke and Flanagan, 2020); these factors have been exacerbated by the pandemic and this, combined with the increased psychological distress resulting from lockdown (S. K. Brooks et al., 2020; Gillespie et al., 2021), has led to an increased risk of intimate partner violence (Clemens et al., 2019; Curtis et al., 2019; Straus and Douglas, 2019).

For example, in Spain the incidence of intimate partner violence increased by 24 % during the 3 months of lockdown. This increase can be explained by the lockdown itself as well as by economic stress, health concerns, working under pressure, closure of schools and increased caring demands (Arenas-Arroyo et al., 2020). The stressors arising from the quarantine and having to live with an aggressor without options to escape can aggravate violent dynamics between members of a couple (Hsu and Henke, 2020; Hussein, 2020). As discussed in the domain of violence chapter, lockdown restrictions make it more difficult to find help arise , thereby increasing tensions and leading to a rise in violence (Hsu and Henke, 2020), including femicide (Townsend, 2020; Vagianos, 2020). It is broadly recognised that the end of the lockdown will not lead to a decline in intimate partner violence; the consequent economic instability is highly likely to aggravate already high levels of violence (Arenas-Arroyo et al., 2020).

Researchers have also noted that new forms of control have emerged as a result of the pandemic (Peterman et al., 2020). Perpetrators use the 'fear of contracting COVID-19' as an excuse to control a partner's movements and prevent them from having contact with their support networks (Gearing, 2020) and from accessing services, family or friends (Smyth et al., 2021). This constant control impairs victims' autonomy, and leads to fear and loss of control over their own lives (Weil, 2020). As a result, many cases of intimate partner violence remain unreported (UN Women and WHO, 2020).

Lockdown measures may have compounded the risks of violence against vulnerable groups such as women with disabilities, homeless women, undocumented migrants or migrants with temporary visa, families with low socioeconomic status, families with children and LGBTIQ* couples (Arenas-Arroyo et al., 2020; De Schrijver et al., 2021; Flatau et al., 2020; Pleace et al., 2021; Segrave and Pfitzner, 2020; Zero and Geary, 2020). While evidence is still scarce, lockdown measures leading to the closure of temporary shelters are likely to have exposed homeless women to greater risks of violence. Even before the pandemic, homeless shelters were not fully able to address the complex issues of women suffering gender-based violence (Bretherton and Mayock, 2021). More evidence is available on the impact of COVID-19 on sexual minorities (ILGA Europe, 2020; Phillips et al., 2020). Stressors such as the lack of social support (Song et al., 2020), specifically for those who did not share their sexual orientation/identity with their family or are part of a family that rejects their orientation/identity (ILGA Europe, 2020), may increase the likelihood of intimate partner violence. Research in Belgium shows that a third of the LGBTIQ* community experienced some form of violence at home during the first 6 weeks of the lockdown (De Schrijver et al., 2021).

The COVID-19 pandemic challenges the quality of sexual and reproductive health services

There is increasing evidence of the pandemic's severe toll on the SRHR of women, girls and other marginalised groups.

With abortion banned in Malta and pandemic-related travel restrictions preventing women from travelling abroad for an abortion, imports of abortion pills in Malta surged (Caruana-Finkel, 2020). During the pandemic, Poland passed additional restrictive legislation, while Hungary was the only Member State to suspend surgical abortions because of pandemic pressure on public hospitals. Belgium, Germany, Latvia, Luxembourg and Slovenia introduced longer waiting periods for abortions for those who tested positive for COVID-19 or were symptomatic (Moreau et al., 2020).

Lockdown led to isolation of pregnant women, during childbirth, as fathers and birth partners were not allowed to attend. This could have long-term consequences for parent–child bonding and increase post-partum depression. Elsewhere, it has been estimated that disruptions to counselling programmes will lead to an increase in FGM of 2 million cases over the next decade (UNFPA, 2020), while school closures have generally curtailed access to SRHR information for young people.

More positively for SRH, the COVID-19 pandemic has made telemedicine more common (Porter et al., 2020). The option to receive sexual and reproductive healthcare online or through messenger apps has made healthcare more accessible and available for people with limited mobility or who are unable to leave home because of care responsibilities.

10. Conclusions

Gender inequalities in health

The conditions in which women and men live, work and spend their time affect their health. Gender and other factors, such as age, education, ethnicity, economic status, sexual orientation or disability, influence the resources that women and men can access, their exposure to environmental risks, their options for tackling ill health and the support they can receive from public institutions.

Men's lower life expectancy and women's poorer mental well-being reflect the effect of gender inequality and gendered norms on health by leading to differences in exposures and vulnerabilities to disease, health-related behaviours and access to care. Employment status influences people's physical and mental health through working conditions, income and social status, while gender-biased health research and healthcare systems reinforce and reproduce gender inequalities.

In the wake of the COVID-19 pandemic, health inequalities will continue to accumulate and have the greatest impact on those not in paid work and those with a low income, such as women with a low level of education and women and men with disabilities. Although healthcare in the EU is generally accessible, these groups are most likely to be in poor health and to have poor access to healthcare services. With costs and waiting lists the most common reasons for unmet health needs in 2019, any pandemic-related economic crisis and unemployment could be expected to significantly restrict healthcare access for far more people. The EU's population is ageing, and this means that access to affordable and high-quality long-term care is increasingly important. The European Pillar of Social Rights reflects this. A strong commitment to the implementation of the recommendations of the European Pillar of Social Rights – particularly those relating to long-term care needs – has taken on a greater urgency in the light of the COVID-19 pandemic.

Pathways to poor health are gendered

Gender influences the development and course of risk factors and conditions for **NCDs**, with norms and behaviours profoundly affecting health throughout life. The COVID-19 pandemic is taking a particularly high toll on women and men already suffering from NCDs. A renewed commitment to fully implement the WHO strategies adopted in 2016 and 2018 relating to the health of women and men is needed to mitigate the impact of gender inequalities on public health (WHO Regional Office for Europe, 2016a, 2018b).

Mental health disorders have profound consequences on an individual's ability to learn and work, and on family and social life, as well as ramifications for society as a whole. Untreated mental illnesses are a significant economic cost to society through reduced productivity and lost healthy years of life (Mackenbach et al., 2011; Stefko et al., 2020). Of particular concern is morbidity and mortality among young people.

There is ample evidence of the connection between low socioeconomic status and poor mental and physical health. It is widely argued that reducing socioeconomic inequalities would improve overall population health (Allen et al., 2014; Cairns et al., 2017; Reiss, 2013; Silva et al., 2016). Social policies to reduce gender and income inequalities through universal health coverage, providing care leave to improve work–life balance and expanding educational attainment opportunities can also reduce gender inequalities in mental health morbidity and mortality (Cairns et al., 2017; Patel et al., 2018). Preventing all types of violence against women is among the most effective and impactful mental and physical health interventions (Bhui, 2018). Providing treatment and support is just as important. Mental illness symptoms observed by health service providers should be considered as a potential indicator of past or current inti-

mate partner violence or non-partner domestic violence (Ferrari et al., 2016). Mental health services need to be both aware of such violence among women and men and provide gender-sensitive and cross-cutting support to address it (Sian Oram et al., 2017).

Harmful gender norms, such as toxic masculinities and unachievable beauty standards, have similarly far-reaching negative impacts on mental health. This is exemplified by high suicide rates among young men, poor mental health among LGBTI people and the high prevalence of anxiety and eating disorders among young women. Stigma remains a barrier to seeking help for mental health problems, affecting men more than women (Clement et al., 2015). Reducing mental health stigma should be a health priority, as it would encourage more people to seek help, reduce mental health treatment gaps and improve mental health globally (Wainberg et al., 2017).

Sexual and reproductive health and rights

Gender inequalities undermine the ability of women and men to control their SRHR, with significant consequences. Availability, access, cost and stigma issues around contraceptives introduce barriers to SRH, especially for young people. In parallel, laws, policies and comprehensive sexuality education vary across the EU. The curricula in many Member States focus on the biological aspects of SRHR, leaving knowledge gaps on key areas, such as sexual pleasure, consent, gender-based violence and access to abortion (BZgA and IPPF EN, 2018; Picken, 2020). Such gaps contribute to higher birth rates among adolescents (UNFPA, 2021). Abortion services and care are an essential part of public health and are essential for good SRH outcomes for women and girls (WHO, 2012). Abortion legislation and services also vary across the EU. With free movement of people and goods a pillar of the European single market, abortion tourism (Mecinska et al., 2020) and cross-border sales of abortion pills (Calkin, 2021) enable women and girls to obtain otherwise inaccessible services. However, age, (dis)ability, race, ethnicity, migration status and sexual orientation influence access to SRH, meaning that certain groups of women are disproportionately affected.

Data gaps on SRH prevail, particularly on men's contraceptive use and unmet family planning needs. SRH data needs to be broader in its scope and demographics to make this aspect of public health a visible concern for everyone, not just girls and women. Information on laws and regulations providing women and men equal access to SRH services and education – an SDG indicator essential for monitoring SRH (UNFPA, 2021) – is incomplete in most Member States. This limits the ability to evaluate and compare key SRHR policy areas across the EU, for example on maternal health and abortion. Another gap concerns the thorough disaggregation of data for the most common STIs by gender, age, sexual orientation and HIV status (ECDC, 2021). Without this, the mechanisms of transmission and options for prevention remain unknown, ensuring HIV's continued threat to public health.

Although the EU 2020–2025 anti-racism action plan calls for race to be mainstreamed into EU public policies, race is often not recorded in EU research. Based on the findings of UK research, it is very likely that the race gap in maternal mortality in the EU-27 is underexplored. Most women and girls exposed to FGM are black and face racial and gender inequalities, limiting their access to and representation in maternal healthcare.

The COVID-19 pandemic

The full impact of the pandemic on the EU population will take time to emerge, as numbers of registered cases and deaths are believed to be underestimated. On average, the mortality rate between 2020 and 2021 was 17 % higher for men than in previous years and 14 % higher for women. Beyond the effects of biological differences, pre-existing gender inequalities in society have shaped the pandemic's impact on the health and lives of all women and men.

With NCDs linked to an increased risk of severe COVID-19, the pandemic has underlined the importance of tackling causes of illness, such as

unhealthy lifestyles or highly gendered risky behaviours. The need for immediate and long-term mental healthcare acknowledging gender differences has become clearly evident.

The pandemic has taken a high toll on men. While infection rates are rather similar for women and men overall, men have been at significantly higher risk of hospitalisation and death from COVID-19. As of June 2021, EU data shows that men account for 55 % of COVID-19-related deaths. Older men, men with NCDs and those in essential and precarious jobs have been particularly affected. The pandemic has also been devastating for nursing home residents.

Working-age women in the EU have been greatly exposed to infection, partly because of their over-representation in some frontline professions. Vulnerable workers, such as migrant women or women in precarious jobs, have been most at risk. Evidence is emerging that women are more affected by 'long COVID', pointing to potentially long-term consequences for large segments of the female population. Classifying COVID-19 as an occupational disease would help ensure that workers have adequate social protection while dealing with long-terms effects of the infection.

Apart from the direct health consequences of the virus, there are also secondary impacts on physical and mental health. These are likely to be gender specific and long-lasting. The true extent of the pandemic's mental health consequences will take time to unfurl, with experts warning that the peak may come long after the pandemic is controlled. Mental well-being is the lowest since the outbreak, with large segments of the population at risk of depression (Eurofound, 2021c). Women have had lower levels of mental well-being than men in each of the three pandemic waves, with the lowest levels noted among working-age women during the third wave. This reflects not only the pervasive impact of social isolation, but also the increased and sustained burden of unpaid work triggered by school closures and movement restrictions during lockdowns (EIGE, 2021c).

The COVID-19 pandemic has raised barriers to accessing healthcare services in the EU, including for SRHR. This is either because some medical procedures and treatments have been deferred or deprioritised, or because help has not been sought for fear of infection. The situation has put long-term strain on public healthcare systems, which are now expected to resolve this care debt with very limited resources. Healthcare professionals are at particular risk of severe mental illnesses and should have access to appropriate mental healthcare services. The pandemic has also highlighted poor working conditions and staff shortages in the health and social care sector. These will need urgent redress if health system resilience is to be strengthened.

There is great concern over the global surge in intimate partner violence (Graham-Harrison et al., 2020; UNFPA, 2021; WHO, 2020c), causing a 'shadow pandemic' (UN Women, 2020) that is likely to peak only when restrictions are lifted.

In this situation, the strategic objectives of the EU health programme within and between Member States and WHO's strategy to improve health and reduce health inequalities will not be achieved without a clearly gendered approach to mitigating the impact of COVID-19. At the Global Health Summit in Rome in May 2021, the EU and G20 countries committed to 16 principles to guide action on managing the current pandemic and preparing for future health emergencies ([119]). Among them are the need to invest in the health and care workforce and the need to develop gender-sensitive public health responses to future health crises. High-level political will and resources are required in policy responses to long-term health impacts – and to build resilient and gender-responsive health systems better able to tackle all health inequalities.

([119]) Global Health Summit, the Rome Declaration, https://global-health-summit.europa.eu/rome-declaration_en.

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Annexes

Annex 1. List of indicators of the Gender Equality Index

Domain	Sub-domain	N	Indicator and reference population	Description	Source	Index edition					
						2013	2015	2017	2019	2020	2021
						Data used					
WORK	Participation	1	FTE employment rate (%, 15+ population)	The FTE employment rate is a unit to measure employed persons in a way that makes them comparable even though they may work a different number of hours per week. The unit is obtained by comparing an employee's average number of hours worked to the average number of hours worked by a full-time worker. A full-time worker is therefore counted as one FTE employee, while a part-time worker gets a score in proportion to the hours she or he works. For example, a part-time worker employed for 20 hours a week where full-time work consists of 40 hours is counted as 0.5 FTE.	Eurostat, EU-LFS Eurostat calculations according to EIGE's request (2005–2015). Author's calculations 2017, 2018, 2019	2010	2012	2015	2017	2018	2019
		2	Duration of working life (years, 15+ population)	The duration of working life indicator measures the number of years a person aged 15 is expected to be active in the labour market throughout his/her life.	Eurostat, EU-LFS Duration of working life (lfsi_dwl_a)	2010	2012	2015	2017	2018	2019
	Segregation and quality of work	3	Employed people in education, human health and social work activities (%, 15+ employed)	Percentage of people employed in the following economic activities out of total employed (based on NACE Rev. 2) are included: P. Education + Q. Human health and social work, as percentage of total activities (all NACE activities).	Eurostat, EU-LFS Employment by sex, age and economic activity (lfsa_egan2)	2010	2012	2015	2017	2018	2019
		4	Ability to take 1 or 2 hours off during working hours to take care of personal or family matters (%,15+ workers)	Percentage of persons who answered 'very easy' out of total (1, 2, 3, 4), question Q47. Would you say that, for you, arranging to take an hour or two off during working hours to take care of personal or family matters is ...? (1) Very easy; (2) Fairly easy; (3) Fairly difficult; (4) Very difficult.	Eurofound, European Working Conditions Survey (EWCS) Author's calculation with microdata	2015	2015	2015	2015	2015	2015
		5	Career Prospects Index (points, 0–100)	The Career Prospects Index combines the indicators of employment status (self-employed or employee), type of contract, the prospects for career advancement as perceived by the worker, perceived likelihood of losing one's job and experience of downsizing in the organisation. It is measured on a scale of 0–100, where the higher the score, the higher the job quality.	Eurofound, EWCS Calculated by Eurofound	2015	2015	2015	2015	2015	2015

Domain	Sub-domain	N	Indicator and reference population	Description	Source	Index edition					
						2013	2015	2017	2019	2020	2021
						Data used					
MONEY	Financial resources	6	Mean monthly earnings (PPS, working population)	Mean monthly earnings in PPS (Purchasing Power Standard), in the sectors of Industry, construction and services (except public administration, defence, compulsory social security) (NACE_R2: B-S_X_O, total age group, working in companies with 10 or more employees)	Eurostat, Structure of Earnings Survey (SES) Mean monthly earnings by sex, age and economic activity (earn_ses10_20), (earn_ses14_20), (earn_ses18_20)	2010	2010	2014 EL and HR 2010	2014	2014	2018 EL 2014
	Financial resources	7	Mean equivalised net income (PPS, 16+ population)	Equivalised disposable income in PPS (Purchasing Power Standard), is the total income of a household, after tax and other deductions, that is available for spending or saving, divided by the number of household members converted into equalised adults; household members are equalised or made equivalent by weighting each according to their age, using the so-called modified OECD equivalence scale.	Eurostat, EU-SILC Mean and median income by age and sex [ilc_di03] EU27: Author's calculations (2010, 2012, 2015, 2017)	2010	2012	2015	2017	2018	2019
	Economic situation	8	Not-at-risk-of-poverty, ≥60 % of median income (%, 16+ population)	Reversed indicator of at-risk-of poverty rate, calculated as 100 minus at-risk-of-poverty rate. The at-risk-of-poverty rate is the share of people with an equivalised disposable income (after social transfers) below the at-risk-of-poverty threshold, which is set at 60 % of the national median equivalised disposable income after social transfers.	Eurostat, EU-SILC At-risk-of-poverty rate by poverty threshold, age and sex (ilc_li02)	2010	2012	2015	2017	2018	2019
		9	S20/S80 income quintile share (16+ population)	Calculated as 1/'S80/S20 income quintile share ratio' * 100. The income quintile share ratio (also called the S80/S20 ratio) is a measure of the inequality of income distribution. It is calculated as the ratio of total income received by the 20 % of the population with the highest income (the top quintile) to that received by the 20% of the population with the lowest income (the bottom quintile). The Index uses a 'reversed' version of this indicator.	Eurostat, EU-SILC Eurostat calculations on EIGE's request	2010	2012	2015 IE 2014	2017	2018	2019

Domain	Sub-domain	N	Indicator and reference population	Description	Source	Index edition					
						2013	2015	2017	2019	2020	2021
						Data used					
KNOWLEDGE	Attainment and participation	10	Graduates of tertiary education (%, 15+ population)	Educational attainment measures the share of highly educated people among men and women. People with tertiary education as their highest level successfully completed (levels 5–8), percentage from total +15 population	Eurostat, EU-LFS Eurostat calculations as per EIGE's request (2005–2015). Author's calculations 2017, 2018, 2019	2010	2012	2015	2017	2018	2019
		11	People participating in formal or non-formal education and training (%, 15+ population)	Percentage of people participating in formal or non-formal education and training, out of total population of 15+. Lifelong learning encompasses all purposeful learning activity, whether formal, non-formal or informal, undertaken on an ongoing basis with the aim of improving knowledge, skills and competence. The reference period for the participation in education and training is the 4 weeks preceding the interview.	Eurostat, EU-LFS Eurostat calculations as per EIGE's request (2005–2015). EIGE's calculations 2017, 2018, 2019	2010	2012	2015	2017	2018	2019
	Segregation	12	Tertiary students in the fields of education, health and welfare, humanities and art (tertiary students) (%, 15+ population)	Percentage of persons who are studying in the following areas: (2010–2012), EF14 (teacher training and education science) + EF2 (humanities and arts) + EF7 (health and welfare) out of total students. (2013–2018) (F01 – education, F02 – arts and humanities, F09 – health and welfare) Until 2012, International Standard Classification of Education (ISCED) levels 5–6; after that, ISCED levels 5–8.	Eurostat, education statistics Tertiary students by field of education and sex (2010–2012) (educ_enrl5). Students enrolled in tertiary education by education level, programme orientation, sex and field of education (2013–2018) [educ_uoe_enrt03]	2010 LU 2011	2012	2015 IE, EL, 2014	2017 BG, CZ, IE, EL, FR, HR, IT, CY, HU, MT, PT, RO, SK, FI, SE, UK. 2016. SI, ED7 (Master or equivalent) n/a, 2016 used	2017 SI, ED7 (Master or equivalent) n/a, 2016 used	2018 BG, EE, EL, LT, RO, FI, ED5 – short-cycle tertiary education n/a

Domain	Sub-domain	N	Indicator and reference population	Description	Source	Index edition					
						2013	2015	2017	2019	2020	2021
						Data used					
TIME	Care activities	13	People caring for and educating their children or grandchildren, elderly or people with disabilities, every day (%, 18+ population)	Percentage of people involved in at least one of these caring activities outside paid work every day: care for children, grandchildren, elderly and/or disabled people. Question: (in general) how often are you involved in any of the following activities outside paid work? 2016: Q42a Caring for and/or educating your children; Q42b Caring for and/or educating your grandchildren; Q42d Caring for disabled or infirm family members, neighbours or friends under 75 years old; Q42e Caring for disabled or infirm family members, neighbours or friends aged 75 or older; 2012: Q36a caring for your children/grandchildren; Q36c Caring for elderly or disabled relatives; 2007: Q36c Caring for elderly or disabled relatives; 2003: Q37a Caring for and educating children; Q37c Caring for elderly or disabled relatives	Eurofound, EQLS EIGE's calculation with microdata	2007	2012	2016	2016	2016	2016
	Social activities	14	People doing cooking and/or housework, every day (%, 18+ population)	Percentage of people involved in cooking and/or housework outside paid work, every day. Questions: How often are you involved in any of the following activities outside paid work? 2016: Q42c Cooking and/or housework; 2012 Q36b Cooking and/or housework; 2007: Q36b Cooking and housework; 2003:Q37b Housework	Eurofound, EQLS EIGE's calculation with microdata	2007	2012	2016	2016	2016	2016
		15	Workers doing sporting, cultural or leisure activities outside their home, at least daily or several times a week (%, 15+ workers)	Percentage of working people doing sporting, cultural or leisure activities at least every other day (daily + several times a month out of total). Question: 2015 On average, how many hours per day do you spend on the activity? Q95g Sporting, cultural or leisure activity outside your home.	Eurofound, EWCS EIGE's calculation with microdata	2015	2015	2015	2015	2015	2015
	Social activities	16	Workers involved in voluntary or charitable activities, at least once a month (%, 15+ workers)	Percentage of working people involved in voluntary or charitable activities, at least once a month. Questions: 2015 On average, how many hours per day do you spend on the activity? Q95a Voluntary or charitable activities; daily; several times a week; several times a month; less often; never. (1–3 out of total (who answered 1–5)). 2005 (EF4.1a), 2010 (EF3a) In general, how often are you involved in voluntary or charitable activity outside your home/outside work? (1) Every day for 1 hour or more; (2) Every day or every second day for less than 1 hour; (3) Once or twice a week; (4) Once or twice a month; (5) Once or twice a year; (6) Never. (1–4 out of total (who answered 1–6)).	Eurofound, EWCS EIGE's calculation with microdata	2010	2010	2015	2015	2015	2015

Domain	Sub-domain	N	Indicator and reference population	Description	Source	Index edition					
						2013	2015	2017	2019	2020	2021
						Data used					
POWER	Political	17	Share of ministers (% W, M)	Share of ministers.	EIGE, Gender Statistics Database, WMID EIGE's calculation	2009–2010–2011	2011–2012–2013	2014–2015–2016	2016–2017–2018	2017–2018–2019	2018–2019–2020
		18	Share of members of parliament (% W, M)	Share of members of parliament.	EIGE, Gender Statistics Database, WMID EIGE's calculation	2009–2010–2011	2011–2012–2013	2014–2015–2016	2016–2017–2018	2017–2018–2019	2018–2019–2020
		19	Share of members of regional assemblies (% W, M)	Share of members of regional assemblies.	EIGE, Gender Statistics Database, WMID EIGE's calculation	Regional assembly 2009–2010–2011	Regional assembly 2011–2012–2013	Regional assembly 2014–2015–2016	Regional assembly 2016–2017–2018	Regional assembly 2017–2018–2019	Regional assembly 2018–2019–2020
						Local level politics 2011	Local level politics 2013	Local level politics 2015	Local level politics 2017	Local level politics 2019	Local level politics 2020
	Economic	20	Share of members of boards in largest quoted companies, supervisory board or board of directors (% W, M)	Share of members of boards in largest quoted companies.	EIGE, Gender Statistics Database, WMID EIGE's calculation	2009–2010–2011	2011–2012–2013	2014–2015–2016	2016–2017–2018	2017–2018–2019	2018–2019–2020
		21	Share of board members of central bank (% W, M)	Share of board members of central bank.	EIGE, Gender Statistics Database, WMID EIGE's calculation	2009–2010–2011	2011–2012–2013	2014–2015–2016	2016–2017–2018	2017–2018–2019	2018–2019–2020
	Social	22	Share of board members of research funding organisations (% W, M)	Members of the highest decision-making bodies of research funding organisations	EIGE, Gender Statistics Database, WMID EIGE's calculation	2017	2017	2017	2017–2018 IT: only 2017	2017–2018–2019 IT, RO: only 2018 (break in time series)	2018–2019–2020 IT, RO: only 2018 (break in time series)
		23	Share of board members in publicly owned broadcasting organisations (% W, M)	Share of board members in publicly owned broadcasting organisations.	EIGE, Gender Statistics Database, WMID EIGE's calculation	2014	2014	2014–2015–2016	2016–2017–2018	2017–2018–2019	2018–2019–2020
		24	Share of members of highest decision-making body of the national Olympic sport organisations (% W, M)	Share of members of highest decision-making body of the 10 most popular national Olympic sport organisations.	EIGE, Gender Statistics Database, WMID EIGE's calculation	2015	2015	2015	2015–2018	2015–2018–2019	2018–2019–2020

Domain	Sub-domain	N	Indicator and reference population	Description	Source	Index edition					
						2013	2015	2017	2019	2020	2021
						Data used					
HEALTH	Status	25	Self-perceived health, good or very good (%, 16+ population)	Percentage of people assessing their health as 'Very good' or 'Good' out of total. The concept is operationalised by a question on how a person perceives his/her health in general using one of the answer categories very good/good/fair/bad/very bad.	Eurostat, EU-SILC Self-perceived health by sex, age and labour status (%) [hlth_silc_01]	2010	2012 HR, 2011 (M)	2015	2017	2018	2019
	Status	26	Life expectancy in absolute value at birth (years)	Life expectancy at a certain age is the mean additional number of years that a person of that age can expect to live, if subjected throughout the rest of his or her life to the current mortality conditions (age-specific probabilities of dying, i.e. the death rates observed for the current period).	Eurostat, Mortality data Healthy life years (from 2004 onwards) [hlth_hlye], indicators F_0_LE – Life expectancy in absolute value at birth – females and M_0_LE – Life expectancy in absolute value at birth.	2010 Total: average of women and men IT: 2009	2012 Total: average of women and men SE: 2011	2015 Total: average of women and men	**2016** Total: average of women and men	2018	2019
	Status	27	Healthy life years in absolute value at birth (years)	Healthy life years measures the number of remaining years that a person of specific age is expected to live without any severe or moderate health problems. Healthy life years is a composite indicator that combines mortality data with health status data from health mini-module (EU-SILC): the self-perceived question, which aims to measure the extent of any limitations, for at least 6 months, because of a health problem that may have affected respondents as regards activities they usually do.	Eurostat, EU-SILC and mortality data Healthy Life Years (from 2004 onwards) [hlth_hlye], indicators F_0_DFLE – Healthy life years in absolute value at birth – females and M_0_DFLE – Healthy life years in absolute value at birth – males	2010 Total: average of women and men IT: 2009	2012 Total: average of women and men SE: 2011	2015 Total: average of women and men	2016 Total: average of women and men	2018	2019 BE: break in times series

Domain	Sub-domain	N	Indicator and reference population	Description	Source	Index edition					
						2013	2015	2017	2019	2020	2021
						Data used					
HEALTH	Behaviour	28	People who do not smoke and are not involved in harmful drinking (%, 16+ population)	Percentage of people who are not involved in risky behaviour, that is do not smoke and are not involved in heavy episodic drinking. Heavy episodic drinking is intaking six drinks or 60+ g of pure alcohol on one occasion, monthly or more often, during the previous 12 months. A drink is defined as a glass of wine, glass of beer, shot of whiskey, etc. Everyone smoking and/or involved in harmful drinking is regarded as exercising risky behaviour.	Eurostat, EHIS Eurostat calculations according to EIGE's request	2014 EU: Non-weighted average FR, NL: EIGE estimation	2014 EU: Non-weighted average FR, NL: EIGE estimation	2014 EU: Non-weighted average FR, NL: EIGE estimation	2014 EU: Non-weighted average FR, NL: EIGE estimation	2014 EU: Non-weighted average FR, NL: EIGE estimation	2014 EU: Non-weighted average FR, NL: EIGE estimation
		29	People doing physical activities and/or consuming fruits and vegetables (%, 16+ population)	Percentage of people who are physically active for at least 150 minutes per week and/or consume at least five portions of fruit and vegetables per day. Both reflect the official recommendation of WHO. Eurostat provides information on the time spent on health-enhancing (non-work-related) aerobic physical activity (in minutes per week), including sports and cycling to get to and from places. Five portions (400 g) of fruit and vegetables exclude juices from concentrates and potatoes (starches).	Eurostat, EHIS Eurostat calculations on EIGE's request	2014 EU: Non-weighted average BE, NL: EIGE estimation	2014 EU: Non-weighted average BE, NL: EIGE estimation	2014 EU: Non-weighted average BE, NL: EIGE estimation	2014 EU: Non-weighted average BE, NL: EIGE estimation	2014 EU: Non-weighted average BE, NL: EIGE estimation	2014 EU: Non-weighted average BE, NL: EIGE estimation
	Access	30	Population without unmet needs for medical examination (%, 16+ population)	Self-reported unmet needs for medical examination. The variables refer to the respondent's own assessment of whether he or she needed examination or treatment, but did not have it. Percentage of persons 'No unmet needs to declare'. Medical care: refers to individual healthcare services (medical examination or treatment excluding dental care) provided by or under direct supervision of medical doctors or equivalent professions according to national healthcare systems.	Eurostat, EU-SILC Self-reported unmet needs for medical examination by sex, age, detailed reason and income quintile (%) [hlth_silc_08]	2010	2012	2015	2017	2018	2019
		31	People without unmet needs for dental examination (%, 16+ population)	Self-reported unmet needs for dental examination. The variables refer to the respondent's own assessment of whether he or she needed the examination or treatment, but did not have it. Percentage of persons 'No unmet needs to declare'. Dental care: refers to individual healthcare services provided by or under direct supervision of stomatologists (dentists). Healthcare provided by orthodontists is included.	Eurostat, EU-SILC Self-reported unmet needs for dental examination by sex, age, detailed reason and income quintile (%) [hlth_silc_09]	2010	2012	2015	2017	2018	2019

Domain	Sub-domain	N	Indicator and reference population	Description	Source	Index edition					
						2013	2015	2017	2019	2020	2021
						Data used					
Additional variable			Population in age group 18+	Number of people aged 18 years and older in the country	Eurostat, population statistics (1) Population on 1 January by broad age group and sex [demo_pjanbroad] (2) Population on 1 January by age and sex [demo_pjan]	2009–2010–2011	2011–2012–2013	2014–2015–2016	2016–2017–2018	2017–2018–2019	2018–2019–2020

Annex 2. Gender Equality Index scores

Table 4. Gender Equality Index scores, ranks and changes in score in points, by EU Member State (2010, 2012, 2015, 2017, 2018 and 2019)

MS	Scores (points)						Ranks						Changes in scores	
	2010	2012	2015	2017	2018	2019	2010	2012	2015	2017	2018	2019	2010 to 2019	2018 to 2019
EU	**63.1**	**64.4**	**65.7**	**66.9**	**67.4**	**68.0**	–	–	–	–	–	–	**4.9**	**0.6**
BE	69.3	70.2	70.5	71.1	71.4	72.7	5	5	6	7	8	8	3.4	1.3
BG	55.0	56.9	58.0	58.8	59.6	59.9	16	14	15	18	18	18	4.9	0.3
CZ	55.6	56.7	53.6	55.7	56.2	56.7	13	16	22	20	22	22	1.1	0.5
DK	75.2	75.6	76.8	77.5	77.4	77.8	2	2	2	2	2	2	2.6	0.4
DE	62.6	64.9	65.5	66.9	67.5	68.6	10	11	11	11	11	10	6.0	1.1
EE	53.4	53.5	56.7	59.8	60.7	61.6	20	21	19	16	17	17	8.2	0.9
IE	65.4	67.7	69.5	71.3	72.2	73.1	8	7	7	6	6	7	7.7	0.9
EL	48.6	50.1	50.0	51.2	52.2	52.5	27	27	27	27	27	27	3.9	0.3
ES	66.4	67.4	68.3	70.1	72.0	73.7	7	8	10	8	7	6	7.3	1.7
FR	67.5	68.9	72.6	74.6	75.1	75.5	6	6	5	3	3	4	8.0	0.4
HR	52.3	52.6	53.1	55.6	57.9	59.2	24	22	23	21	19	19	6.9	1.3
IT	53.3	56.5	62.1	63.0	63.5	63.8	21	17	13	13	13	14	10.5	0.3
CY	49.0	50.6	55.1	56.3	56.9	57.0	26	26	21	19	20	21	8.0	0.1
LV	55.2	56.2	57.9	59.7	60.8	62.1	15	18	16	17	16	16	6.9	1.3
LT	54.9	54.2	56.8	55.5	56.3	58.4	17	20	18	22	21	20	3.5	2.1
LU	61.2	65.9	69.0	69.2	70.3	72.4	11	10	8	9	9	9	11.2	2.1
HU	52.4	51.8	50.8	51.9	53.0	53.4	23	24	26	26	26	26	1.0	0.4
MT	54.4	57.8	60.1	62.5	63.4	65.0	18	13	14	14	14	13	10.6	1.6
NL	74.0	74.0	72.9	72.1	74.1	75.9	3	4	4	5	5	3	1.9	1.8
AT	58.7	61.3	63.3	65.3	66.5	68.0	12	12	12	12	12	11	9.3	1.5
PL	55.5	56.9	56.8	55.2	55.8	56.6	14	15	17	23	23	23	1.1	0.8
PT	53.7	54.4	56.0	59.9	61.3	62.2	19	19	20	15	15	15	8.5	0.9
RO	50.8	51.2	52.4	54.5	54.4	54.5	25	25	24	24	25	25	3.7	0.1
SI	62.7	66.1	68.4	68.3	67.7	67.6	9	9	9	10	10	12	4.9	– 0.1
SK	53.0	52.4	52.4	54.1	55.5	56.0	22	23	25	25	24	24	3.0	0.5
FI	73.1	74.4	73.0	73.4	74.7	75.3	4	3	3	4	4	5	2.2	0.6
SE	80.1	79.7	82.6	83.6	83.8	83.9	1	1	1	1	1	1	3.8	0.1

Table 5. Gender Equality Index scores and ranks, by domain and EU Member State (2010)

MS	Scores (points)							Ranks						
	Index	Work	Money	Knowledge	Time	Power	Health	Index	Work	Money	Knowledge	Time	Power	Health
EU	**63.1**	**69.7**	**79.1**	**59.8**	**65.2**	**41.9**	**86.7**	–	–	–	–	–	–	–
BE	69.3	72.7	85.5	70.6	70.3	47.9	86.5	5	7	4	3	7	7	13
BG	55.0	67.9	60.8	50.4	43.9	45.8	75.3	16	19	24	23	24	8	26
CZ	55.6	64.9	73.8	55.4	53.8	31.0	85.7	13	24	17	16	19	15	16
DK	75.2	79.8	83.6	73.2	80.4	58.0	90.3	2	2	7	1	3	3	5
DE	62.6	70.0	83.2	56.3	69.8	38.3	89.3	10	17	9	14	9	10	9
EE	53.4	71.2	65.5	51.6	73.7	21.9	82.7	20	14	23	22	5	25	21
IE	65.4	73.5	85.5	65.3	70.8	37.2	90.7	8	6	3	7	6	11	3
EL	48.6	63.6	75.3	53.4	35.6	22.3	84.3	27	26	16	21	27	24	19
ES	66.4	71.8	77.1	63.5	60.8	52.6	88.6	7	11	15	8	13	5	10
FR	67.5	71.5	83.5	62.0	66.6	52.4	86.7	6	12	8	9	11	6	12
HR	52.3	67.2	68.6	49.9	49.8	28.4	81.5	24	20	22	25	22	20	23
IT	53.3	61.3	78.9	53.8	55.1	25.2	86.3	21	27	14	20	15	22	15
CY	49.0	70.5	80.7	55.5	45.9	15.4	86.4	26	16	11	15	23	27	14
LV	55.2	72.6	58.9	49.2	62.0	34.8	77.3	15	8	27	26	12	13	25
LT	54.9	72.6	60.8	54.3	52.2	32.9	80.4	17	9	25	19	20	14	24
LU	61.2	70.9	91.8	66.3	70.2	25.6	89.8	11	15	1	5	8	21	7
HU	52.4	66.0	70.8	54.5	54.1	23.5	85.4	23	22	19	18	18	23	17
MT	54.4	65.1	79.2	65.4	54.3	20.9	90.6	18	23	13	6	16	26	4
NL	74.0	76.3	86.6	66.9	85.9	56.9	90.3	3	3	2	4	1	4	6
AT	58.7	75.3	82.8	58.9	56.0	28.4	91.1	12	4	10	11	14	19	2
PL	55.5	66.3	69.5	57.8	54.2	30.6	81.6	14	21	21	13	17	17	22
PT	53.7	71.4	71.8	50.1	38.7	34.9	84.3	19	13	18	24	26	12	20
RO	50.8	67.9	59.8	47.2	50.6	30.8	69.9	25	18	26	27	21	16	27
SI	62.7	71.9	80.3	55.0	68.3	41.1	86.8	9	10	12	17	10	9	11
SK	53.0	64.8	70.2	59.5	39.9	29.5	84.8	22	25	20	10	25	18	18
FI	73.1	74.5	84.1	58.6	80.1	69.1	89.5	4	5	6	12	4	2	8
SE	80.1	80.4	85.3	70.7	84.5	77.8	93.2	1	1	5	2	2	1	1

Table 6. Gender Equality Index scores and ranks, by domain and EU Member State (2019)

MS	Scores (points)							Ranks						
	Index	Work	Money	Knowledge	Time	Power	Health	Index	Work	Money	Knowledge	Time	Power	Health
EU	**68.0**	**71.6**	**82.4**	**62.7**	**64.9**	**55.0**	**87.8**	–	–	–	–	–	–	–
BE	72.7	74.9	89.9	70.8	65.3	61.0	86.3	8	9	2	4	11	8	16
BG	59.9	69.6	64.5	55.2	42.7	60.2	77.2	18	20	27	22	27	9	26
CZ	56.7	67.4	78.9	58.5	57.3	28.1	86.3	22	23	15	14	17	25	17
DK	77.8	79.4	89.1	71.0	83.1	66.8	89.5	2	2	3	2	3	5	9
DE	68.6	72.4	86.0	54.7	65.0	62.8	90.7	10	17	9	24	12	7	5
EE	61.6	72.5	73.2	57.3	74.7	36.6	82.2	17	16	23	16	5	20	23
IE	73.1	76.5	87.8	67.4	74.2	58.4	91.3	7	6	5	6	6	10	4
EL	52.5	65.3	73.7	54.9	44.7	27.0	84.3	27	26	20	23	26	26	20
ES	73.7	73.7	78.4	67.9	64.0	76.9	90.3	6	12	16	5	14	3	6
FR	75.5	73.2	86.3	67.0	67.3	81.4	87.4	4	14	8	8	9	2	14
HR	59.2	70.1	74.0	51.8	51.0	45.3	83.8	19	19	19	26	21	17	21
IT	63.8	63.7	79.4	59.0	59.3	52.2	88.4	14	27	14	13	16	14	11
CY	57.0	70.6	82.6	56.0	51.3	30.0	87.9	21	18	13	21	20	24	12
LV	62.1	74.3	68.7	50.9	65.8	50.4	79.3	16	10	26	27	10	15	25
LT	58.4	74.2	69.9	56.1	50.6	39.3	80.3	20	11	24	20	22	18	24
LU	72.4	76.3	92.4	70.8	69.1	53.4	89.9	9	7	1	3	8	12	8
HU	53.4	68.0	73.3	57.2	54.3	22.9	86.7	26	21	22	17	18	27	15
MT	65.0	76.8	84.2	65.2	64.2	37.5	92.3	13	5	11	9	13	19	2
NL	75.9	78.3	87.0	67.4	83.9	64.0	90.2	3	3	7	7	2	6	7
AT	68.0	76.8	87.7	64.3	61.2	48.2	91.9	11	4	6	10	15	16	3
PL	56.6	67.2	76.7	57.6	52.5	31.5	83.3	23	24	17	15	19	22	22
PT	62.2	73.2	73.6	56.5	47.5	53.6	84.8	15	13	21	19	24	11	19
RO	54.5	67.5	69.1	52.8	50.3	34.7	71.3	25	22	25	25	23	21	27
SI	67.6	73.0	83.7	56.6	72.9	53.0	87.8	12	15	12	18	7	13	13
SK	56.0	66.8	75.1	61.6	46.3	30.7	85.5	24	25	18	12	25	23	18
FI	75.3	75.5	87.9	61.9	77.4	74.3	89.5	5	8	4	11	4	4	10
SE	83.9	83.1	85.4	75.2	90.1	84.5	94.6	1	1	10	1	1	1	1

Table 7. Gender Equality Index scores in the domain of work and its subdomains, by EU Member State (2010, 2012, 2015, 2017, 2018 and 2019)

Member State	Score (points)																	
	Domain of work						Participation						Segregation and quality of work					
	2010	2012	2015	2017	2018	2019	2010	2012	2015	2017	2018	2019	2010	2012	2015	2017	2018	2019
EU	**69.7**	**70.2**	**70.6**	**71.1**	**71.4**	**71.6**	**77.6**	**78.3**	**79.2**	**80.4**	**80.9**	**81.3**	**62.6**	**62.9**	**62.9**	**62.9**	**62.9**	**63.1**
BE	72.7	72.8	73.8	74.1	74.7	74.9	75.7	75.4	77.5	78.2	79.5	80.2	69.8	70.4	70.2	70.2	70.1	69.9
BG	67.9	68.7	68.6	69.0	69.0	69.6	81.3	82.0	82.7	83.5	83.5	84.6	56.7	57.6	56.9	57.0	57.0	57.3
CZ	64.9	65.3	66.1	67.0	67.0	67.4	78.9	79.9	81.8	83.5	84.3	84.5	53.3	53.3	53.5	53.7	53.3	53.8
DK	79.8	79.7	79.2	79.6	79.7	79.4	88.5	88.3	87.2	88.3	88.7	88.4	71.9	72.1	72.0	71.8	71.5	71.4
DE	70.0	70.6	71.4	72.1	72.1	72.4	79.0	80.2	81.9	83.3	83.6	84.2	62.1	62.1	62.2	62.3	62.2	62.3
EE	71.2	71.4	72.1	71.5	72.1	72.5	87.3	87.7	88.6	89.8	90.6	90.8	58.1	58.1	58.7	57.0	57.5	57.9
IE	73.5	73.7	73.9	75.5	75.9	76.5	77.4	77.3	78.3	81.7	82.4	82.8	69.8	70.2	69.7	69.8	69.9	70.6
EL	63.6	63.6	64.2	64.2	64.4	65.3	71.1	69.4	71.0	71.4	71.6	72.7	57.0	58.4	58.0	57.7	58.0	58.7
ES	71.8	72.3	72.4	72.9	73.2	73.7	77.0	77.5	78.0	79.1	79.3	80.2	66.9	67.4	67.3	67.1	67.5	67.8
FR	71.5	71.9	72.1	72.4	72.8	73.2	81.1	81.4	82.3	82.4	83.5	83.7	63.1	63.5	63.2	63.5	63.5	63.9
HR	67.2	68.3	69.4	69.2	69.9	70.1	75.0	75.5	78.5	78.9	79.6	79.7	60.3	61.8	61.4	60.7	61.4	61.6
IT	61.3	62.4	62.4	63.1	63.3	63.7	64.9	66.7	66.7	68.2	68.6	69.1	57.8	58.5	58.4	58.5	58.5	58.6
CY	70.5	68.9	70.7	70.7	70.8	70.6	85.2	83.4	84.7	84.9	86.2	86.0	58.3	56.9	59.0	58.8	58.2	57.9
LV	72.6	74.3	73.6	74.2	74.0	74.3	86.9	86.9	87.8	89.3	90.1	89.9	60.7	63.5	61.8	61.7	60.8	61.4
LT	72.6	72.6	73.2	73.6	74.1	74.2	86.0	86.8	88.2	89.7	90.7	91.1	61.3	60.8	60.7	60.4	60.4	60.4
LU	70.9	72.5	74.0	74.1	75.2	76.3	74.8	77.7	81.3	82.4	83.5	83.3	67.3	67.7	67.4	66.7	67.6	69.8
HU	66.0	66.4	67.2	67.4	68.0	68.0	75.8	76.9	79.6	81.0	81.3	81.1	57.5	57.4	56.7	56.0	56.9	57.0
MT	65.1	68.2	71.0	73.3	75.4	76.8	58.6	63.2	68.9	73.1	76.9	79.8	72.3	73.7	73.1	73.5	74.0	73.9
NL	76.3	76.2	76.7	77.4	77.8	78.3	78.5	78.6	79.2	80.7	81.7	82.8	74.1	73.9	74.3	74.2	74.2	73.9
AT	75.3	75.6	76.1	76.6	76.4	76.8	80.3	80.9	81.4	82.4	82.4	82.7	70.6	70.6	71.2	71.2	70.7	71.4
PL	66.3	66.6	66.8	67.0	67.3	67.2	77.9	78.3	79.5	80.2	80.8	80.6	56.5	56.5	56.2	56.0	56.1	56.0
PT	71.4	71.4	72.0	72.5	72.9	73.2	85.6	84.1	85.4	86.6	87.8	88.2	59.5	60.6	60.8	60.7	60.6	60.8
RO	67.9	67.8	67.1	67.7	67.6	67.5	78.8	78.5	77.5	79.0	78.8	78.8	58.6	58.5	58.1	58.0	58.0	57.9
SI	71.9	71.3	71.8	73.3	73.1	73.0	84.4	83.7	83.5	86.5	86.7	87.2	61.3	60.7	61.7	62.1	61.6	61.1
SK	64.8	64.9	65.5	66.5	66.6	66.8	79.0	78.8	80.6	82.6	82.7	83.2	53.1	53.4	53.2	53.5	53.7	53.7
FI	74.5	74.8	74.7	74.9	75.4	75.5	88.9	89.2	89.2	88.9	90.0	90.1	62.4	62.7	62.6	63.1	63.2	63.3
SE	80.4	81.4	82.6	83.0	82.9	83.1	91.9	93.8	95.4	95.7	95.8	95.9	70.4	70.6	71.5	71.9	71.7	72.0

Table 8. Gender Equality Index scores in the domain of money and its subdomains, by EU Member State (2010, 2012, 2015, 2017, 2018 and 2019)

Member State	Score (points)																	
	Domain of money						Financial resources						Economic situation					
	2010	2012	2015	2017	2018	2019	2010	2012	2015	2017	2018	2019	2010	2012	2015	2017	2018	2019
EU	79.1	79.1	80.1	81.1	81.6	82.4	70.6	71.2	73.9	74.9	75.5	76.9	88.7	88.0	86.7	88.0	88.1	88.3
BE	85.5	85.6	87.5	88.3	88.7	89.9	77.9	78.6	82.7	83.3	83.8	84.6	94.0	93.3	92.6	93.6	93.8	95.4
BG	60.8	60.5	61.9	61.8	62.3	64.5	44.7	44.2	48.2	50.2	49.6	54.6	82.8	82.7	79.5	76.1	78.2	76.1
CZ	73.8	74.0	75.9	76.7	76.8	78.9	55.1	55.8	58.8	59.8	60.4	63.8	98.7	98.1	98.1	98.2	97.6	97.5
DK	83.6	85.7	86.6	87.1	86.8	89.1	78.3	80.4	82.4	83.2	83.3	85.8	89.3	91.4	91.1	91.2	90.5	92.4
DE	83.2	84.0	84.2	86.0	84.9	86.0	77.1	78.1	81.2	82.1	82.9	84.5	89.8	90.2	87.4	90.1	86.9	87.5
EE	65.5	64.9	66.7	69.4	70.0	73.2	49.5	50.2	56.4	58.3	59.3	63.6	86.7	84.0	79.0	82.5	82.7	84.1
IE	85.5	84.4	84.7	85.5	86.5	87.8	81.1	80.7	81.0	81.7	83.3	82.6	90.2	88.2	88.6	89.5	89.8	93.3
EL	75.3	71.1	70.7	71.4	72.5	73.7	66.7	62.7	61.4	61.3	61.4	62.2	84.9	80.7	81.4	83.2	85.6	87.3
ES	77.1	76.0	75.9	76.7	77.8	78.4	70.4	69.6	71.0	72.2	72.3	73.5	84.4	82.9	81.2	81.4	83.6	83.7
FR	83.5	83.7	86.1	86.4	87.0	86.3	75.9	77.2	80.4	81.0	80.9	80.8	91.8	90.6	92.3	92.1	93.5	92.1
HR	68.6	68.9	69.9	72.2	72.6	74.0	56.2	55.7	57.1	60.1	60.6	62.1	83.8	85.2	85.6	86.9	86.9	88.1
IT	78.9	78.7	78.6	78.8	79.0	79.4	72.5	72.8	73.0	74.4	74.8	75.8	86.0	85.1	84.6	83.5	83.4	83.1
CY	80.7	81.7	79.2	80.8	81.7	82.6	74.8	76.4	72.1	72.8	72.8	76.0	87.1	87.4	87.1	89.7	91.6	89.8
LV	58.9	59.6	64.3	65.5	65.2	68.7	43.5	43.5	51.9	53.7	54.6	59.4	79.8	81.5	79.5	80.0	78.0	79.4
LT	60.8	64.3	65.6	64.7	66.1	69.9	47.8	48.4	53.5	55.0	56.0	60.9	77.3	85.5	80.4	76.1	78.0	80.4
LU	91.8	92.1	94.4	91.8	90.0	92.4	91.2	91.6	97.0	96.8	97.3	98.0	92.5	92.7	92.0	87.2	83.2	87.2
HU	70.8	69.8	70.7	71.6	72.0	73.3	51.0	52.5	55.2	55.5	56.2	58.2	98.3	92.9	90.5	92.5	92.2	92.2
MT	79.2	80.6	82.4	82.5	82.6	84.2	68.6	69.5	73.3	74.4	74.8	77.6	91.3	93.3	92.8	91.4	91.1	91.4
NL	86.6	87.0	86.8	86.7	86.2	87.0	77.7	77.6	79.1	80.4	80.4	80.9	96.5	97.5	95.4	93.5	92.4	93.5
AT	82.8	83.6	85.9	86.4	86.7	87.7	74.7	75.8	79.8	81.4	80.9	82.8	91.8	92.2	92.5	91.7	93.1	92.9
PL	69.5	70.3	73.3	75.1	75.5	76.7	54.6	56.2	61.4	62.8	63.0	65.1	88.5	88.0	87.5	89.9	90.5	90.4
PT	71.8	71.7	70.9	72.1	72.8	73.6	60.4	60.7	60.3	61.2	61.2	62.3	85.3	84.8	83.5	84.8	86.8	87.0
RO	59.8	59.2	59.4	62.0	63.0	69.1	42.5	42.7	45.7	47.2	49.3	60.1	84.2	82.1	77.3	81.6	80.4	79.5
SI	80.3	81.3	81.6	82.4	83.0	83.7	67.3	68.3	69.8	70.0	70.7	71.6	95.8	96.7	95.5	97.1	97.4	97.9
SK	70.2	72.1	74.0	74.2	75.1	75.1	51.9	53.9	56.4	56.8	57.1	57.5	95.1	96.4	97.2	96.9	98.8	98.2
FI	84.1	84.8	86.4	87.6	87.1	87.9	74.6	76.2	78.5	79.2	79.4	80.4	94.9	94.4	95.2	96.9	95.5	96.1
SE	85.3	85.3	87.5	86.8	86.8	85.4	75.9	77.4	82.3	82.1	82.0	81.9	95.8	93.9	93.1	91.9	91.9	88.9

Table 9. Gender Equality Index scores in the domain of knowledge and its subdomains, by EU Member State (2010, 2012, 2015, 2017, 2018 and 2019)

Member State	Score (points)																	
	Domain of knowledge						Attainment and participation						Segregation					
	2010	2012	2015	2017	2018	2019	2010	2012	2015	2017	2018	2019	2010	2012	2015	2017	2018	2019
EU	**59.8**	**61.1**	**62.4**	**62.6**	**62.8**	**62.7**	**66.0**	**68.2**	**71.2**	**71.8**	**72.2**	**72.5**	**54.2**	**54.7**	**54.7**	**54.5**	**54.5**	**54.1**
BE	70.6	70.6	71.1	71.3	71.4	70.8	73.3	72.5	73.3	74.3	73.8	74.0	68.1	68.8	68.9	68.4	69.0	67.7
BG	50.4	51.9	53.3	53.2	54.9	55.2	53.9	54.6	56.1	55.4	57.3	56.3	47.1	49.3	50.7	51.0	52.7	54.1
CZ	55.4	57.7	57.3	59.0	58.4	58.5	61.4	66.3	66.9	69.9	67.7	66.4	50.0	50.2	49.2	49.8	50.3	51.6
DK	73.2	71.3	73.6	72.3	71.3	71.0	81.7	80.5	82.1	81.8	79.5	80.7	65.6	63.1	66.0	64.0	64.0	62.5
DE	56.3	57.1	52.9	53.7	54.0	54.7	59.9	62.7	61.0	62.4	63.2	64.3	53.0	51.9	45.9	46.2	46.2	46.6
EE	51.6	53.8	53.2	55.5	56.3	57.3	67.4	70.5	67.9	70.1	72.1	73.7	39.5	41.1	41.7	44.0	44.0	44.5
IE	65.3	67.7	66.4	66.9	67.3	67.4	72.7	74.0	74.1	77.8	79.3	80.2	58.6	62.0	59.6	57.6	57.2	56.7
EL	53.4	54.3	55.6	55.7	54.8	54.9	59.8	60.7	63.9	66.3	66.8	67.3	47.7	48.5	48.4	46.8	45.0	44.8
ES	63.5	64.2	65.3	67.4	67.6	67.9	71.8	73.0	73.3	76.0	76.6	76.4	56.2	56.6	58.1	59.7	59.7	60.3
FR	62.0	62.4	66.1	66.0	66.3	67.0	67.9	69.7	77.5	78.5	79.6	80.3	56.6	55.8	56.4	55.6	55.2	55.9
HR	49.9	48.5	49.8	50.4	51.6	51.8	57.5	58.7	59.3	59.2	60.6	60.1	43.3	40.0	41.8	42.9	43.9	44.7
IT	53.8	56.7	61.4	61.2	61.9	59.0	53.7	54.4	56.1	57.0	58.0	58.3	53.9	59.2	67.1	65.8	66.0	59.7
CY	55.5	58.2	58.5	56.5	56.2	56.0	73.6	73.2	73.3	73.2	73.1	71.1	41.9	46.2	46.6	43.5	43.3	44.1
LV	49.2	48.8	48.9	49.7	49.3	50.9	60.5	62.2	59.1	62.3	61.1	65.6	40.0	38.3	40.5	39.7	39.7	39.4
LT	54.3	54.7	55.8	55.9	56.2	56.1	65.0	66.2	68.4	69.4	70.0	71.0	45.4	45.3	45.4	45.0	45.0	44.3
LU	66.3	68.7	69.4	69.5	70.0	70.8	74.8	78.6	84.1	84.5	85.9	88.7	58.7	60.1	57.2	57.1	57.1	56.5
HU	54.5	54.3	56.9	56.9	57.4	57.2	59.2	59.6	64.6	63.4	64.1	63.2	50.1	49.5	50.0	51.0	51.5	51.8
MT	65.4	66.3	65.2	65.8	67.1	65.2	59.2	60.2	61.3	65.9	67.0	67.3	72.3	73.0	69.5	65.8	67.3	63.2
NL	66.9	66.9	67.3	67.1	67.3	67.4	77.1	78.0	80.9	83.4	84.1	85.5	58.1	57.5	56.0	53.9	53.9	53.1
AT	58.9	59.9	63.2	64.1	63.8	64.3	61.2	61.8	72.0	74.1	73.3	73.6	56.6	58.1	55.5	55.5	55.5	56.2
PL	57.8	56.5	56.0	56.5	57.2	57.6	62.3	61.5	61.3	61.5	63.0	62.8	53.6	51.9	51.1	51.9	51.9	52.9
PT	50.1	54.9	54.8	55.1	55.7	56.5	50.8	59.1	59.5	60.4	61.3	62.6	49.5	51.0	50.6	50.3	50.7	51.0
RO	47.2	50.2	51.8	51.5	52.4	52.8	50.1	52.7	52.9	52.4	52.6	53.4	44.4	47.9	50.7	50.7	52.2	52.1
SI	55.0	54.9	55.0	56.0	55.9	56.6	68.4	67.1	67.4	66.9	66.6	67.5	44.2	45.0	44.9	46.9	46.9	47.4
SK	59.5	59.6	60.0	60.4	61.2	61.6	59.1	58.8	58.8	59.7	60.9	60.9	59.9	60.3	61.2	61.1	61.5	62.4
FI	58.6	59.5	61.3	61.1	61.6	61.9	78.3	79.5	81.4	83.0	83.6	84.2	43.9	44.6	46.1	45.0	45.5	45.5
SE	70.7	70.9	72.8	73.8	74.2	75.2	74.4	75.6	78.5	80.2	80.5	82.6	67.1	66.6	67.5	67.9	68.4	68.4

Table 10. Gender Equality Index scores in the domain of time and its subdomains, by EU Member State (2010, 2012, 2015, 2017, 2018 and 2019)

Member State	Score (points)																	
	Domain of time						Care activities						Social activities					
	2010	2012	2015	2017	2018	2019	2010	2012	2015	2017	2018	2019	2010	2012	2015	2017	2018	2019
EU	**65.2**	**68.1**	**64.9**	**64.9**	**64.9**	**64.9**	**65.4**	**71.3**	**69.1**	**69.1**	**69.1**	**69.1**	**65.0**	**65.0**	**61.0**	**61.0**	**61.0**	**61.0**
BE	70.3	71.8	65.3	65.3	65.3	65.3	72.6	75.7	68.9	68.9	68.9	68.9	68.1	68.1	61.9	61.9	61.9	61.9
BG	43.9	47.4	42.7	42.7	42.7	42.7	48.6	56.6	55.7	55.7	55.7	55.7	39.7	39.7	32.6	32.6	32.6	32.6
CZ	53.8	55.5	57.3	57.3	57.3	57.3	55.8	59.4	56.8	56.8	56.8	56.8	51.9	51.9	57.7	57.7	57.7	57.7
DK	80.4	85.4	83.1	83.1	83.1	83.1	75.8	85.5	86.1	86.1	86.1	86.1	85.3	85.3	80.2	80.2	80.2	80.2
DE	69.8	67.8	65.0	65.0	65.0	65.0	70.1	66.1	71.3	71.3	71.3	71.3	69.6	69.6	59.3	59.3	59.3	59.3
EE	73.7	70.1	74.7	74.7	74.7	74.7	80.7	73.0	85.9	85.9	85.9	85.9	67.2	67.2	65.0	65.0	65.0	65.0
IE	70.8	76.5	74.2	74.2	74.2	74.2	69.9	81.6	76.2	76.2	76.2	76.2	71.8	71.8	72.1	72.1	72.1	72.1
EL	35.6	45.2	44.7	44.7	44.7	44.7	34.2	55.1	50.9	50.9	50.9	50.9	37.1	37.1	39.3	39.3	39.3	39.3
ES	60.8	65.8	64.0	64.0	64.0	64.0	60.9	71.4	74.5	74.5	74.5	74.5	60.6	60.6	55.0	55.0	55.0	55.0
FR	66.6	70.3	67.3	67.3	67.3	67.3	70.3	78.5	70.4	70.4	70.4	70.4	63.0	63.0	64.4	64.4	64.4	64.4
HR	49.8	54.7	51.0	51.0	51.0	51.0	53.0	63.9	54.4	54.4	54.4	54.4	46.7	46.7	47.9	47.9	47.9	47.9
IT	55.1	61.4	59.3	59.3	59.3	59.3	54.5	67.6	61.2	61.2	61.2	61.2	55.7	55.7	57.4	57.4	57.4	57.4
CY	45.9	45.9	51.3	51.3	51.3	51.3	52.6	52.7	65.7	65.7	65.7	65.7	40.0	40.0	40.0	40.0	40.0	40.0
LV	62.0	60.8	65.8	65.8	65.8	65.8	78.2	75.1	89.8	89.8	89.8	89.8	49.2	49.2	48.2	48.2	48.2	48.2
LT	52.2	55.7	50.6	50.6	50.6	50.6	65.4	74.5	64.0	64.0	64.0	64.0	41.7	41.7	40.0	40.0	40.0	40.0
LU	70.2	71.5	69.1	69.1	69.1	69.1	72.1	74.8	79.4	79.4	79.4	79.4	68.3	68.3	60.2	60.2	60.2	60.2
HU	54.1	55.2	54.3	54.3	54.3	54.3	68.7	71.6	65.0	65.0	65.0	65.0	42.6	42.6	45.4	45.4	45.4	45.4
MT	54.3	58.7	64.2	64.2	64.2	64.2	49.7	57.9	69.0	69.0	69.0	69.0	59.4	59.4	59.8	59.8	59.8	59.8
NL	85.9	86.7	83.9	83.9	83.9	83.9	76.5	78.0	79.3	79.3	79.3	79.3	96.4	96.4	88.7	88.7	88.7	88.7
AT	56.0	65.3	61.2	61.2	61.2	61.2	44.9	61.0	62.7	62.7	62.7	62.7	69.8	69.8	59.7	59.7	59.7	59.7
PL	54.2	55.3	52.5	52.5	52.5	52.5	63.0	65.6	64.1	64.1	64.1	64.1	46.5	46.5	43.0	43.0	43.0	43.0
PT	38.7	46.0	47.5	47.5	47.5	47.5	49.3	69.5	63.3	63.3	63.3	63.3	30.4	30.4	35.7	35.7	35.7	35.7
RO	50.6	53.2	50.3	50.3	50.3	50.3	70.9	78.1	70.7	70.7	70.7	70.7	36.2	36.2	35.8	35.8	35.8	35.8
SI	68.3	72.4	72.9	72.9	72.9	72.9	64.5	72.3	69.5	69.5	69.5	69.5	72.4	72.4	76.4	76.4	76.4	76.4
SK	39.9	43.4	46.3	46.3	46.3	46.3	52.7	62.5	56.5	56.5	56.5	56.5	30.2	30.2	37.9	37.9	37.9	37.9
FI	80.1	81.0	77.4	77.4	77.4	77.4	84.2	86.0	82.2	82.2	82.2	82.2	76.3	76.3	72.9	72.9	72.9	72.9
SE	84.5	83.5	90.1	90.1	90.1	90.1	84.6	82.6	90.9	90.9	90.9	90.9	84.3	84.3	89.3	89.3	89.3	89.3

NB: Scores for the domain of time have not changed since the previous edition of the Index because of a lack of new data.

Table 11. Gender Equality Index scores in the domain of power and its subdomains, by EU Member State (2010, 2012, 2015, 2017, 2018 and 2019)

Member State	Score (points)																							
	Domain of power						Political						Economic						Social					
	2010	2012	2015	2017	2018	2019	2010	2012	2015	2017	2018	2019	2010	2012	2015	2017	2018	2019	2010	2012	2015	2017	2018	2019
EU	**41.9**	**43.6**	**48.4**	**51.6**	**53.1**	**55.0**	**47.5**	**49.0**	**53.0**	**55.0**	**56.8**	**58.5**	**29.0**	**31.9**	**39.2**	**43.0**	**45.9**	**48.8**	**53.2**	**53.2**	**54.5**	**58.2**	**57.4**	**58.2**
BE	47.9	50.5	53.4	55.2	55.7	61.0	65.8	70.0	70.2	67.8	68.1	72.0	32.8	36.0	38.0	40.2	41.8	53.3	50.9	51.0	57.1	61.7	60.8	59.2
BG	45.8	49.4	56.0	59.9	61.5	60.2	50.3	53.4	49.2	53.8	56.5	58.8	27.6	32.7	53.2	59.9	60.0	60.2	69.3	69.3	67.0	66.8	68.5	61.8
CZ	31.0	32.0	22.6	26.1	27.7	28.1	30.7	31.7	36.6	37.8	40.0	43.2	27.4	29.0	9.2	13.6	16.4	17.1	35.6	35.6	34.2	34.3	32.5	30.1
DK	58.0	57.5	61.5	64.9	66.2	66.8	75.1	76.1	71.2	74.2	76.0	75.3	47.5	45.6	55.7	56.5	56.0	55.1	54.8	54.8	58.7	65.3	68.3	71.8
DE	38.3	46.0	53.0	56.6	59.5	62.8	60.2	59.9	71.5	69.6	67.8	66.7	19.0	33.0	42.1	49.7	56.5	64.4	49.2	49.1	49.5	52.4	55.0	57.5
EE	21.9	22.0	28.2	34.6	36.1	36.6	34.9	33.7	44.9	48.5	49.3	47.3	21.6	22.7	23.2	23.4	24.2	27.5	13.9	13.9	21.4	36.5	39.4	37.8
IE	37.2	40.7	48.6	53.4	55.8	58.4	32.9	37.0	39.8	44.1	45.3	47.0	21.7	25.4	39.9	46.4	50.0	55.6	72.1	71.7	72.4	74.5	76.8	76.1
EL	22.3	22.3	21.7	24.3	27.0	27.0	34.3	30.7	34.7	35.8	36.5	36.1	13.6	15.3	12.1	14.9	20.4	21.1	23.8	23.6	24.2	27.0	26.4	25.7
ES	52.6	52.9	57.0	62.0	69.4	76.9	73.7	69.7	72.3	76.8	82.5	86.5	33.3	35.8	43.5	53.4	64.8	70.1	59.4	59.2	58.9	58.1	62.7	75.1
FR	52.4	55.1	68.2	78.3	79.8	81.4	64.1	70.8	77.1	80.8	83.1	84.9	41.2	43.2	70.2	82.9	84.6	85.4	54.6	54.6	58.4	71.7	72.3	74.2
HR	28.4	27.3	28.5	34.8	41.4	45.3	40.2	40.0	38.7	42.2	45.1	46.3	24.8	22.2	19.0	19.8	28.6	37.2	22.9	22.9	31.6	50.2	55.1	54.2
IT	25.2	29.4	45.3	47.6	48.8	52.2	31.7	35.8	47.4	47.9	49.3	52.8	10.6	14.8	44.7	53.1	54.9	56.7	47.8	47.8	43.7	42.5	43.1	47.5
CY	15.4	17.4	24.7	28.2	29.8	30.0	30.1	30.2	25.8	27.5	29.9	32.3	4.7	6.8	22.6	23.0	23.0	22.9	25.9	25.7	25.8	35.6	38.6	36.6
LV	34.8	37.9	39.0	44.1	49.4	50.4	38.1	43.7	40.5	36.7	40.6	43.4	37.5	42.1	44.2	45.6	46.1	48.2	29.5	29.5	33.2	51.4	64.3	61.2
LT	32.9	27.7	36.6	32.5	34.1	39.3	34.0	34.8	40.0	40.9	45.5	48.5	23.7	13.9	30.1	18.5	18.1	24.5	44.3	44.2	40.9	45.3	48.2	51.2
LU	25.6	34.9	43.5	44.8	48.4	53.4	45.3	47.6	51.1	48.9	51.5	54.6	5.2	12.5	23.5	28.2	32.1	37.5	71.5	71.2	68.2	65.2	68.6	74.2
HU	23.5	21.9	18.7	20.6	22.2	22.9	16.1	15.9	14.3	15.0	17.8	21.8	37.8	31.0	22.1	23.1	23.7	23.0	21.4	21.5	20.9	25.1	25.8	24.1
MT	20.9	25.0	27.4	32.2	32.8	37.5	30.0	29.1	30.5	32.9	33.1	35.3	12.4	21.9	24.4	24.0	24.2	29.9	24.5	24.6	27.5	42.2	44.2	49.8
NL	56.9	56.6	52.9	50.0	57.2	64.0	69.5	66.0	70.6	70.6	71.9	73.4	40.4	41.8	33.1	29.3	45.9	58.7	65.8	65.8	63.4	60.2	56.7	60.7
AT	28.4	30.8	34.9	39.9	44.2	48.2	60.3	60.3	59.1	61.1	65.9	74.7	9.3	11.8	17.4	21.1	24.4	28.0	40.7	40.8	41.1	49.3	53.7	53.6
PL	30.6	34.8	35.1	29.1	30.0	31.5	36.6	43.5	46.1	43.6	44.3	45.6	27.5	33.8	38.2	33.1	34.1	35.7	28.6	28.6	24.4	17.0	17.8	19.2
PT	34.9	29.7	33.9	46.7	51.1	53.6	41.9	42.4	48.7	56.7	59.0	62.6	20.4	12.6	16.4	36.3	44.9	47.9	49.6	49.3	48.9	49.4	50.4	51.4
RO	30.8	28.8	33.2	38.8	37.5	34.7	23.5	26.5	32.9	40.8	41.6	41.0	28.0	20.4	21.4	20.5	21.5	19.0	44.4	44.4	51.8	69.7	59.3	53.6
SI	41.1	51.5	60.6	57.6	55.0	53.0	44.5	46.3	65.4	67.3	64.4	59.2	29.9	56.4	61.5	50.4	44.7	45.1	52.3	52.3	55.3	56.2	57.7	55.8
SK	29.5	25.4	23.1	26.8	29.6	30.7	31.0	28.4	29.0	35.3	36.9	37.2	34.1	23.7	14.6	17.9	23.3	26.3	24.3	24.4	29.1	30.4	30.0	29.6
FI	69.1	73.2	65.3	66.7	71.9	74.3	86.1	86.3	84.8	78.8	83.9	90.4	52.5	62.0	47.6	52.5	59.2	60.8	73.1	73.2	68.9	71.5	74.8	74.6
SE	77.8	75.2	79.5	83.4	84.2	84.5	92.1	93.0	93.9	95.1	94.9	95.0	58.7	52.6	60.8	69.4	71.7	70.7	87.1	87.1	87.8	87.9	87.8	89.8

Table 12. Gender Equality Index scores in the domain of health and its subdomains, by EU Member State (2010, 2012, 2015, 2017, 2018 and 2019)

Member State	Score (points)																							
	Domain of health						Status						Behaviour						Access					
	2010	2012	2015	2017	2018	2019	2010	2012	2015	2017	2018	2019	2010	2012	2015	2017	2018	2019	2010	2012	2015	2017	2018	2019
EU	**86.7**	**86.7**	**87.1**	**87.8**	**87.8**	**87.8**	**90.4**	**90.6**	**90.9**	**91.9**	**92.0**	**92.1**	**74.8**	**74.8**	**74.8**	**74.8**	**74.8**	**74.8**	**96.2**	**96.2**	**97.0**	**98.3**	**98.3**	**98.2**
BE	86.5	86.4	86.3	86.3	86.5	86.3	92.6	93.4	93.3	93.3	93.6	93.3	70.3	70.3	70.3	70.3	70.3	70.3	99.3	98.1	98.0	97.9	98.4	98.1
BG	75.3	75.8	76.4	77.1	77.2	77.2	88.1	88.4	88.1	89.0	89.1	89.1	52.3	52.3	52.3	52.3	52.3	52.3	92.6	94.1	96.9	98.5	98.5	98.8
CZ	85.7	85.7	86.0	86.3	86.3	86.3	89.1	89.0	89.6	90.0	90.0	89.9	72.3	72.3	72.3	72.3	72.3	72.3	97.9	98.0	98.2	98.7	98.9	98.9
DK	90.3	90.2	89.6	89.9	89.7	89.5	92.2	92.6	91.6	92.4	91.1	91.6	81.7	81.7	81.7	81.7	81.7	81.7	97.8	96.9	96.2	96.3	96.8	95.9
DE	89.3	89.4	90.5	90.5	90.6	90.7	90.4	90.2	91.8	92.0	92.3	92.5	80.9	80.9	80.9	80.9	80.9	80.9	97.5	97.9	99.7	99.7	99.7	99.8
EE	82.7	82.1	81.5	81.9	81.6	82.2	83.4	83.2	84.1	83.9	83.8	85.2	70.1	70.1	70.1	70.1	70.1	70.1	96.8	94.7	91.9	93.5	92.6	92.9
IE	90.7	90.4	90.6	90.9	91.3	91.3	96.5	96.5	96.8	97.1	97.6	97.7	79.0	79.0	79.0	79.0	79.0	79.0	98.0	97.0	97.3	97.9	98.8	98.6
EL	84.3	83.9	83.1	83.5	84.0	84.3	94.1	93.5	93.4	93.3	94.4	95.2	66.6	66.6	66.6	66.6	66.6	66.6	95.7	94.8	92.3	93.8	94.1	94.5
ES	88.6	89.1	89.6	90.1	90.1	90.3	92.4	93.6	93.2	94.1	94.4	95.2	78.6	78.6	78.6	78.6	78.6	78.6	95.7	96.2	98.3	98.9	98.7	98.6
FR	86.7	86.8	87.1	87.4	87.4	87.4	91.0	91.6	91.6	91.9	92.1	92.1	74.0	74.0	74.0	74.0	74.0	74.0	96.8	96.6	97.6	98.1	97.9	98.1
HR	81.5	82.8	83.3	83.7	83.7	83.8	85.1	85.7	86.4	87.5	87.4	87.6	68.3	68.3	68.3	68.3	68.3	68.3	93.1	97.0	97.8	98.1	98.3	98.3
IT	86.3	86.5	86.3	88.7	88.4	88.4	91.1	91.3	91.3	95.1	94.3	94.4	74.2	74.2	74.2	74.2	74.2	74.2	94.9	95.5	94.8	99.0	98.6	98.6
CY	86.4	87.1	88.2	88.4	88.0	87.9	93.7	94.4	95.5	96.1	94.8	94.6	73.0	73.0	73.0	73.0	73.0	73.0	94.4	96.0	98.4	98.4	98.4	98.4
LV	77.3	77.9	78.4	78.3	78.4	79.3	80.0	80.5	79.8	79.0	79.9	80.4	65.5	65.5	65.5	65.5	65.5	65.5	88.3	89.7	92.3	92.9	92.1	94.6
LT	80.4	79.6	79.1	79.8	80.0	80.3	81.9	79.7	78.5	80.0	81.0	81.2	64.8	64.8	64.8	64.8	64.8	64.8	98.1	97.7	97.5	98.2	97.8	98.3
LU	89.8	90.0	89.0	89.6	89.5	89.9	93.8	94.4	92.0	91.9	91.5	93.0	78.5	78.5	78.5	78.5	78.5	78.5	98.3	98.4	97.7	99.7	99.7	99.7
HU	85.4	85.9	86.0	86.6	87.0	86.7	84.2	85.9	85.8	86.6	87.6	86.9	76.8	76.8	76.8	76.8	76.8	76.8	96.3	96.0	96.5	97.6	97.9	97.6
MT	90.6	91.6	91.8	92.1	92.0	92.3	93.8	95.3	95.6	96.2	95.8	96.4	81.7	81.7	81.7	81.7	81.7	81.7	97.0	98.6	99.0	99.6	99.4	99.8
NL	90.3	89.7	89.9	90.0	90.0	90.2	93.6	91.8	91.7	92.1	92.2	92.8	79.3	79.3	79.3	79.3	79.3	79.3	99.2	99.3	99.9	99.9	99.9	99.6
AT	91.1	91.5	91.7	91.7	91.9	91.9	91.0	91.7	91.3	91.5	91.8	91.9	84.6	84.6	84.6	84.6	84.6	84.6	98.1	98.8	99.8	99.7	99.9	99.7
PL	81.6	81.7	82.2	83.2	83.1	83.3	85.8	85.9	86.6	87.3	87.4	87.7	67.9	67.9	67.9	67.9	67.9	67.9	93.4	93.6	94.5	97.0	96.7	97.2
PT	84.3	84.4	83.6	84.5	84.6	84.8	83.3	84.6	82.6	84.0	84.2	84.5	75.5	75.5	75.5	75.5	75.5	75.5	95.2	94.2	93.9	95.2	95.2	95.8
RO	69.9	70.2	70.4	71.1	71.2	71.3	87.9	88.5	88.6	88.6	88.7	89.2	42.5	42.5	42.5	42.5	42.5	42.5	91.6	92.1	92.9	95.7	96.0	95.9
SI	86.8	87.3	87.7	87.1	86.9	87.8	86.3	87.9	89.1	89.4	88.3	90.7	75.9	75.9	75.9	75.9	75.9	75.9	99.8	99.8	99.8	97.5	97.8	98.2
SK	84.8	85.0	85.3	85.8	85.5	85.5	85.4	86.1	87.4	88.1	87.8	87.7	73.1	73.1	73.1	73.1	73.1	73.1	97.6	97.5	97.3	98.0	97.4	97.6
FI	89.5	89.3	89.7	89.7	89.3	89.5	90.5	90.2	91.1	90.9	90.3	90.5	81.9	81.9	81.9	81.9	81.9	81.9	96.6	96.4	96.8	96.8	96.3	96.6
SE	93.2	93.0	94.1	94.7	94.5	94.6	95.7	95.7	97.4	96.9	96.3	96.4	89.3	89.3	89.3	89.3	89.3	89.3	94.5	94.2	95.8	98.0	98.1	98.2

Annex 3. Indicators included in the Gender Equality Index 2021

Table 13. Indicators included in the domain of work, by EU Member State

MS	Participation								Segregation and quality of work											
	FTE employment (%, 15+)				Duration of working life (years)				Employed people in education, human health and social work activities (%, 15+ employed)				Ability to take 1 or 2 hours off during working hours to take care of personal or family matters (%,15+ employed)				Career Prospect Index (0–100 points)			
	Women	Men	Total	Gap	Women	Men	Total	Gap	Women	Men	Total	Gap	Women	Men	Total	Gap	Women	Men	Total	Gap
EU	**41.5**	**57.3**	**49.0**	**– 15.8**	**33.4**	**38.3**	**35.9**	**– 4.9**	**29.6**	**8.1**	**17.9**	**21.5**	**21.7**	**25.7**	**23.8**	**– 4.0**	**61.5**	**63.1**	**62.4**	**– 1.6**
BE	40.0	53.4	46.3	– 13.4	31.6	35.4	33.6	– 3.8	39.1	10.7	24.0	28.4	29.5	33.2	31.5	– 3.7	66.2	66.5	66.4	– 0.3
BG	46.7	58.2	52.1	– 11.5	32.3	35.6	34.0	– 3.3	18.5	4.3	10.9	14.2	20.3	31.3	25.8	– 11.0	65.6	62.3	63.9	3.3
CZ	49.1	66.6	57.6	– 17.5	33.2	39.2	36.3	– 6.0	25.0	5.4	14.1	19.6	11.0	10.6	10.8	0.4	60.9	65.4	63.1	– 4.5
DK	46.6	58.1	52.1	– 11.5	38.2	41.7	40.0	– 3.5	43.0	13.0	27.0	30.0	31.8	50.1	41.4	– 18.3	70.4	72.9	71.7	– 2.5
DE	42.8	61.0	51.6	– 18.2	36.9	41.1	39.1	– 4.2	32.3	9.3	20.0	23.0	15.8	18.2	17.0	– 2.4	65.5	67.9	66.7	– 2.4
EE	51.2	65.9	58.0	– 14.7	38.5	39.5	39.0	– 1.0	26.6	5.1	15.5	21.5	15.4	15.8	15.6	– 0.4	65.8	64.8	65.3	1.0
IE	45.0	61.5	52.8	– 16.5	33.9	40.7	37.4	– 6.8	33.9	8.9	20.4	25.0	37.1	43.4	40.4	– 6.3	64.6	64.1	64.3	0.5
EL	32.6	50.4	41.1	– 17.8	29.6	36.6	33.2	– 7.0	22.7	8.6	14.6	14.1	14.4	16.1	15.4	– 1.7	51.0	52.2	51.6	– 1.2
ES	38.6	52.4	45.1	– 13.8	33.1	37.4	35.3	– 4.3	24.4	7.9	15.4	16.5	32.9	35.3	34.2	– 2.4	56.1	57.3	56.8	– 1.2
FR	42.5	52.7	47.2	– 10.2	33.8	37.0	35.4	– 3.2	34.3	10.6	22.1	23.7	17.9	22.1	20.0	– 4.2	63.8	66.7	65.3	– 2.9
HR	40.6	53.4	46.7	– 12.8	30.5	34.5	32.5	– 4.0	26.4	5.7	15.2	20.7	25.1	29.4	27.3	– 4.3	59.8	61.0	60.4	– 1.2
IT	31.4	51.5	40.9	– 20.1	27.3	36.4	32.0	– 9.1	25.7	7.2	15.0	18.5	19.3	22.0	20.8	– 2.7	51.9	55.7	54.0	– 3.8
CY	49.2	62.4	55.5	– 13.2	34.4	40.5	37.5	– 6.1	19.0	6.1	12.2	12.9	17.5	18.5	18.0	– 1.0	53.0	50.8	51.9	2.2
LV	50.3	62.9	55.9	– 12.6	36.8	36.8	36.8	0.0	26.0	4.9	15.5	21.1	24.9	26.0	25.4	– 1.1	62.7	60.7	61.8	2.0
LT	52.3	62.1	56.7	– 9.8	37.5	36.7	37.1	0.8	27.6	6.2	17.0	21.4	19.0	21.0	19.9	– 2.0	61.9	63.2	62.5	– 1.3
LU	46.4	59.9	53.0	– 13.5	31.6	36.0	33.9	– 4.4	26.5	11.6	18.4	14.9	22.7	30.0	26.5	– 7.3	70.1	72.5	71.3	– 2.4
HU	45.7	63.6	54.1	– 17.9	31.2	37.4	34.4	– 6.2	25.6	6.0	14.8	19.6	16.5	13.4	15.0	3.1	64.4	63.5	64.0	0.9
MT	44.9	66.7	56.0	– 21.8	31.8	41.1	36.5	– 9.3	30.4	10.6	18.6	19.8	36.5	37.8	37.3	– 1.3	69.0	67.0	67.8	2.0
NL	39.1	58.3	48.1	– 19.2	38.6	43.3	41.0	– 4.7	35.9	9.4	21.8	26.5	48.5	56.3	52.6	– 7.8	61.0	62.4	61.7	– 1.4
AT	42.5	61.2	51.3	– 18.7	35.3	39.8	37.6	– 4.5	27.9	8.5	17.6	19.4	35.5	36.4	35.9	– 0.9	64.3	65.4	64.9	– 1.1
PL	45.0	63.1	53.6	– 18.1	30.7	36.3	33.6	– 5.6	24.8	4.9	13.8	19.9	16.1	18.8	17.4	– 2.7	60.1	59.2	59.7	0.9
PT	47.3	57.7	52.1	– 10.4	36.8	39.6	38.2	– 2.8	29.9	6.9	18.2	23.0	23.4	28.3	25.7	– 4.9	55.6	57.0	56.3	– 1.4
RO	42.7	61.4	51.7	– 18.7	30.3	37.0	33.8	– 6.7	16.6	3.4	9.1	13.2	18.2	20.2	19.2	– 2.0	66.0	67.1	66.6	– 1.1
SI	48.0	59.4	53.6	– 11.4	34.7	37.0	35.9	– 2.3	27.5	5.7	15.7	21.8	25.1	31.8	28.5	– 6.7	60.4	61.5	61.0	– 1.1
SK	47.4	62.9	54.9	– 15.5	31.6	36.6	34.2	– 5.0	28.1	4.9	15.4	23.2	11.0	15.1	13.0	– 4.1	65.7	66.8	66.2	– 1.1
FI	47.4	55.4	51.2	– 8.0	38.3	39.6	38.9	– 1.3	39.5	9.1	23.8	30.4	26.7	50.7	38.5	– 24.0	65.4	66.7	66.1	– 1.3
SE	59.3	66.9	63.0	– 7.6	41.0	42.9	42.0	– 1.9	41.9	12.1	26.3	29.8	34.9	47.1	41.3	– 12.2	66.7	68.1	67.4	– 1.4
	Source: Eurostat, EU-LFS, 2019 Authors' calculation				Source: Eurostat, EU-LFS (lfsi_dwl_a), 2019				Source: Eurostat, EU-LFS (lfsa_egan2), 2019				Source: Eurofound, EWCS, 2015 Authors' calculation				Source: Eurofound, EWCS, 2015 Authors' calculation			

Table 14. Indicators included in the domain of money, by EU Member State

MS	Financial resources								Economic situation							
	Mean monthly earnings (PPS, working population)				Mean equivalised net income (PPS,16+)				Not-at-risk-of-poverty, ≥60 % of median income (%, 16+)				S20/S80 income quintile share (%, 16+)			
	Women	Men	Total	Gap	Women	Men	Total	Gap	Women	Men	Total	Gap	Women	Men	Total	Gap
EU	**2 333**	**2 819**	**2 587**	**– 486**	**19 495**	**20 420**	**19 942**	**– 925**	**83.0**	**84.7**	**83.8**	**– 1.7**	**20.0**	**20.1**	**20.0**	**– 0.1**
BE	2 778	3 075	2 927	– 297	23 204	24 609	23 892	– 1 405	85.5	87.0	86.2	– 1.5	28.2	27.2	27.7	1.0
BG	1 078	1 256	1 168	– 178	10 612	11 641	11 106	– 1 029	76.3	80.2	78.2	– 3.9	12.9	11.9	12.3	1.0
CZ	1 463	1 845	1 669	– 382	15 050	16 207	15 612	– 1 157	87.7	92.6	90.1	– 4.9	29.7	30.5	29.9	– 0.8
DK	2 868	3 479	3 160	– 611	24 706	25 316	25 006	– 610	87.3	86.9	87.1	0.4	25.3	23.7	24.4	1.6
DE	2 765	3 461	3 135	– 696	24 645	26 152	25 380	– 1 507	83.9	85.5	84.7	– 1.6	19.7	21.3	20.4	– 1.6
EE	1 461	1 896	1 653	– 435	15 282	16 093	15 658	– 811	75.0	80.0	77.3	– 5.0	20.2	19.2	19.7	1.0
IE	2 597	3 084	2 833	– 487	23 138	23 829	23 477	– 691	85.7	88.8	87.2	– 3.1	24.6	25.0	24.8	– 0.4
EL	1 669	1 971	1 829	– 302	11 154	11 470	11 306	– 316	82.3	82.9	82.6	– 0.6	19.8	19.3	19.6	0.5
ES	1 961	2 290	2 135	– 329	18 664	19 069	18 861	– 405	80.2	81.0	80.6	– 0.8	16.5	17.1	16.8	– 0.6
FR	2 282	2 798	2 548	– 516	24 130	24 717	24 409	– 587	86.7	88.0	87.3	– 1.3	23.1	23.8	23.4	– 0.7
HR	1 572	1 783	1 681	– 211	11 654	12 070	11 854	– 416	80.2	82.8	81.4	– 2.6	20.8	21.2	21.0	– 0.4
IT	2 201	2 620	2 435	– 419	19 324	20 402	19 844	– 1 078	79.6	81.8	80.6	– 2.2	16.9	16.4	16.6	0.5
CY	1 941	2 303	2 123	– 362	21 910	22 652	22 269	– 742	84.6	87.0	85.7	– 2.4	21.5	22.2	21.8	– 0.7
LV	1 349	1 697	1 514	– 348	12 483	13 517	12 946	– 1 034	72.8	78.4	75.3	– 5.6	15.2	15.4	15.3	– 0.2
LT	1 316	1 549	1 427	– 233	13 622	14 888	14 197	– 1 266	77.0	83.4	79.9	– 6.4	15.9	15.3	15.5	0.6
LU	3 497	3 625	3 576	– 128	34 056	35 613	34 832	– 1 557	83.5	84.6	84.0	– 1.1	18.7	18.7	18.7	0.0
HU	1 408	1 677	1 546	– 269	10 314	10 776	10 532	– 462	86.9	87.8	87.3	– 0.9	24.1	23.2	23.6	0.9
MT	2 238	2 660	2 474	– 422	20 663	21 426	21 053	– 763	82.1	85.1	83.6	– 3.0	24.1	23.7	23.9	0.4
NL	2 374	2 938	2 663	– 564	23 859	25 032	24 439	– 1 173	86.5	87.1	86.8	– 0.6	26.1	24.8	25.4	1.3
AT	2 343	3 018	2 738	– 675	26 442	27 666	27 041	– 1 224	85.9	88.1	87.0	– 2.2	24.1	24.1	24.0	0.0
PL	1 677	2 018	1 855	– 341	13 633	14 091	13 852	– 458	83.5	84.5	84.0	– 1.0	23.4	22.3	22.9	1.1
PT	1 367	1 541	1 452	– 174	13 534	13 928	13 718	– 394	82.2	83.5	82.8	– 1.3	19.7	19.1	19.4	0.6
RO	1 732	1 782	1 758	– 50	8 361	8 756	8 552	– 395	75.9	78.9	77.4	– 3.0	14.2	14.1	14.1	0.1
SI	1 847	2 084	1 972	– 237	17 698	18 374	18 033	– 676	86.5	89.1	87.8	– 2.6	29.5	29.6	29.5	– 0.1
SK	1 285	1 628	1 461	– 343	11 073	11 482	11 271	– 409	89.0	89.8	89.4	– 0.8	30.5	29.3	29.9	1.2
FI	2 419	2 953	2 667	– 534	22 728	23 531	23 120	– 803	87.5	88.4	88.0	– 0.9	27.3	26.9	27.1	0.4
SE	2 628	3 024	2 822	– 396	21 940	23 091	22 515	– 1 151	83.2	84.5	83.9	– 1.3	24.5	21.8	23.1	2.7
	Source: Eurostat, SES (earn_ses18_20), 2018 EL, 2014				Source: Eurostat, EU-SILC (ilc_di03), 2019				Source: Eurostat, EU-SILC (ilc_li02), 2019				Source: Eurostat calculations, EU-SILC, 2019			

Table 15. Indicators included in the domain of knowledge, by EU Member State

MS	Attainment and participation								Segregation			
	Graduates of tertiary education (%, 15+)				People participating in formal or non-formal education and training (%, 15+)				Tertiary students in the fields of education, health and welfare, humanities and art (tertiary students) (%, 15+)			
	Women	Men	Total	Gap	Women	Men	Total	Gap	Women	Men	Total	Gap
EU	**25.6**	**24.6**	**25.1**	**1.0**	**17.4**	**16.3**	**16.9**	**1.1**	**42.9**	**20.8**	**32.7**	**22.1**
BE	33.9	29.5	31.7	4.4	15.1	14.7	14.9	0.4	53.9	29.8	43.2	24.1
BG	26.2	18.9	22.7	7.3	8.3	8.8	8.5	– 0.5	36.2	19.4	28.5	16.8
CZ	19.5	18.8	19.2	0.7	15.2	14.8	15.0	0.4	44.4	19.5	33.7	24.9
DK	34.0	27.6	30.8	6.4	36.0	27.9	31.9	8.1	52.5	26.6	41.2	25.9
DE	21.1	29.0	25.0	– 7.9	13.7	14.8	14.3	– 1.1	41.0	17.4	28.9	23.6
EE	44.7	27.5	36.4	17.2	22.9	20.7	21.9	2.2	42.8	15.9	31.7	26.9
IE	39.6	34.3	37.0	5.3	21.4	18.8	20.1	2.6	48.9	23.3	36.6	25.6
EL	23.6	23.6	23.6	0.0	11.3	11.3	11.3	0.0	36.4	15.7	25.8	20.7
ES	31.1	29.7	30.4	1.4	17.3	16.3	16.8	1.0	49.2	25.0	38.0	24.2
FR	31.0	28.6	29.9	2.4	28.2	23.3	25.8	4.9	41.4	21.2	32.2	20.2
HR	21.8	18.8	20.4	3.0	10.5	10.1	10.3	0.4	34.9	14.9	26.3	20.0
IT	16.2	13.6	15.0	2.6	13.0	12.9	12.9	0.1	44.7	23.7	35.3	21.0
CY	38.6	31.5	35.2	7.1	12.7	11.7	12.2	1.0	43.5	16.3	30.7	27.2
LV	37.4	25.3	31.7	12.1	15.2	13.0	14.1	2.2	39.8	13.4	28.7	26.4
LT	37.8	29.1	33.8	8.7	13.9	13.4	13.6	0.5	42.3	15.9	30.8	26.4
LU	37.1	37.6	37.3	– 0.5	24.1	24.9	24.5	– 0.8	38.8	21.2	30.3	17.6
HU	23.2	18.9	21.2	4.3	13.0	13.1	13.0	– 0.1	41.1	19.3	31.1	21.8
MT	23.9	21.3	22.6	2.6	16.7	15.0	15.8	1.7	50.1	26.5	39.7	23.6
NL	31.7	33.6	32.6	– 1.9	25.4	24.8	25.1	0.6	37.7	19.4	29.0	18.3
AT	26.5	30.2	28.3	– 3.7	19.6	17.4	18.5	2.2	40.6	21.4	31.5	19.2
PL	28.4	21.6	25.1	6.8	11.4	11.2	11.3	0.2	39.5	19.1	31.2	20.4
PT	22.2	16.5	19.6	5.7	15.4	16.2	15.8	– 0.8	39.0	18.6	29.5	20.4
RO	14.1	13.6	13.8	0.5	8.4	9.0	8.7	– 0.6	33.1	17.9	26.1	15.2
SI	29.2	22.7	26.0	6.5	17.2	15.3	16.2	1.9	42.6	17.3	31.9	25.3
SK	23.2	19.2	21.2	4.0	10.9	10.7	10.8	0.2	49.3	25.7	39.6	23.6
FI	39.9	31.3	35.7	8.6	36.2	29.1	32.6	7.1	51.2	18.1	35.6	33.1
SE	42.8	30.8	36.7	12.0	45.8	31.6	38.6	14.2	53.9	29.7	44.3	24.2
	Source: Authors' calculations, Eurostat, EU-LFS, 2019				Source: Authors' calculations, Eurostat, EU-LFS, 2019				Source: Eurostat, education statistics (educ_uoe_enrt03), 2018 BG, EE, EL, LT, RO, FI, ED5 – short-cycle tertiary education n/a			

Table 16. Indicators included in the domain of time, by EU Member State

MS	Care activities								Social activities							
	People caring for and educating their children or grandchildren, elderly or people with disabilities, every day (%, 18+)				People cooking and/or doing housework, every day (%, 18+)				Workers doing sporting, cultural or leisure activities outside their home, at least daily or several times a week (%, 15+, employed)				Workers involved in voluntary or charitable activities, at least once a month (%, 15+, employed)			
	Women	Men	Total	Gap	Women	Men	Total	Gap	Women	Men	Total	Gap	Women	Men	Total	Gap
EU	**37.0**	**24.6**	**31.0**	**12.4**	**77.9**	**31.6**	**55.6**	**46.3**	**26.6**	**31.3**	**29.0**	**– 4.7**	**12.0**	**11.4**	**11.7**	**0.6**
BE	43.1	28.7	36.1	14.4	81.2	32.5	57.5	48.7	32.3	38.7	35.7	– 6.4	9.5	9.9	9.7	– 0.4
BG	38.5	25.8	32.4	12.7	72.9	13.0	44.1	59.9	11.7	19.5	15.6	– 7.8	2.9	2.4	2.7	0.5
CZ	33.2	19.8	26.7	13.4	67.4	15.8	42.3	51.6	22.6	27.8	25.2	– 5.2	12.3	11.3	11.8	1.0
DK	25.0	21.3	23.2	3.7	82.3	55.0	68.9	27.3	52.8	50.5	51.6	2.3	17.3	20.3	18.9	– 3.0
DE	25.5	18.7	22.2	6.8	72.3	29.1	51.3	43.2	21.8	25.2	23.5	– 3.4	15.8	13.3	14.5	2.5
EE	34.6	31.0	32.9	3.6	75.8	47.4	62.8	28.4	33.5	38.4	35.7	– 4.9	12.5	11.4	12.0	1.1
IE	44.1	30.5	37.5	13.6	88.7	48.0	68.9	40.7	40.4	48.4	44.6	– 8.0	15.4	17.9	16.7	– 2.5
EL	38.2	20.2	29.6	18.0	85.3	16.0	52.0	69.3	11.0	17.6	14.7	– 6.6	6.6	5.7	6.1	0.9
ES	39.8	27.7	33.9	12.1	84.5	41.9	63.8	42.6	39.3	45.5	42.6	– 6.2	5.7	3.8	4.7	1.9
FR	45.6	29.4	37.9	16.2	79.6	35.6	58.6	44.0	32.1	39.0	35.6	– 6.9	12.3	14.1	13.2	– 1.8
HR	34.9	21.3	28.4	13.6	62.4	11.9	38.2	50.5	12.5	19.1	15.9	– 6.6	10.8	10.3	10.5	0.5
IT	34.1	24.0	29.3	10.1	80.9	19.7	51.6	61.2	23.6	28.2	26.1	– 4.6	12.8	10.8	11.7	2.0
CY	50.1	34.1	42.4	16.0	80.8	26.6	54.8	54.2	9.7	21.7	15.8	– 12.0	8.8	8.0	8.4	0.8
LV	39.9	38.0	39.0	1.9	81.7	56.6	70.5	25.1	17.4	22.6	19.9	– 5.2	8.5	7.4	7.9	1.1
LT	41.3	24.2	33.6	17.1	79.0	28.8	56.4	50.2	13.5	17.9	15.5	– 4.4	5.2	4.4	4.9	0.8
LU	41.5	35.6	38.5	5.9	78.3	38.6	58.5	39.7	36.8	45.8	41.5	– 9.0	10.4	22.2	16.5	– 11.8
HU	30.1	24.5	27.5	5.6	55.8	13.8	36.3	42.0	16.6	12.5	14.6	4.1	11.3	8.7	10.0	2.6
MT	42.3	24.9	33.7	17.4	80.5	37.3	59.1	43.2	25.4	26.2	25.9	– 0.8	10.0	10.7	10.4	– 0.7
NL	38.5	28.2	33.5	10.3	81.4	47.4	64.7	34.0	56.0	58.3	57.2	– 2.3	22.3	22.3	22.3	0.0
AT	35.6	20.8	28.4	14.8	83.3	28.4	56.8	54.9	24.6	25.3	24.9	– 0.7	11.6	14.8	13.1	– 3.2
PL	47.0	25.0	36.5	22.0	81.7	33.5	58.7	48.2	16.9	21.3	19.0	– 4.4	6.5	4.7	5.7	1.8
PT	36.5	28.1	32.5	8.4	78.1	18.8	50.4	59.3	10.3	19.6	14.7	– 9.3	6.9	5.1	6.1	1.8
RO	45.8	25.0	35.8	20.8	75.3	40.6	58.5	34.7	6.3	8.4	7.4	– 2.1	6.1	7.6	6.9	– 1.5
SI	35.2	27.5	31.4	7.7	81.0	27.5	54.7	53.5	41.4	42.7	42.0	– 1.3	18.0	21.5	19.8	– 3.5
SK	35.3	19.2	27.5	16.1	59.5	15.7	38.6	43.8	10.6	19.9	15.2	– 9.3	8.6	6.3	7.4	2.3
FI	36.3	26.3	31.4	10.0	85.7	57.2	71.8	28.5	60.1	44.5	52.4	15.6	14.9	15.9	15.4	– 1.0
SE	29.5	26.7	28.1	2.8	73.6	56.1	64.9	17.5	51.0	55.0	53.1	– 4.0	27.2	29.8	28.5	– 2.6
	Source: Authors' calculations, Eurofound, EQLS, 2016				Source: Authors' calculations, Eurofound, EQLS, 2016				Source: Authors' calculations, Eurofound, EWCS, 2015				Source: Authors' calculations, Eurofound, EWCS, 2015			

Table 17. Indicators included in the domain of power, by EU Member State

MS	Political						Economic				Social					
	Share of ministers (%)		Share of members of parliament (%)		Share of members of regional assemblies (%)		Share of members of boards in largest quoted companies, supervisory board or board of directors (%)		Share of members of central bank (%)		Share of members of public research funding (%)		Share of board members in publicly owned broadcasting organisations (%)		Share of members of highest decision-making body of the national Olympic sport organisations (%)	
	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men
EU	**30.7**	**69.3**	**31.5**	**68.5**	**29.3**	**70.7**	**27.7**	**72.3**	**23.1**	**76.9**	**38.1**	**61.9**	**36.4**	**63.6**	**16.2**	**83.8**
BE	27.9	72.1	41.3	58.7	41.7	58.3	34.7	65.3	20.0	80.0	47.5	52.5	31.6	68.4	11.8	88.2
BG	39.1	60.9	26.5	73.5	27.2	72.8	15.9	84.1	57.1	42.9	41.9	58.1	33.3	66.7	22.1	77.9
CZ	24.6	75.4	20.8	79.2	21.0	79.0	16.9	83.1	0.0	100.0	24.1	75.9	14.8	85.2	7.0	93.0
DK	37.8	62.2	38.2	61.8	38.2	61.8	31.0	69.0	24.7	75.3	41.8	58.2	48.3	51.7	18.8	81.2
DE	40.2	59.8	31.6	68.4	30.7	69.3	34.7	65.3	31.3	68.8	39.5	60.5	33.3	66.7	15.3	84.7
EE	21.1	78.9	28.8	71.2	28.6	71.4	8.5	91.5	21.9	78.1	14.3	85.7	37.0	63.0	11.0	89.0
IE	21.5	78.5	24.8	75.2	25.5	74.5	23.4	76.6	33.3	66.7	46.2	53.8	50.0	50.0	20.3	79.7
EL	15.5	84.5	20.0	80.0	21.3	78.7	10.8	89.2	11.1	88.9	12.5	87.5	17.6	82.4	9.9	90.1
ES	46.5	53.5	40.8	59.2	46.7	53.3	25.8	74.2	46.7	53.3	48.6	51.4	45.5	54.5	22.2	77.8
FR	49.0	51.0	37.2	62.8	48.1	51.9	44.6	55.4	45.5	54.5	39.0	61.0	46.4	53.6	32.3	67.7
HR	23.6	76.4	21.7	78.3	28.1	71.9	23.2	76.8	16.0	84.0	28.6	71.4	57.1	42.9	9.5	90.5
IT	26.7	73.3	35.1	64.9	21.1	78.9	36.6	63.4	22.6	77.4	30.4	69.6	30.0	70.0	13.9	86.1
CY	16.0	84.0	18.9	81.1	15.3	84.7	10.4	89.6	13.0	87.0	24.2	75.8	25.9	74.1	6.6	93.4
LV	25.1	74.9	26.8	73.2	23.4	76.6	29.0	71.0	26.7	73.3	37.9	62.1	66.7	33.3	23.5	76.5
LT	29.8	70.2	23.0	77.0	29.8	70.2	12.6	87.4	15.4	84.6	37.0	63.0	33.3	66.7	16.3	83.7
LU	27.1	72.9	28.2	71.8	25.9	74.1	14.6	85.4	22.2	77.8	51.9	48.1	44.4	55.6	18.3	81.7
HU	10.1	89.9	12.0	88.0	12.7	87.3	13.5	86.5	11.1	88.9	0.0	100.0	28.6	71.4	9.7	90.3
MT	9.9	90.1	14.1	85.9	26.3	73.7	9.6	90.4	18.6	81.4	43.2	56.8	21.1	78.9	7.7	92.3
NL	44.4	55.6	34.1	65.9	33.1	66.9	32.9	67.1	26.7	73.3	33.3	66.7	32.4	67.6	26.5	73.5
AT	45.2	54.8	37.7	62.3	32.4	67.6	28.3	71.7	0.0	100.0	28.7	71.3	40.0	60.0	13.8	86.2
PL	18.3	81.7	26.8	73.2	27.2	72.8	21.7	78.3	16.0	84.0	26.2	73.8	0.0	100.0	3.3	96.7
PT	36.3	63.7	37.7	62.3	28.6	71.4	23.2	76.8	29.4	70.6	40.0	60.0	33.3	66.7	10.8	89.2
RO	25.8	74.2	19.7	80.3	18.4	81.6	11.9	88.1	7.4	92.6	44.9	55.1	27.3	72.7	11.0	89.0
SI	34.2	65.8	22.6	77.4	32.3	67.7	25.1	74.9	20.0	80.0	42.9	57.1	36.4	63.6	4.7	95.3
SK	22.8	77.2	21.2	78.8	14.1	85.9	26.9	73.1	0.0	100.0	15.4	84.6	22.2	77.8	8.3	91.7
FI	48.6	51.4	44.3	55.8	45.7	54.3	34.4	65.6	27.8	72.2	42.5	57.5	42.9	57.1	29.1	70.9
SE	52.2	47.8	47.1	52.9	47.5	52.5	37.2	62.8	33.3	66.7	56.9	43.1	57.0	43.0	48.4	51.6
	Source: Authors' calculations, EIGE, Gender Statistics Database, WMID (3-year average, 2018–2019–2020) National governments (all ministers: junior ministers +senior ministers)		Source: Authors' calculations, EIGE, Gender Statistics Database, WMID (3-year average, 2018–2019–2020) National parliaments (both houses)		Source: Authors' calculations, EIGE, Gender Statistics Database, WMID (3-year average, 2018–2019–2020). BG, EE, IE, CY, LT, LU, MT, SI: local level is used (2020)		Source: Authors' calculations, EIGE, Gender Statistics Database, WMID (3-year average, 2018–2019–2020)		Source: Authors' calculations, EIGE, Gender Statistics Database, WMID (3-year average, 2018–2019–2020)		Source: Authors' calculations, EIGE, Gender Statistics Database, WMID (3-year average, 2018–2019–2020). IT, RO: break in time series (only 2018)		Source: Authors' calculations, EIGE, Gender Statistics Database, WMID (3-year average, 2018–2019–2020)		Source: Authors' calculations, EIGE, Gender Statistics Database, WMID (3-year average, 2018–2019–2020)	

Table 18. Indicators included in the domain of health, by EU Member State

MS	Status												Behaviour								Access							
	Self-perceived health, good or very good (%, 16+)				Life expectancy in absolute value at birth (years)				Healthy life years in absolute value at birth (years)				Population who do not smoke and are not involved in harmful drinking (%, 16+)				Population doing physical activities and/ or consuming fruits and vegetables (%, 16+)				Population without unmet needs for medical examination (%, 16+)				Population without unmet needs for dental examination (%, 16+)			
	Women	Men	Total	Gap	Women	Men	Total	Gap	Women	Men	Total	Gap	Women	Men	Total	Gap	Women	Men	Total	Gap	Women	Men	Total	Gap	Women	Men	Total	Gap
EU	**66.2**	**71.1**	**68.5**	**–4.9**	**84.0**	**78.5**	**81.3**	**5.5**	**65.1**	**64.2**	**64.6**	**0.9**	**72.4**	**52.0**	**62.6**	**20.4**	**35.4**	**39.5**	**37.3**	**–4.1**	**96.7**	**97.2**	**96.9**	**–0.5**	**95.8**	**96.2**	**96.0**	**–0.4**
BE	71.8	76.3	74.0	–4.5	84.3	79.8	82.1	4.5	62.8	62.1	62.5	0.7	68.3	50.1	59.5	18.2	29.5	36.4	32.9	–6.9	97.4	97.9	97.7	–0.5	94.9	94.4	94.7	0.5
BG	63.0	71.5	67.1	–8.5	78.8	71.6	75.1	7.2	68.4	64.4	66.4	4.0	67.5	46.7	57.9	20.8	9.4	18.2	13.5	–8.8	97.7	97.6	97.6	0.1	97.1	97.6	97.4	–0.5
CZ	60.5	63.9	61.9	–3.4	82.2	76.4	79.3	5.8	62.6	61.7	62.2	0.9	72.7	54.2	63.8	18.5	30.1	37.5	33.6	–7.4	97.5	97.8	97.6	–0.3	97.4	97.4	97.4	0.0
DK	67.3	72.0	69.6	–4.7	83.5	79.5	81.5	4.0	58.8	59.0	58.9	–0.2	60.7	43.7	52.3	17.0	68.2	59.1	63.6	9.1	92.3	91.4	91.8	0.9	92.7	93.9	93.3	–1.2
DE	64.6	66.4	65.5	–1.8	83.7	79.0	81.3	4.7	67.1	65.4	66.3	1.7	63.3	46.6	55.1	16.7	50.8	53.1	51.9	–2.3	99.3	99.2	99.3	0.1	98.9	99.0	99.0	–0.1
EE	54.2	59.1	56.5	–4.9	83.0	74.5	79.0	8.5	57.7	53.9	55.8	3.8	74.0	43.2	58.2	30.8	35.4	35.8	35.6	–0.4	80.1	85.2	82.5	–5.1	94.6	95.0	94.8	–0.4
IE	83.8	84.1	83.9	–0.3	84.7	80.8	82.8	3.9	70.5	68.6	69.6	1.9	65.8	46.5	56.3	19.3	48.4	47.2	47.8	1.2	97.4	98.2	97.8	–0.8	96.5	97.0	96.8	–0.5
EL	77.2	81.2	79.1	–4.0	84.2	79.2	81.7	5.0	66.4	65.6	66.0	0.8	70.4	54.2	62.8	16.2	19.8	24.7	22.2	–4.9	89.4	92.2	90.7	–2.8	90.0	91.0	90.5	–1.0
ES	72.7	77.7	75.2	–5.0	86.7	81.1	84.0	5.6	70.4	69.4	69.9	1.0	75.9	61.6	68.9	14.3	36.1	46.0	40.9	–9.9	99.6	99.7	99.7	–0.1	93.9	94.2	94.0	–0.3
FR	64.9	68.5	66.6	–3.6	85.9	79.9	83.0	6.0	64.6	63.7	64.2	0.9	69.7	54.2	62.2	15.5	32.0	38.7	35.2	–6.7	97.0	96.7	96.9	0.3	94.9	95.3	95.1	–0.4
HR	58.2	62.6	60.3	–4.4	81.6	75.5	78.6	6.1	58.5	56.4	57.5	2.1	72.5	57.2	65.3	15.3	21.1	28.0	24.4	–6.9	95.9	95.5	95.8	0.4	98.4	97.3	97.8	1.1
IT	69.9	76.0	72.8	–6.1	85.8	81.4	83.7	4.4	68.6	68.1	68.4	0.5	79.9	65.6	73.1	14.3	24.5	30.4	27.3	–5.9	97.7	98.4	98.0	–0.7	96.5	97.3	96.9	–0.8
CY	76.5	79.1	77.7	–2.6	84.4	80.3	82.3	4.1	63.0	62.1	62.6	0.9	81.4	53.9	68.4	27.5	33.0	38.6	35.7	–5.6	98.5	99.1	98.8	–0.6	94.9	94.7	94.8	0.2
LV	42.8	52.5	47.1	–9.7	80.1	70.9	75.7	9.2	54.1	52.2	53.2	1.9	76.4	43.5	61.9	32.9	28.7	34.0	31.1	–5.3	92.0	92.2	92.1	–0.2	86.7	86.2	86.5	0.5
LT	42.4	51.9	46.1	–9.5	81.2	71.6	76.5	9.6	59.1	56.0	57.6	3.1	81.5	45.0	65.0	36.5	27.6	33.6	30.3	–6.0	97.7	98.3	98.0	–0.6	95.7	97.0	96.3	–1.3
LU	70.1	73.4	71.7	–3.3	85.2	80.2	82.7	5.0	61.9	63.2	62.6	–1.3	65.1	45.6	55.3	19.5	48.0	51.5	49.7	–3.5	99.4	98.8	99.1	0.6	99.1	99.1	99.1	0.0
HU	54.8	62.1	58.2	–7.3	79.7	73.1	76.5	6.6	62.8	60.7	61.8	2.1	75.7	59.4	68.1	16.3	32.7	37.7	35.1	–5.0	93.7	93.3	93.5	0.4	96.7	97.1	96.9	–0.4
MT	71.9	76.0	74.0	–4.1	84.6	81.2	82.9	3.4	73.5	72.9	73.2	0.6	70.0	56.3	63.2	13.7	42.7	45.1	43.9	–2.4	99.6	99.6	99.6	0.0	98.7	98.9	98.8	–0.2
NL	72.5	77.1	74.8	–4.6	83.7	80.6	82.2	3.1	59.4	62.5	61.0	–3.1	72.2	58.4	65.4	13.8	37.0	41.0	38.9	–4.0	99.1	98.5	98.8	0.6	99.4	99.2	99.3	0.2
AT	70.5	72.0	71.2	–1.5	84.2	79.7	82.0	4.5	58.0	56.7	57.4	1.3	65.3	53.3	59.4	12.0	51.5	54.7	53.1	–3.2	99.3	99.4	99.3	–0.1	98.9	98.8	98.8	0.1
PL	57.2	63.0	59.8	–5.8	81.9	74.1	78.0	7.8	64.1	60.9	62.5	3.2	74.5	51.9	64.1	22.6	23.4	26.2	24.7	–2.8	91.4	91.6	91.5	–0.2	96.6	96.6	96.6	0.0
PT	45.3	55.4	50.0	–10.1	84.8	78.7	81.9	6.1	57.8	60.6	59.2	–2.8	84.5	62.6	74.3	21.9	29.7	35.0	32.2	–5.3	97.0	97.7	97.3	–0.7	86.5	87.4	86.9	–0.9
RO	66.8	75.9	71.2	–9.1	79.5	71.9	75.6	7.6	60.6	59.9	60.3	0.7	73.4	36.2	55.4	37.2	7.4	16.3	11.7	–8.9	91.8	94.5	93.1	–2.7	92.8	93.6	93.2	–0.8
SI	63.7	69.7	66.6	–6.0	84.5	78.7	81.6	5.8	61.2	60.8	61.0	0.4	72.2	54.0	63.3	18.2	37.0	45.6	41.3	–8.6	96.8	96.6	96.7	0.2	95.5	95.4	95.4	0.1
SK	61.2	69.2	65.1	–8.0	81.2	74.3	77.8	6.9	56.3	56.0	56.2	0.3	75.6	53.2	64.8	22.4	33.0	39.7	36.2	–6.7	93.7	94.2	94.0	–0.5	95.8	95.9	95.9	–0.1
FI	67.7	68.9	68.3	–1.2	84.8	79.3	82.1	5.5	54.8	57.7	56.3	–2.9	69.9	45.7	58.4	24.2	60.1	56.9	58.6	3.2	93.3	95.6	94.5	–2.3	93.5	93.8	93.6	–0.3
SE	73.1	78.8	76.0	–5.7	84.8	81.5	83.2	3.3	72.7	73.8	73.3	–1.1	76.3	61.3	68.8	15.0	58.0	55.8	56.9	2.2	95.1	96.2	95.7	–1.1	97.6	97.3	97.4	0.3
	Source: Eurostat, EU-SILC, hlth_ silc_01), 2019				Source: Eurostat, Mortality data ([hlth_hlye), 2019				Source: Eurostat, Mortality data ([hlth_hlye), 2019 BE: break in time series				Source: Eurostat's calculations,, EHIS, 2014 FR, NL: EIGE estimation EU: Non-weighted average				Source: Eurostat's calculations, EHIS, 2014 BE, NL: EIGE estimation EU: Non-weighted average				Source: Eurostat, EU-SILC (hlth_ silc_08), 2019				Source: Eurostat, EU-SILC (hlth_ silc_09), 2019			

Annex 4. Indicators of health

Table 19. Self-perceived health (very good and good), by sex and type of intersecting inequalities (%, EU, different years)

Group type and source	Groups	Women/girls	Men/boys
Type of family (16+) Authors' calculations based on EU-SILC microdata, 2019	Single	50.2	61.4
	Lone parents	71.0	75.1
	Couple without children	58.4	57.8
	Couple with children	83.3	83.2
Age (11–13–15) ([1]) HBSC, 2017–2018 Age (16+) Authors' calculations based on EU-SILC microdata, 2019	11–13–15	30.1	39.2
	16–24	91.6	93.6
	25–49	82.1	84.1
	50–64	60.6	62.9
	65+	36.9	42.5
Education level (16+) Authors' calculations based on EU-SILC microdata, 2019	Low	50.5	62.1
	Medium	68.0	70.6
	High	80.7	79.8
Country of birth (16+) Authors' calculations based on EU-SILC microdata, 2019	Native born	65.4	70.4
	Foreign born	68.5	72.2
	EU born	70.8	74.4
	Non-EU born	71.5	75.7
Citizenship (16+) Eurostat, EU-SILC (hlth_silc_24), 2019	EU-27 countries except reporting country	75.6	76.9
	Non-EU-27 countries nor reporting country	73.5	76.0
	Reporting country	65.7	70.7

Group type and source	Groups	Women/girls	Men/boys
Disability status (16+) Authors' calculations based on EU-SILC microdata, 2019	With disabilities	18.9	21.1
	Without disabilities	82.7	84.6
Income (16+) Eurostat, EU-SILC (hlth_silc_10), 2019	First quintile	55.5	61.9
	Second quintile	60.0	64.6
	Third quintile	66.9	71.1
	Fourth quintile	72.5	75.5
	Fifth quintile	78.6	80.6
Labour status (16+) Eurostat, EU_SILC (hlth_silc_01), 2019	Employed persons	79.9	82.2
	Employees	79.7	82.2
	Employed persons except employees	81.7	82.2
	Not employed persons	54.5	55.6
	Unemployed persons	66.5	67.6
	Retired persons	39.9	44.5
	Other inactive persons	67.3	72.9
Degree of urbanisation (16+) Eurostat, EU_SILC (hlth_silc_18), 2019	Cities	68.0	72.8
	Towns and suburbs	67.1	72.1
	Rural areas	63.0	67.8
Respondent category (15+) Authors' calculations based on LGBT II FRA survey, 2019	Lesbian/gay	82.7	85.9
	Bisexual	75.5	83.1
	Trans	64.9	
	Intersex	67.0	

Group type and source	Groups	Women/girls	Men/boys
Immigrants and descendants of immigrants ([2]) FRA's Second European Union Minorities and Discrimination Survey (EU-MIDIS II), 2016	Turkey	79.0	80.0
	North Africa	72.0	74.0
	Sub-Saharan Africa	71.0	82.0
	South Asia and Asia	76.0	78.0
	Recent immigrants from other non-EU/non-European Free Trade Association (EFTA) countries	90.0	94.0
	Russian minorities	47.0	56.0
	Roma	66.0	71.0

NB:
(1) EU: unweighted average, CY n/a. 'Response: very good'.
(2) EU not available; data collected in only some EU Member States (and the UK).
Turkey (in six EU Member States – BE, DK, DE, NL, AT, SE).
North Africa (in five EU Member States – BE, ES, FR, IT, NL).
Sub-Saharan Africa (in 11 EU Member States + the UK –DK, DE, IE, FR, IT, LU, MT, AT, PT, FI, SE).
South Asia and Asia (in three EU Member States + the UK – EL, IT, CY).
Other non-EU/non-European Free Trade Association (EFTA) countries (in two EU Member States – PL, SI).
Russian minorities (in three EU Member States – EE, LV, LT).
Roma (in nine EU Member States – BG, CZ, EL, ES, HR, HU, PT, RO, SK).

Table 20. Excess mortality in 2020–2021, compared with 2016–2019, by sex and EU Member State (%, latest data available in 2021)

	Excess mortality			
Member State	Women	Men	Gap	Last data available in 2021 (1)
CZ	22.2	29.6	– 7.4	W19
PL	22.4	25.6	– 3.2	W23
SK	22.5	24.9	– 2.4	W21
BG	18.5	22.6	– 4.1	W23
IT	15.6	19.5	– 3.9	W13
RO	15.2	19.4	– 4.2	W16
SI	17.6	18.4	– 0.8	W20
ES	16.0	17.7	– 1.7	W22
MT	16.0	17.6	– 1.6	W19
EU*	13.6	16.6	– 3.0	W13 (all Member States)
NL	8.9	15.8	– 6.9	W21
PT	15.8	14.9	0.9	W22
HU	14.0	14.8	– 0.8	W20
AT	8.5	14.2	– 5.7	W20
CY	14.3	13.4	0.9	W18
BE	11.2	13.3	– 2.1	W23
LT	11.7	12.8	– 1.1	W23
HR	10.3	12.6	– 2.3	W17
FR	10.8	12.6	– 1.8	W22
LU	9.3	11.5	– 2.2	W17
SE	3.5	9.6	– 6.1	W23
EE	8.1	9.0	– 0.9	W23
EL	9.2	9.0	0.2	W17
DE	5.0	8.8	– 3.8	W23
LV	7.3	5.9	1.4	W22
DK	0.8	3.6	– 2.8	W23
FI	1.4	3.1	– 1.7	W23

Source: EIGE's elaboration, based on deaths by week and sex [demo_r_mwk_ts], extracted on 25 June 2021.
NB:
Excess mortality indicator is expressed as a percentage of additional deaths in a week (average of 2020–2021) compared with a baseline period.
The baseline is given by average weekly deaths for 2016–2019.
The higher the value, the more additional deaths have occurred, compared with the baseline.
2021: provisional data.
2020: provisional data, except for BG, LV, LT, LU, NL, RO, FI, SE.
2019: provisional data for RO.
IE: 2016–2019 n/a.
(1) Last week in 2021 for which data is available. EU calculated using W13, available for all Member States.
(*) EU: only 26 Member States.

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