INTRODUCTION

On 1 May 2004, the European Union (EU) enlarged from 15 countries to 25 Member States, it now has a population of over 457 million, a territory of 3.9 million square kilometres and 20 official languages.

This booklet was commissioned by the European Institute of Women's Health and endeavours to capture the state of women's health across the EU, including for the first time, data from the ten new Member States. It is divided into three sections: demographic and socio-economic trends; women's health issues; policy recommendations and suggestions for future research in the field of women's health at the EU level.

Table 1. Present and future countries of the EU.

Member States pre-1 May 2004 (EU-15)	Member States who joined 1 May 2004
Belgium	Czech Republic
Denmark	Estonia
Germany	Cyprus
Greece	Latvia
Spain	Lithuania
France	Hungary
Ireland	Malta
Italy	Poland
Luxembourg	Slovenia
Netherlands	Slovakia
Austria	
Portugal	**Accession Countries in 2007**
Finland	Bulgaria
Sweden	Romania
UK	

Sources

The main sources used for the collection of data for this booklet include the official documentation of the statistical office of the European Communities (*Eurostat*) and the World Health Organisation's '*Health for All Database*', as well as publications from various charities and organisations working on particular diseases mentioned in this report.

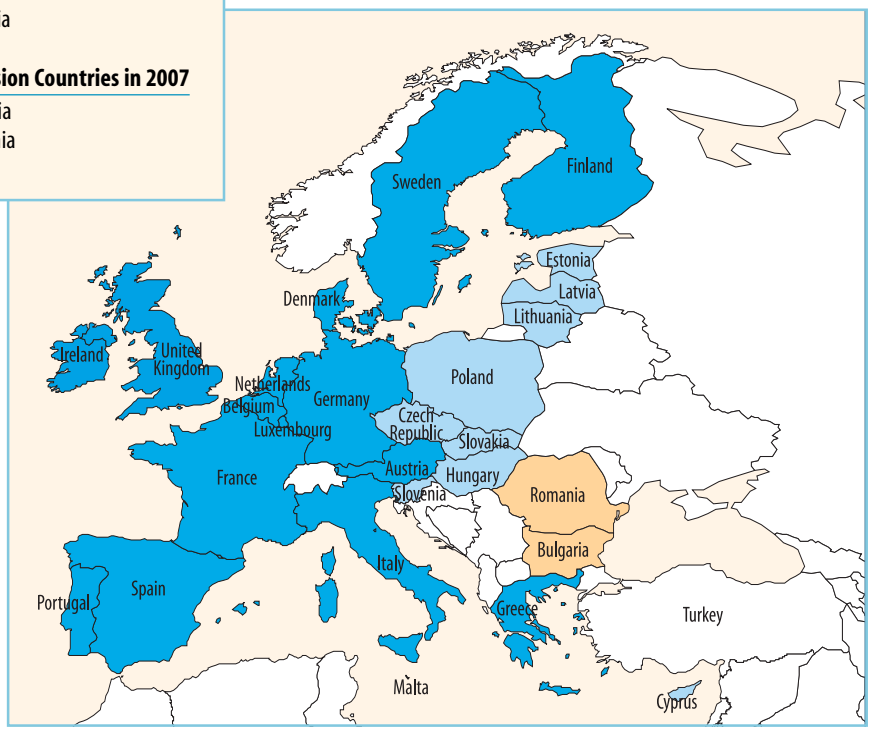
In addition, literature searches of academic publications were undertaken on the PubMed database. Data from all 25 countries currently comprising the EU were searched and where available, data from all 25 countries is reported.

Rather than looking at trends over time, the data collected focuses on the last three to four years so as to compare the older EU countries to the new EU countries. Data is presented in a mixture of formats and references are provided at the end of the booklet.

Throughout this booklet we will often refer to EU-25, but also to EU-15 to describe the EU pre-May 2004 before ten new Member States joined. The countries which currently make up the EU are shown in Table 1.

Bulgaria and Romania are also expected to join the EU in 2007.

Figure 1. The European Union[1].



Pre-1 May 2004 EU Members
1 May 2004 new Member States
Accession Countries in 2007

DEMOGRAPHIC AND SOCIO-ECONOMIC TRENDS

Important aspects of the demographic characteristics of countries include the total size of the population and its age and sex structure, or the proportion of people at each age, by sex. Generally, total populations in the EU-15 countries are rising, albeit very slowly. Populations however, in most of the new Member States are falling, owing to a combination of emigration and deaths exceeding births. This has particularly affected countries such as Bulgaria and Estonia.[2]

We know that almost 55% of the total world population consists of women,[3] and that this percentage is likely to steadily increase over the first quarter of the 21st century. In Europe, women as a percentage of the total population varies, but ranges from 50.3% of the population in Ireland to 53.9% of the population in Latvia. There is no country in Europe where women constitute less than 50% of the total population.

Table 2. Percentage of women in the total population[4].

Country	% of total population (2000)	Country	% of total population (2000)
Latvia	53.9	Spain	51.1
Estonia	53.4	Belgium	51.0
Lithuania	52.8	Germany	51.0
Portugal	51.9	UK	50.8
Czech Republic	51.4	Greece	50.7
Italy	51.5	Sweden	50.5
Slovakia	51.4	Denmark	50.5
Slovenia	51.4	Netherlands	50.4
Poland	51.4	Ireland	50.3
France	51.3	Cyprus	n/a
Austria	51.2	Luxembourg	n/a
Finland	51.2	Malta	n/a

Older Women

One of the main features of the world population today is the considerable increase in the absolute and relative numbers of older people. By 2020, it is estimated that there will be more than 1,000 million people aged 60 years and older in the world. This older population is ageing also; the 'oldest old,' namely those over 75 years old, are the fastest growing group. The number of people worldwide who will reach 100 years or more is expected to exceed two million by 2050.

Europe has the highest proportion of older women in the world. There are now approximately three women for every two men between the ages of 65 and 79, with over twice as many women over the age of 80. The percentage of women in different age groups for each Member State in 2004 is illustrated in Figure 2.

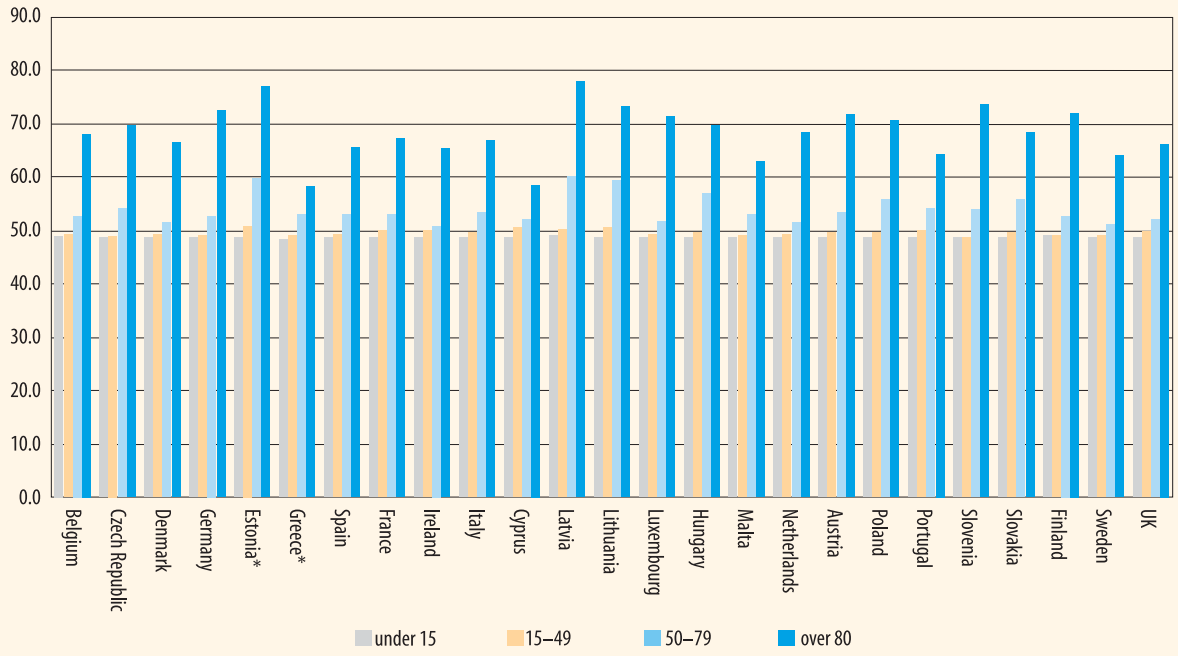
Life Expectancy[a]

Life expectancy for men and women is increasing in all countries across the EU[1] and in all countries life expectancy for women is greater than that for men. In 2003 the average life expectancy at birth was 81.1 years for women and 74.8 years for men in Europe.[6]

Generally, life expectancy stagnated for many years in the newest ten Member States before rising in the late 1990s; however, in the older age groups life expectancy is below EU-15 levels. Only Slovenia and the Czech Republic are approaching the life expectancies of the older EU countries.[2]

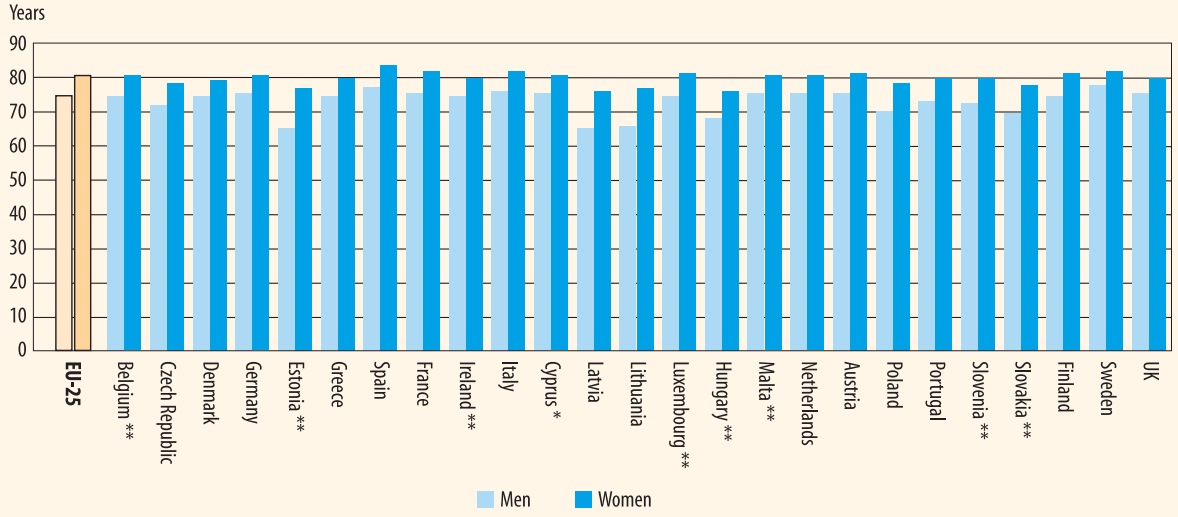
Figure 3 illustrates that the highest life expectancy rates are to be found in France, Italy, Luxembourg, Spain, Austria, Sweden and Finland, and the lowest in countries like Estonia, Latvia, Lithuania, Hungary and Slovakia.

Figure 2. Percentage of women in different age groups (2004)[5].



Note: * dates for 2001 instead of 2004.

Figure 3. Life expectancy at birth (2003)[7].



Life expectancy at birth is the number of years a newborn infant would live if prevailing patterns of mortality at the time of its birth were to stay the same throughout its life.
Note: * dates for 2001, ** dates for 2002.

Marriage and Divorce

Women's and men's lives are changing significantly throughout Europe, and this is particularly well illustrated by changing trends in marriage and divorce. In 2001 the rate of marriage in the countries that make up the EU was estimated at 5.1 per 1,000 population compared to 6.3 in 1980. Overall, there is a general decline in marriage rates with Cyprus having the highest marriage rate per 1,000 population.

There has also been an increase in the number of divorces across Europe with the highest number of divorces in Estonia, Latvia and the Czech Republic; Austria and Sweden have similarly high rates too. Those countries with large Catholic populations such as Ireland, Italy and Spain have the lowest divorce rates. At the same time, the average age of first marriage and the average age at first birth are also rising, whilst the number of children is falling. These are trends which have important consequences for women's health and quality of life.

Table 3. Trends in Marriage and Divorce[8].

	Notes	Marriages per 1,000 population 2001	Mean age at first marriage (women) 2000	Divorces (% of marriages) 2001
Estonia		4.1	25.2	78
Lithuania		4.5	23.6	71
Latvia	f	3.9	24.4	62
Czech Republic	f	5.1	24.9	61
Austria		4.2	28.1	60
Sweden		4.0	30.1	60
Belgium	a	4.4	26.8	59
Hungary		4.3	24.7	56
Finland		4.8	28.6	54
Luxembourg		4.5	28.0	51
UK	a	5.1	28.3	51
Germany	c	4.7	28.4	47
Malta	b	5.6	24.4	46
Netherlands		5.0	29.1	46
Slovakia	f	4.4	25.6	41
Denmark		6.8	30.3	40
France	b, c	5.1	27.7	37
Portugal		5.7	25.7	32
Slovenia		3.5	26.7	31
Poland		5.0	23.7	24
Greece	a, d	4.3	26.6	21
Spain	c, d	5.1	27.7	19
Ireland		5.0	n/a	14
Italy	c	4.5	n/a	14
Cyprus		14.4	26.0	13

Sources:
National sources
Recent Demographic Developments in Europe 2002
Council of Europe
New Cronos database
Eurostat
TransMONEE database
UNICEF

Notes:
a) Marriages/divorces: data for 2000 not 2001
b) Mean age at first marriage: data for 1998
c) Divorces: data for 2000 instead of 2001
d) Mean age at first marriage: data for 1999
e) Marriages/divorces: data for 1999 not 2001
f) Mean age at first marriage: data for 2001
g) Divorces: data for 1999 instead of 2001

Reproduction

Contemporary women across Europe are generally having fewer children nowadays compared to generations ago. In the older EU Member States approximately 65% of women use some form of contraceptive; this figure drops to 31% in the new Member States. For example, in Poland only 19% of women are said to be using modern contraceptives.[9]

It is also known that abortion rates are much higher in many of the new member countries than in the old EU Member States. According to the Van Lancker Report[10] the limited availability and the high cost of appropriate contraceptives, as well as the lack of counselling services in central and eastern Europe, have resulted in abortion remaining the principal means of fertility regulation.

There are considerable variations between countries as regards rates of Caesarean sections (per 1,000 live births). The highest rates are in Italy, Portugal, Malta and Greece and the lowest rates in countries such as Slovenia and the Czech Republic. Particularly low rates of Caesarean sections can be observed in Luxembourg.

Figure 4. Modern contraceptive prevalence in per cent in selected countries[9].

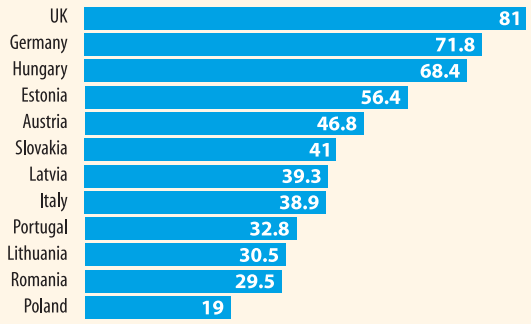
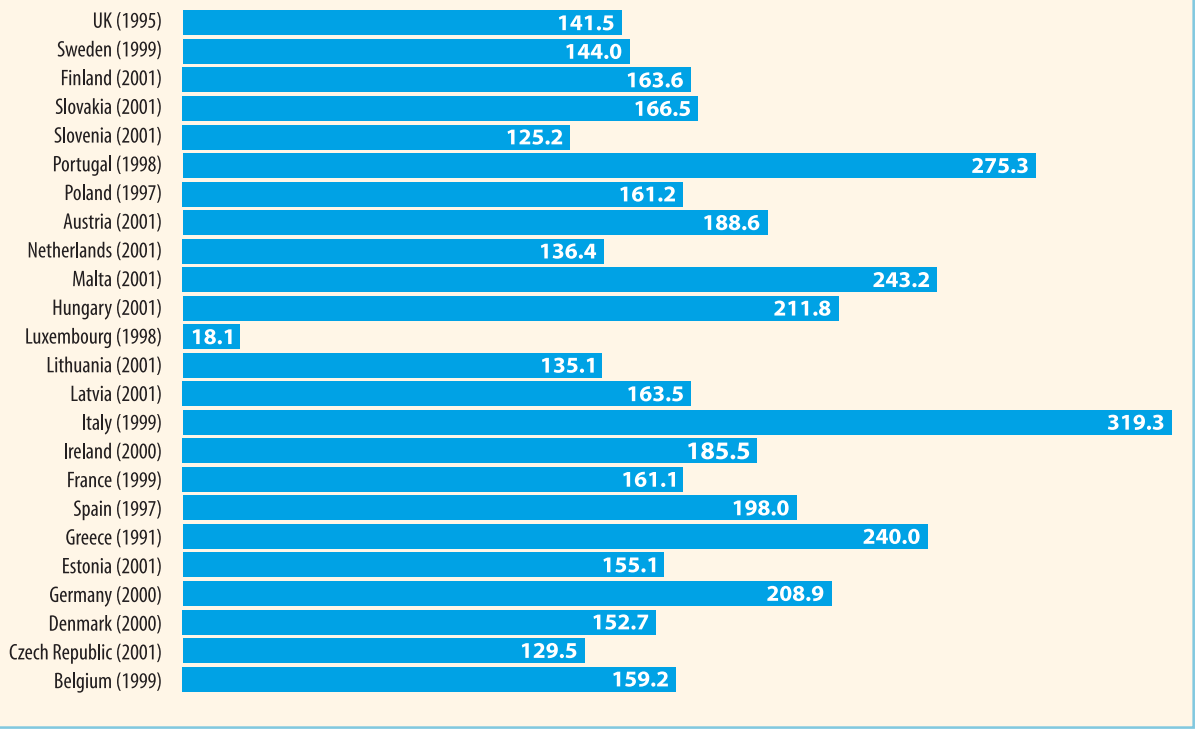


Figure 5. Caesarean sections (per 1,000 live births)[11].



Female-headed Households

The demographic changes described above do not occur in a vacuum; family lives, social attitudes and values, gender roles and working arrangements are all changing too. Economic, social, political and cultural trends will influence how women live their lives and will also have important consequences for women's health and their quality of life.

For example, women are increasingly heading up households in a way that was unthinkable in the latter half of the last century. The percentage of female-headed households varies from 20% in Greece and Portugal up to 42% in Denmark and Finland with the highest being 44% in Slovenia.[12]

Education

One notable development across the EU is the extent to which women are increasingly dominating the educational sector. The table below illustrates that countries with high percentages of females aged 25–64 with at least upper secondary level education, include the Czech Republic, Denmark, Estonia, Lithuania, Poland and Sweden, representing a good mixture of old and new EU Member States.

Across the whole of Europe, more women than men are graduating from tertiary education institutes too, and in general the new Member States have higher proportions of women graduates compared to EU-15.[13]

Table 4. Percentage of female 25–64 year olds with at least upper secondary education (2003)[5].

Country	%	Country	%
Estonia	89.2	Ireland	64.4
Lithuania	87.6	Netherlands	64.1
Latvia	85.3	**EU-25**	**64.0**
Czech Republic	84.2	Cyprus	62.7
Sweden	83.7	France	62.3
Slovakia	83.2	Belgium	61.4
Denmark	80.9	UK	60.4
Poland	80.7	Luxembourg	57.1
Germany	79.6	Greece	52.3
Finland	77.1	Italy	46.4
Slovenia	75.0	Spain	42.2
Austria	72.5	Portugal	23.9
Hungary	70.1	Malta	17.0

Employment

There are generally more women in employment now in Europe than ever before. According to the *Eurostat Yearbook*[14] in 2003 the employment rate stood at 62.9% in the 25 countries that today form the European Union, ranging from 51.2% in Poland to 75.1% in Denmark.

However, the employment rate for women (55%) stood lower than that for men (71%). The percentages of women in the labour force aged 15–64 have increased between 1980 and 2000 with the exception of Estonia, Latvia, Lithuania, Hungary, Poland, Slovenia (Figure 6).[12]

Working part-time is much more widespread amongst women than amongst men, and women who work outside the home often bear a disproportionate share of the responsibility for child care and housework. Women also continue to represent the largest reserve of non-employed and under-employed skilled labour within the EU.

Unemployment remains a problem in the EU. In 2002 the unemployment rate for the 25 EU countries was 8.8%, with 3.9% of the economically active population in 'long-term unemployment', i.e. they had not found a job in over a year.

In 2003 the unemployment rate for women was 9.9% and was higher than that for men (8.2%) in EU-25[14], though there were exceptions in some countries including Germany, Ireland, Sweden and the UK. There is some concern however, that actual unemployment – particularly in the new Member States – is higher than the official statistics demonstrate.

Carers

Much of the responsibility for long-term care continues to fall on families, and it is largely women who continue to meet the majority of society's caring needs. Being a carer typically involves looking after children, or someone with a long-term physical or mental health disability, or with problems related to old age. The range of tasks performed and the time given to caring will vary.

Generally, women are more likely to be carers than men, both within the same household and outside the household. For example, according to Schneekloth and Muller[15] 80% of carers in Germany are women.

The MERI Report[16] states that due to the higher life expectancy of women and their lower average age at marriage, older men in need of care are more likely to be cared for by their spouses than vice versa. In addition, family members – disproportionately daughters and daughters-in-law – are an important source of support and care for older women all over Europe.

The population in residential care is disproportionately female, very old, single or widowed; however there is some indication that older women show a higher resistance than older men to giving up their independence and living in residential homes. Generally, both older men and women in southern European countries receive more care at home than in northern European countries.

Figure 6. Women in Labour Force[12].

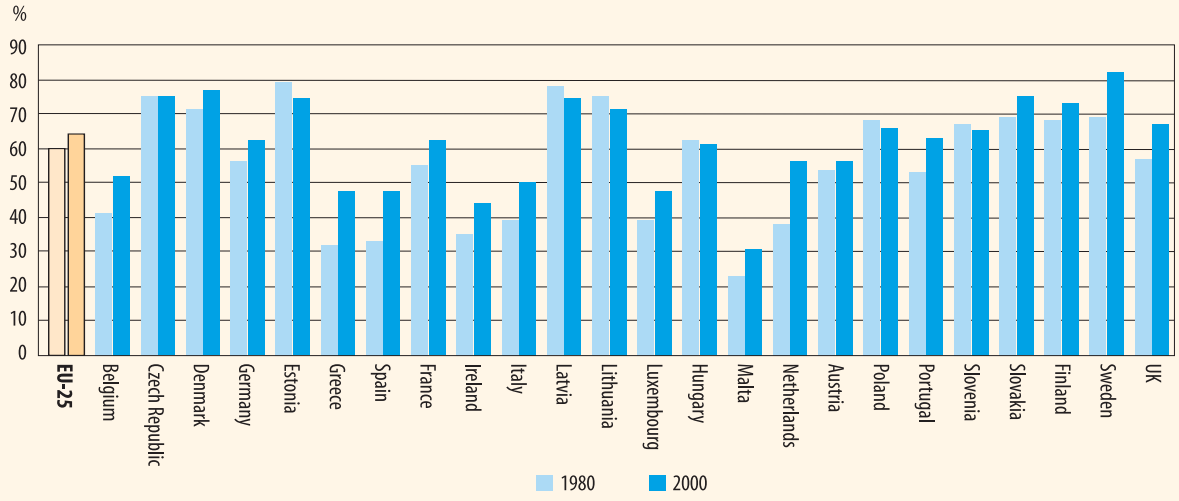
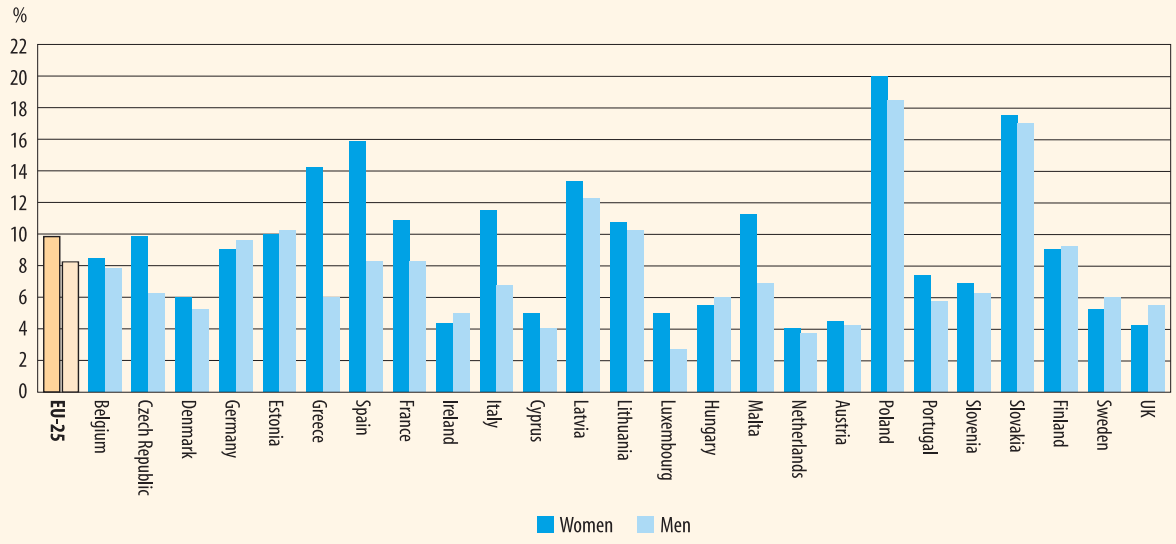


Figure 7. Unemployed persons as a percentage of the labour force, 2003[14].



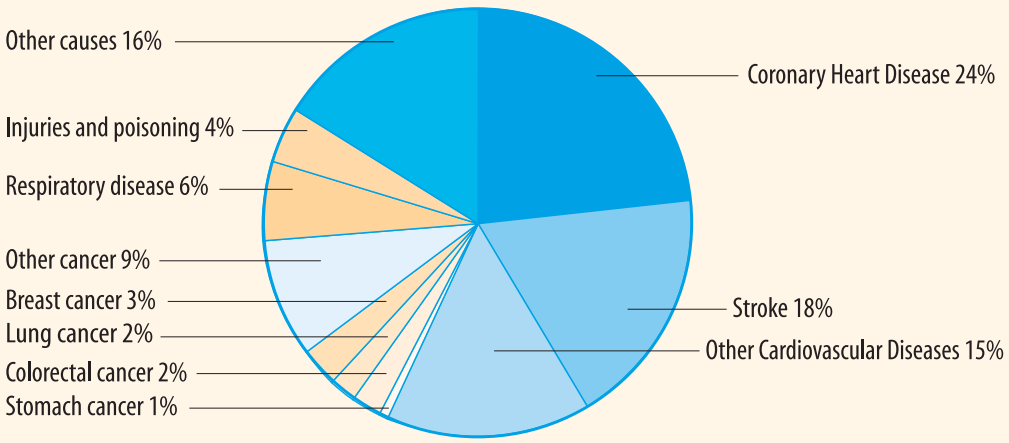
Death Rates

There are large differences between the death rates of men and women in the EU. According to the Eurostat Yearbook[14] the death rate from cancer for men (1999: 216 per 100,000 persons) was higher than the rate for women (118). In 1999 the death rate from ischaemic heart diseases was twice as high for men (127) as for women (62); whilst death rates from suicide and traffic accidents was more than three times higher for men than for women (13.6 for men and 4.3 for women and 14.4 for men and 4.4 for women respectively).

However, it should be noted that female mortality rates sometimes exceed male rates, particularly during early childhood and the reproductive years. The causes of death amongst women in the EU are represented in Figure 8.

The next section deals with many of the above causes of death of women in the European Union in more detail, as well as a range of other health concerns.

Figure 8. Deaths by cause, women, latest available year, Europe [17].



HEALTH ISSUES

Although women generally live longer than men, the quality of life that many women experience can be less than satisfactory. The incidence and prevalence of some diseases are higher in women, whilst others affect men and women differently.[2]

This section describes some main health issues that women in Europe currently face. It is organised according to clusters of diseases, though in no particular order, and includes *inter alia*, cardiovascular disease, cancer, mobility disorders and chronic disabling diseases such as diabetes.

A. Cardiovascular Disease

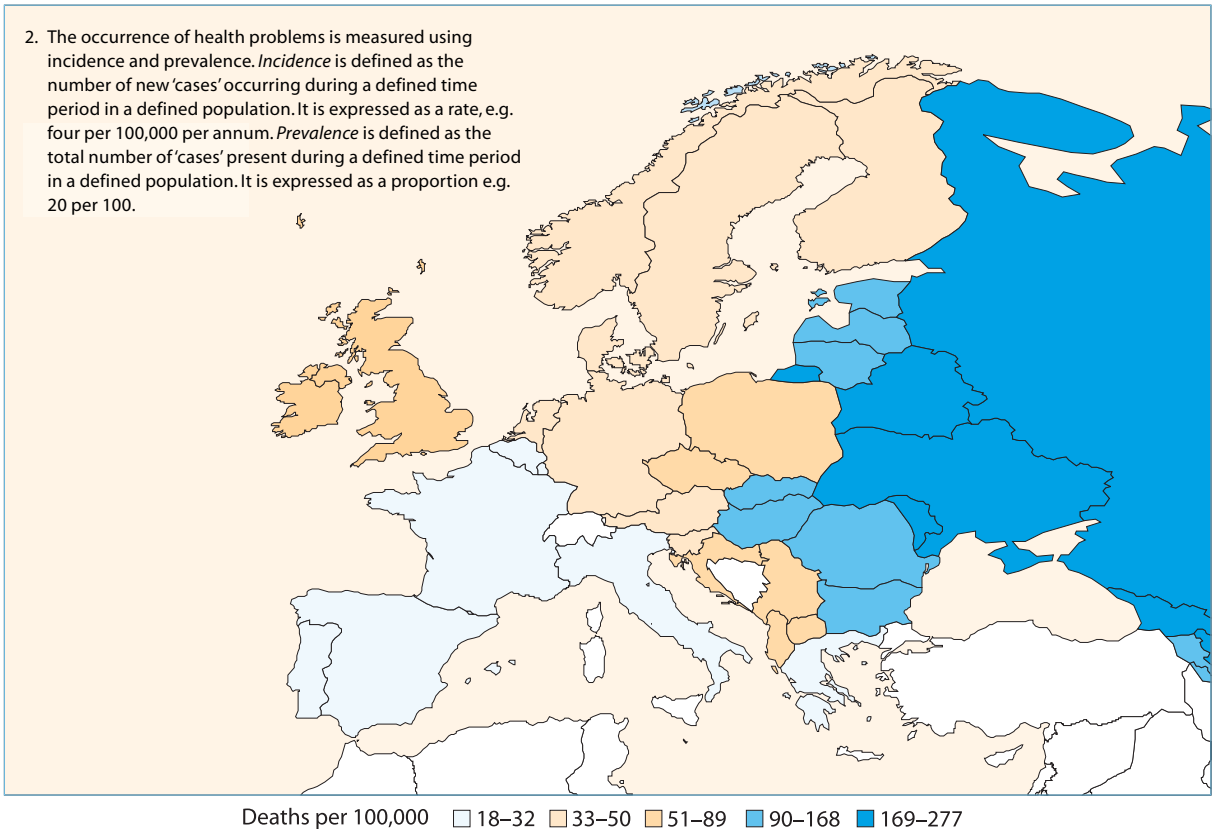
Coronary Heart Disease

Cardiovascular disease (CVD) is the number one cause of death in Europe and most other industrialised countries. It causes 1.9 million deaths a year in the 25 countries of the EU.[18] The most common cardiovascular diseases are coronary heart disease, hypertension, and cerebrovascular disease. The incidence of coronary heart disease in women increases dramatically in middle age, which has led to the speculation that menopause marks the end of a protective effect of ovarian hormones on cardiovascular disease.[19]

Cardiovascular disease is an important cause of premature mortality in the ten new Member States and rates are higher than the EU-15 average. In particular, cerebrovascular mortality is disproportionately higher, with even the best countries having rates higher than any other EU-15 country except Greece.[2]

Factors that have been identified as contributors to coronary heart disease for women include cholesterol, smoking, high blood pressure, obesity, physical inactivity, hormonal changes and diabetes mellitus.[19]

Figure 9. Age standardised death rates from stroke, women aged 35–74, latest available year[17].



Much of the research on cardiovascular disease has been based on long-term studies of men, so the findings are not always applicable to women. Yet, cardiovascular disease remains a lead killer of women in most developed countries.

Stroke

Stroke is also a leading cause of death in most developed countries. It is a highly significant cause of mortality and morbidity in postmenopausal women but information on the existence of sex differences in the management of stroke patients is scarce.

In a European Concerted Action (European BIOMED Study of Stroke Care Group) involving over 4,000 patients in seven countries it was found that compared with males, female patients were significantly older; a history of hypertension was significantly more frequent in women, as were coma, paralysis, swallowing problems and urinary incontinence in the acute phase.[17]

Hypertension

The main risk associated with hypertension is heart attack but it is also the number one risk factor for stroke. By current definitions 40% of men and 33% of women have consistently high blood pressure but there is very little European research on this condition.

Some data on hypertension is available from the MONICA Project. The MONICA (Multinational **MONI**toring of trends and determinants in **CA**rdiovascular disease) Project was established in the early 1980s to monitor trends in cardiovascular diseases, and to relate these to risk factor changes in the population over a ten-year period.[3] According to data from some European centres participating in this project, countries where women have highest blood pressures levels include Finland, the Czech Republic, Lithuania and Poland.

B. Cancer

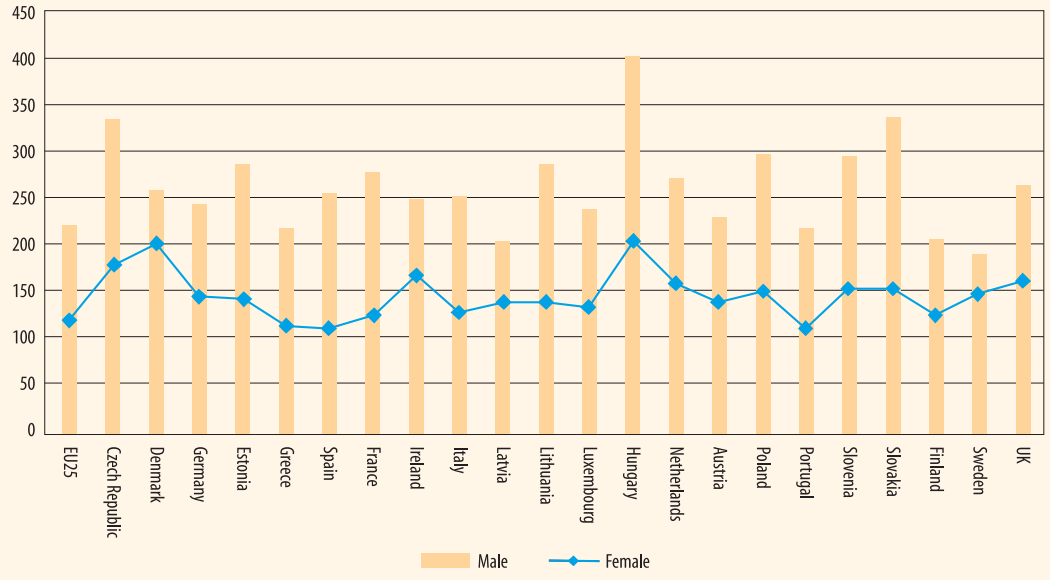
According to the European Commission, cancer kills approximately one in four people in Europe, affecting one in three women at some stage in their lives. According to the International Agency for Research on Cancer (Press release No. 159) there were two million new cases of cancer and 1.2 million deaths in the EU in 2004.

Figure 10 compares deaths from cancer for men and women per 100,000 population in Europe and shows that while female rates are generally lower than male rates, the highest rates overall for women are in Denmark, Ireland and Hungary.

We can also illustrate deaths classified according to particular cancers for women under 65 in the EU (see Figure 11).

3. There were a total of 32 MONICA Collaborating Centres in 21 countries. The total population age 25–64 years monitored was ten million men and women.

Figure 10. Deaths from cancer per 100,000 persons, 1999[14].



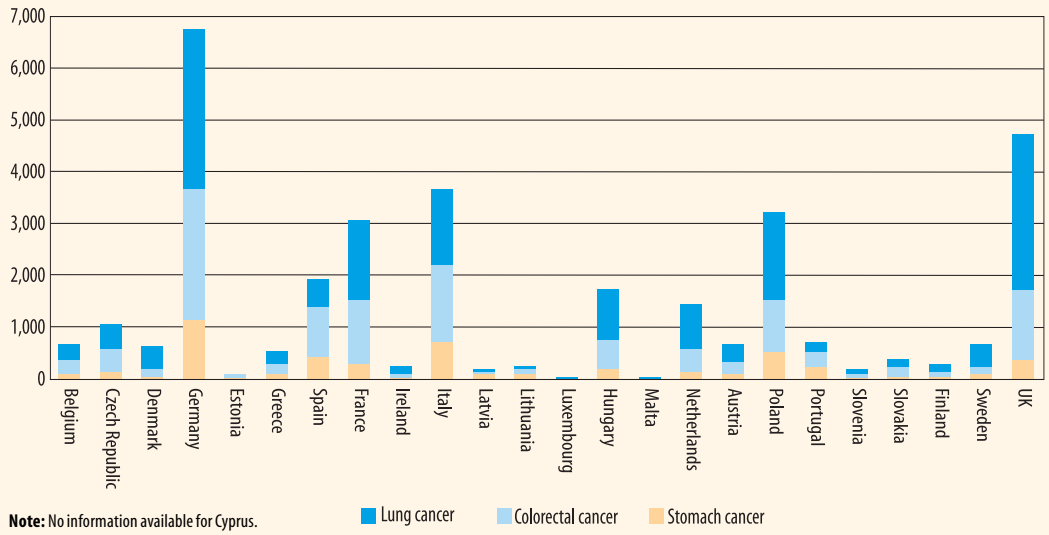
As the incidence of cancer increases steeply with age, and because life expectancy is improving everywhere, the number of cancer cases will continue to rise. At the same time about one-third of new cancer cases are related either to more exposure to risk factors, such as smoking and alcohol consumption, and to the fact that more cancers are being found by more intensive screening methods.

Cancer, particularly breast and cervical cancer, is the main cause of death for women aged 35 to 64 years. The incidence of lung cancer amongst women is increasing rapidly, mainly associated with women's increased up-take in smoking, and is now also one of the most common cancers in women. Among women the rates of colorectal cancer are also high in all European regions. Some data are now presented for each of these cancers.

Breast Cancer

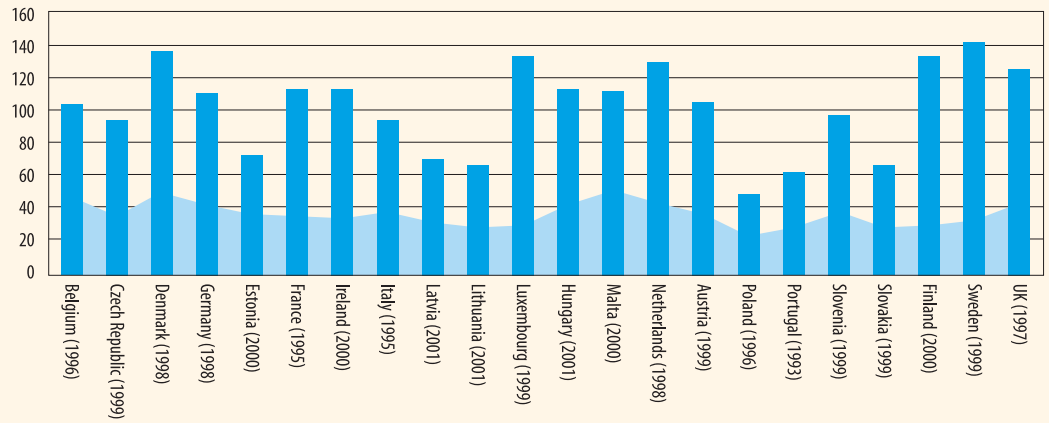
Although men can get breast cancer too, this condition is typically associated with women. It is estimated that one in every 12 women will develop breast cancer at some point in their life. Risk factors for breast cancer can include genetic predisposition, hormonal effects and age.[21]

Figure 11. Deaths from cancer – women under 65, latest available year[17].



Note: No information available for Cyprus.

Figure 12. Breast cancer incidence and deaths[11].



Note: no data available for Cyprus, Greece, Italy and Spain.

Age is in fact the most significant risk factor in breast cancer, as the incidence doubles about every ten years until menopause, when the rate of increase slows dramatically. Every year in Europe over 200,000 women will be confronted with a diagnosis of breast cancer. Death rates and new cases per 100,000 population for breast cancer and cervical cancer are detailed shown in Figures 12 and 13.

The highest rates are to be found in Sweden, Finland, and Luxembourg, with low rates in Latvia, Lithuania and Poland.

Cervical Cancer

High rates of cervical cancer can be observed in Eastern Europe, particularly in Lithuania and Hungary, and the lowest rates in Malta and Finland.

Lung Cancer

Lung cancer is another common form of cancer, and remains the biggest cancer killer in the European Union. It continues to have an enormous impact on the health of men and women living in every country.

Bray *et al*. (2004) claim that there are upsurges in rates of lung cancer in both younger and older women in almost all EU countries in recent decades and little sign that the epidemic has reached a peak.[22] Exceptions however, are the UK and Ireland, where lung cancer death rates are now declining in younger women and stabilising in older women.

According to the maps in Figure 15 the highest lung cancer rates are in Demark, Hungary and the UK while the lowest are in Spain, Portugal and Malta.

Colorectal Cancer

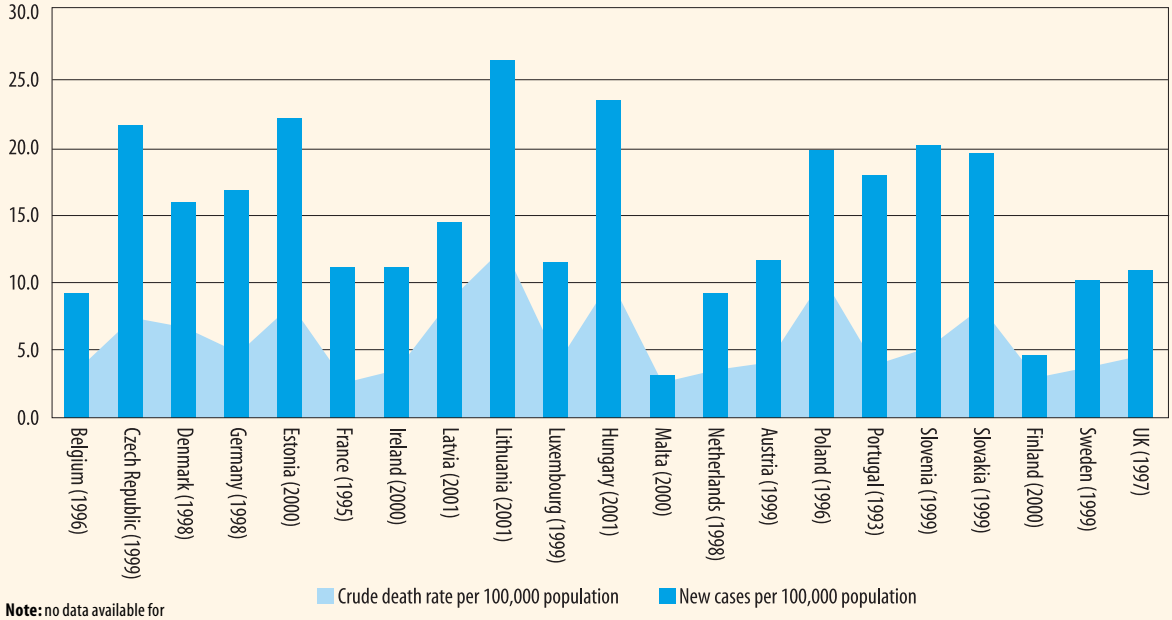
Colorectal cancer is almost equally as common as lung cancer but accounts for fewer deaths. The occurrence of large bowel cancer is strongly related to age, with over 75% of cases arising in people who are over 60. Until age 40 men and women generally have similar rates for bowel cancer, but in later life rates are higher for men. In absolute terms however, there are more female cases at older ages due to the greater numbers of older women in the population. In Eastern European countries the incidence of colorectal cancer has increased rapidly and is of particular concern as rates were originally lower than western Europe.[24]

The highest rates of colorectal cancer are in the Czech Republic and Hungary though high rates amongst women are also to be found in Germany and the Netherlands. The lowest rates for women are in Greece and Cyprus.

Cancer Screening

As the burden of cancer grows across Europe, such that cancer is now the second major cause of death, every country in EU-25 needs to examine its own cancer data and determine its priorities for cancer prevention and care. Many cancer deaths could be

Figure 13. Cervical cancer incidence and deaths[11].



Note: no data available for Cyprus, Greece, Italy and Spain.

avoided each year if best practice in early detection through cancer screening were applied systematically. It is estimated that approximately 25,000 women's lives could be saved each year if best practice in screening for breast cancer for example were available throughout the EU.[26] Deaths from colon and cervical cancer could also be reduced by better screening; however, progress has been slow, particularly in relation to colorectal cancer prevention.

The EU has recognised the potential of population-based cancer screening programmes in its Council Recommendation adopted in 2003 (Official Journal of the EU L327, 16.12.2003). It remains to be seen whether the Recommendation for breast, cervical and colorectal cancer screening will be implemented in the 25 Member States.

So far, detailed quality guidelines have only been developed for breast cancer, largely due to political

Figure 14. Age-standardised colorectal cancer incidence rates per 100,000, 1998 estimates[25].

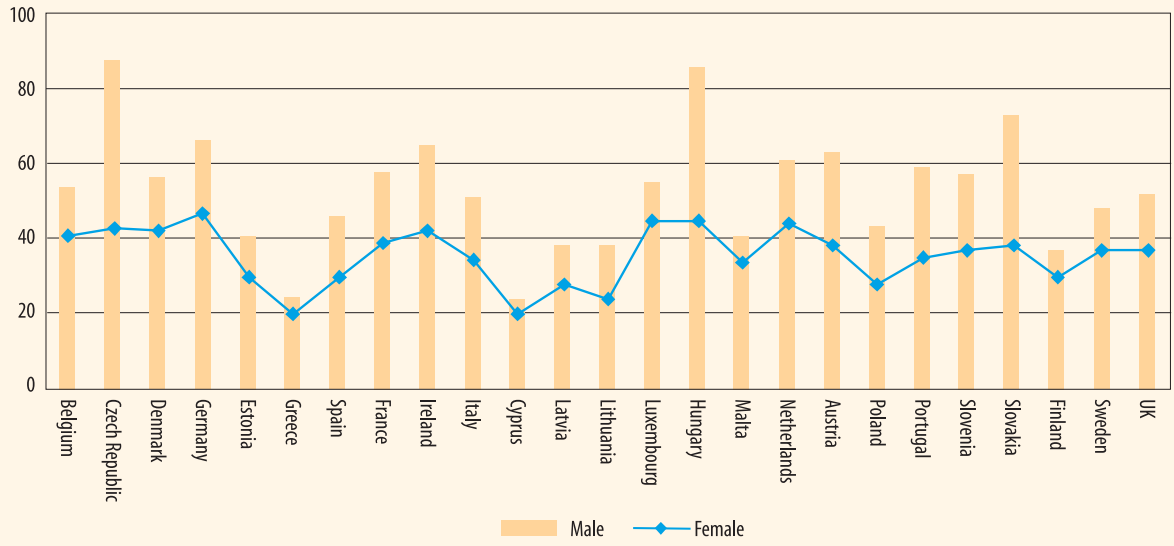
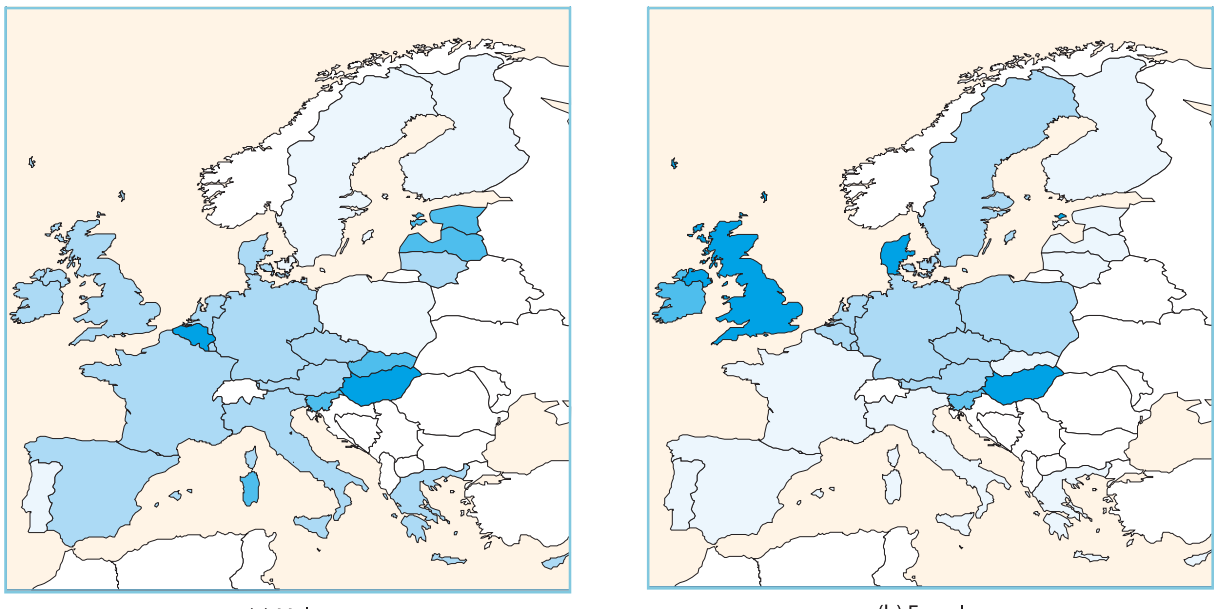


Figure 15. Lung cancer incidence and mortality rates, EU-25, 2000 estimates[23].



pressure exerted by EUROPA DONNA – the European Breast Cancer Coalition. EUROPA DONNA also advocate population-based screening for breast and cervical cancer for women and claim it is especially important that new EU member countries be included in any cancer screening networks.[27]

To date eight European countries have fully implemented national breast screening programmes – Belgium, Finland, France, Hungary, Luxembourg, the Netherlands, Sweden and the UK. National programmes are nearing completion in Spain and Portugal, while the roll-out phase continues in Cyprus, Germany and Ireland. Regional or pilot programmes also exist in Austria, Denmark, Italy and a number of EU-10 Member States.

C. Lifestyle Disorders

Alcoholism

There are disparities within the EU Member States in terms of mortality associated with alcoholism, as differences in patterns of alcohol consumption are affected by cultural and socio-economic factors, such as frequency and amount of consumption, and type of beverage. In France and Germany for example, the worst affected regions are those in which a large proportion of the population is affected by socio-economic problems. According to *Health Statistics – Atlas on Mortality in the European Union*[28] many European studies show that socio-economic category is a significant factor in the causes of mortality associated with alcohol.

In the new Member States registered consumption of alcohol would appear to be lower when compared to EU-15; however, local evidence would suggest that unregistered consumption might be higher than EU averages.

We know that men are generally heavier drinkers than women, but women may be at higher risk due to lower body weight and their different metabolisms. Table 5 and Figure 15 illustrate some drinking patterns for men and women in selected EU countries and show a high percentage of Italian and French women drinking every day. The highest percentage of female binge drinkers are in the UK and Ireland.

Table 5. Drinking patterns among men and women in selected European countries (respondents aged 18–64 years)[29].

	Drinking every day %	Drinking at least once a week %	Binge drinking at least once a week %	Mean drinking occasions past year	Mean binge drinking occasions past 12 months	Binge per 100 drinking occasions
MEN						
Finland	4	60	16	70	20	29
France	21	68	8	121	47	40
Germany	12	60	9	97	13	13
Ireland	1.6	69	48	78	45	58
Italy	42	76	11	179	23	13
Sweden	3	47	8	37	12	32
UK	9	74	38	118	47	40
WOMEN						
Finland	2	33	3	35	6	17
France	9	38	2	62	3	5
Germany	5	40	2	54	4	7
Ireland	0.2	51	16	46	14	30
Italy	26	52	7	121	14	12
Sweden	1	24	1	24	4	17
UK	5	51	12	73	16	22

Figure 16. Total alcohol consumption, 2000[11].

Smoking

The World Health Organisation (WHO) estimates that there are approximately 1.1-thousand million smokers in the world, which represents approximately one-third of the global population aged 15 and over, and who have an average consumption of 14 cigarettes per day.[30] By 2020, it is estimated that there will be a staggering ten million smoking-related deaths per year. Over the past 25 years the prevalence of smoking amongst men has fallen in many European countries. In some northern, western and southern European countries the prevalence of smoking amongst women has also fallen, but this decline has been less marked than that of men. In women, smoking trends are downwards in Belgium, Denmark, Sweden and the Netherlands.[22]

A report about the then ten Accession Countries from 2002[2] stated that there were slightly higher rates of regular daily smokers generally in those countries than the EU-15 (32% vs. 29%) with the highest prevalence in Hungary and Poland. Rates are declining for women in the Czech Republic and Slovenia. Table 6 shows that the highest percentages of women smokers are in Greece and Slovakia.

The consistent differences between the sexes in smoking prevalence rates observed in adults is not found in children. In most populations, girls smoke more than boys, but these data are sparse.

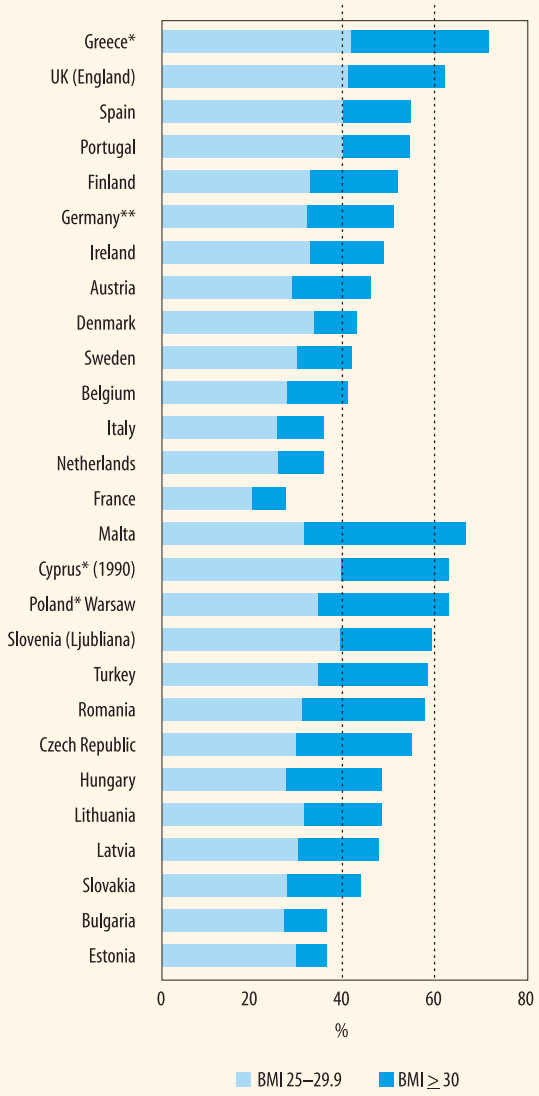
Table 6. Percentage of female adult smoking from 1985 to 2003[31].

Country	1985	2002–2003
Belgium	27	22 (2003)
Czech Republic	26	23
Denmark	42	24 (2003)
Germany	27 (West Germany)	30 (2000)
Estonia	15 (1990)	18
Greece	20	39 (2001)
Spain	23	25
France	32 (1984–86)	25
Ireland	32 (1993)	26
Italy	17 (1986)	17 (2001)
Cyprus	7 (1989)	8 (1997)
Latvia	n/a	19
Lithuania	n/a	12
Luxembourg	25 (1987)	26 (2003)
Hungary	22 (1986)	29 (2003)
Malta	n/a	21 (2003)
Netherlands	35	27 (2003)
Austria	21	26 (2000)
Poland	27 (1996)	23
Portugal	14 (1988)	n/a
Slovenia	27 (1988)	20 (2001)
Slovakia	n/a	32
Finland	14	19 (2003)
Sweden	27	19
UK	31 (1984–86)	24

Obesity

In the majority of European countries the prevalence of obesity has increased over the last decade. It is becoming a pandemic with major health, as well as economic, consequences that is increasing the burden of chronic non-communicable diseases. Obesity is associated with numerous health complications, including osteoarthritis, coronary heart disease and type-2 diabetes.

Figure 17. Estimated country prevalence of overweight and obesity in women[32].



Notes: *restricted age groups ; **Germany overweight figures derived from WHO MONICA studies; BMI: Body Mass Index.

Physical Activity

Although there is no internationally agreed definition or measure of physical activity, insufficient physical activity is known to increase the risk of certain chronic disorders such as coronary heart disease, hypertension and diabetes. Physical activity may also reduce the risk of some cancers, and can improve musculoskeletal health, control body weight and reduce symptoms of depression. Table 7 uses two definitions of physical inactivity to explore the percentage of sedentary women in the EU.

According to Varo (2003) a lower prevalence of sedentary lifestyle is to be found in northern European countries (especially Scandinavian countries) as compared to Mediterranean countries, whereas the prevalence was higher among older, obese, less educated, widowed/divorced individuals, and current smokers.[33]

Table 7. Percentage of sedentary women in the EU according to two definitions: Low Energy Expenditure (LEE); and No Participation in activities and Long Time Sitting Down (NP + LSD)[33].

	Percentage of sedentary people, two definitions	
BMI (kg/m²)	LEE criteria[a]	NP + LSD[b]
<20	62.7	12.3
20–25	59.6	13.9
25–30	65.2	17.5
>30	67.7	22.2
Smoking status		
Non-smoker	61.9	15.0
Ex-smoker	58.6	12.3
Smoker	64.7	18.0
Weight change in the last six months		
Same weight	62.0	15.6
Lost weight	59.1	14.1
Gained weight	64.2	15.3

a LEE criteria = Low Energy Expenditure criteria considered as 'sedentary' individuals expending <10% of their leisure time expenditure in activities requiring =4 metabolic equivalents (MET). Otherwise they were considered as 'active'.

b NP + LSD criteria = No participation in activities + long time sitting down criteria considered as 'sedentary' individuals who did not practice any physical activity during their leisure time and in addition spent a total number of hours sitting down higher than the median (6h/wk) of the distribution of hours sitting down a week for all participants. Otherwise they were considered as 'active'.

BMI: Body Mass Index.

The "International Physical Activity Questionnaire" (IPAQ) was used to assess the physical activity in all Member States of the European Union between October and December 2002.[34] Frequency, duration and level of intensity of physical activity in the previous seven days of both women and men aged 15 years and over, in each EU country, were measured. Overall, women do less physical activity and spend less time on physical activity than men.

Diet and physical activity related diseases are imposing vast costs on the European economy. However, despite the enormous expenditure and the loss of productivity, there have been very few resources allocated across Europe in attempting to prevent these diseases, rather than treating them.

Table 8a. Days of vigorous physical activity in the last seven days by gender[34].

	Women %	Men %
None	65.0	49.1
1 day	7.3	8.5
2 days	8.4	9.9
3 days	6.3	8.2
4 days	2.7	4.3
5 days	3.2	8.0
6 days	1.1	3.1
7 days	4.9	7.4
Don't know	1.1	1.5

Table 8b. Time spent on vigorous physical activity in the last seven days by gender[34].

	Women %	Men %
No vigorous physical activities	67.4	53.6
30 minutes or less	4.3	4.1
31 to 60 minutes	12.0	17.6
61 to 90 minutes	4.0	5.2
91 to 120 minutes	7.5	12.1
More than 120 minutes	2.6	4.4
Don't know	2.2	3.0

D. Mobility Disorders

Musculoskeletal Disorders

Musculoskeletal disorders include neck and shoulder pain, low back pain and osteoarthritis, and affect an increasing proportion of the population, with various degrees of impact on disability and quality of life resulting in a significant number of physician visits, work absence and medication use. A study in Sweden has found the highest incidence and duration of sickness absence for women in male-dominated occupations. For both genders the lowest cumulative incidence and duration occurred in gender-integrated occupations.[35]

These disorders are increasingly common with advancing age, but generally receive little attention, despite enormous costs for society. Table 9 presents data on the standardised death rates amongst women for musculoskeletal diseases. Although the figures overall are low, the countries with the highest rates are predominantly in the EU-15 countries.

Arthritis

More than 100 million European citizens have arthritis/rheumatism.[37] Kvien estimates that rheumatoid arthritis affects between 0.5 and 1.0% of the adult population worldwide, increases in prevalence with age and affects more women than men.[38] Older age and female gender would appear to be risk factors both for the development of rheumatoid arthritis and for a worse outcome.

Table 9. Standardised Death Rate for musculoskeletal diseases amongst women, % per population.

Country	1998	Country	1998
Belgium	n/a	**Luxembourg**	1.83 (total rate)
Czech Republic	0.29	**Hungary**	2.42
Denmark	3.80	**Malta**	n/a
Germany	1.25	**Netherlands**	3.38
Estonia	3.18	**Austria**	0.98
Greece	1.19	**Poland**	n/a
Spain	3.77	**Portugal**	1.36
France	2.38	**Slovenia**	1.94
Ireland	3.95	**Slovakia**	1.04
Italy	1.94	**Finland**	3.74
Cyprus	n/a	**Sweden**	3.14
Latvia	3.12	**UK**	3.65
Lithuania	2.20		

In a study exploring the burden of osteoarthritis and rheumatoid arthritis across Europe, Hunsche *et al.* concluded that comparing countries regarding the burden of disease is difficult because of the variety of ways in which results are presented, e.g. on a per-patient basis, or for the whole population.[39] To better understand the burden of this illness not only is more research required, but the methodology to be applied in the analyses must also be standardised.

Osteoporosis

Osteoporosis is a major public health problem through its association with fracture. Across Europe some 19 million people are considered to suffer from osteoporosis. One in three women and one in eight men over the age of 50 are affected by an enhanced bone fragility and an increased fracture risk.[40] Figure 18 illustrates the highest rates of hip fractures in Sweden, Austria, Germany and Denmark with low rates in France and Portugal.

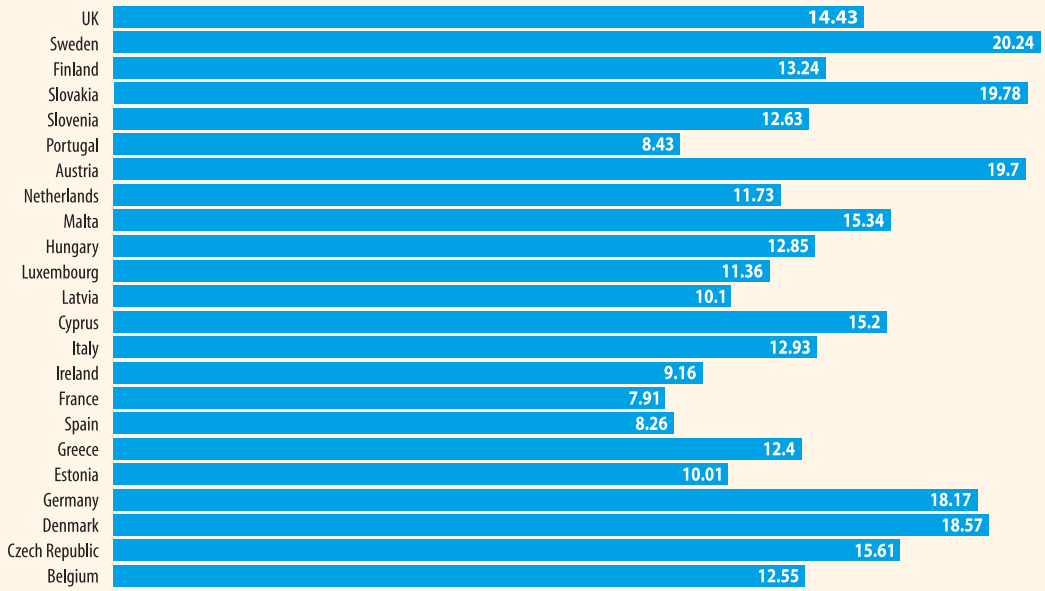
Eighteen European centres are participating in a European Prospective Osteoporosis Study (EPOS) which is examining women over 50 years of age with back pain and disability associated with vertebral fractures.[41] Another EPOS study is examining the incidence of limb fracture by site and gender in different regions of Europe with men and women aged 50–79 recruited from population registers in 31 European centres.[42]

There are substantial differences in the descriptive epidemiology of limb fracture by region and gender. Amongst women the incidence of hip, humerus and distal forearm fracture increases with age, with incidence rates higher in Scandinavia than in other European regions.[42]

There are two groups of postmenopausal women who are at risk of fracture – (a) those with osteoporosis who have not yet had a fracture and who, if they remain untreated are at risk due to the progressive nature of the disease and (b) those women with osteoporosis who have already had a fracture and are at high risk of further fractures.

Since osteoporosis can develop "silently" with no obvious symptoms, the only reliable way to determine whether osteoporosis is present is to have a bone density scan. However, there is limited diagnosis of osteoporosis in Europe. Despite the availability of effective methods for detecting bone loss, many people are not routinely assessed for osteoporosis and may not receive treatment to prevent further loss of bone mass or fractures until the disease worsens.

Figure 18. Number of hip fractures per year per 10,000 population[40].
(Based on latest available annual data, ranging from 2000 to 2003).



Note: no data available for Lithuania and Poland.

Once a fracture has occurred the risk of future fracture is at least doubled within one year. As the population of the EU ages, the absolute number of women suffering an osteoporotic fracture will increase dramatically, and the costs are predicted to double in the next 50 years unless effective preventive strategies are developed.

E. Mental Health

Statistics on mental health problems often conceal the considerable differences that exist between men and women in the prevalence of specific types of mental disorders and at different stages of the life-cycle. Worldwide, the mental disorders of childhood are generally more prevalent in boys, but in later life women are more likely than men to suffer from poor mental health.

Dementia

Although dementia does not only affect older people, rates increase with age, doubling every four years over 65. In a study examining incidence data from eight population-based studies carried out in seven European countries it was found that the incidence of dementia and Alzheimer's Disease (AD) continued to increase with age up to age 85 years, after which rates increased in women but not in men. The study found higher incidence rates of dementia and AD in the very old in northwest countries than in southern countries, and confirmed that AD is the most frequent dementing disorder at all ages.[44]

The EURODEM Studies[45] have also examined gender differences in the incidence of AD in some European countries and conclude that there are significant gender differences in the incidence of AD after 85 years of age. At 90 years of age the rate was 81.7 (95% CI, 63.8 to 104.7) in women and 24.0 (95% CI, 10.3 to 55.6) in men and they conclude that compared with men, women have an increased risk for AD.

One observation to emerge from the EURODEM research is that men and women with dementia are over 30 times more likely to die in an institution than people who do not have dementia. The increase in the prevalence of dementia in the EU will have serious implications for all European healthcare systems. It is currently estimated that European countries need to provide one year of dementia care per person over the age of 65.

Depression

Depression and depression-related problems are today amongst the most pressing public health concerns. The European Commission claim that depression and depression-related problems account for more than 7% of all estimated ill-health and premature mortality in Europe. Depression is the principal cause of suicide.

The burden of depression, beyond that of healthcare systems, includes the loss of quality of life for those affected and their families, a loss of productivity for firms, an increased risk of unemployment for

Table 10. Sex differences in the prevalence of mental disorders across the life-cycle[43].

Life-cycle stage	Mental disorder	Male: female difference
Childhood	Pervasive developmental disorder	Males >> Females
	Attention deficient hyperactivity disorder (ADHD)	Males >> Females
	Conduct disorders	Males >> Females
	Learning disability	Males >> Females
Adolescence	Depression	Females >> Males
	Deliberate self-harm	Females > Males
	Eating disorders	Females >> Males
	Substance abuse	Males >> Females
Adulthood	Depression and anxiety	Females > Males
	Schizophrenia	Males = Females
	Bipolar disorder	Males = Females
	Substance abuse	Males >> Females
Old age[a]	Dementias	Females > Males
	Depression	Females > Males
	Psychoses	Females >> Males

> Prevalence is approximately two- to threefold greater.
>> Greater than a threefold difference in prevalence.
a The difference in old age is likely to be due to the greater longevity of women.

Table 11. Prevalence of depression in European epidemiological studies[46].

Country	Age Range	Gender prevalence (%) Male	Female
Greece	All ages	4.3	10.2
Netherlands	18–64	1.9	3.4
Spain	> 17	4.3	5.5
UK	16–54	1.7	2.7
	54–64	2	1.1

individuals and consequently a higher burden on social security systems. According to the World Bank's Burden of Disease Study, depression in women is now the number one disease worldwide.

The EURODEP Programme examined levels of depression across Europe and explored geographical variation of depression in older people, risk factors, detection and treatment[47] and preliminary evidence showed higher proportions of depression in women than in men in almost all studies.

Suicide

One aspect of mental health that requires consideration is suicide. Suicide rates are generally higher amongst men than among women, but rates of suicide attempts are higher among women. Table 12 illustrates that rates amongst women are highest in Lithuania, Hungary, Latvia and Belgium with low rates in Portugal, the UK and Italy.

Table 12. Suicide Rates (per 100,000)[50].

Country	Year	Male	Female
Belgium	1997	31.2	11.4
Czech Republic	2001	26.0	6.3
Denmark	1999	21.4	7.4
Germany	2001	20.4	7.0
Estonia	2002	47.7	9.8
Greece	1999	5.7	1.6
Spain	2000	13.1	4.0
France	1999	26.1	9.4
Ireland	2000	20.3	4.3
Italy	2000	10.9	3.5
Cyprus	n/a	n/a	n/a
Latvia	2002	48.4	11.8
Lithuania	2002	80.7	13.1
Luxembourg	2002	28.6	10.2
Hungary	2002	45.5	12.2
Malta	2002	5.6	4.0
Netherlands	2000	12.7	6.2
Austria	2002	30.5	8.7
Poland	2001	26.7	4.3
Portugal	2000	8.5	2.0
Slovenia	2002	44.4	10.5
Slovakia	2001	22.2	4.0
Finland	2002	32.3	10.2
Sweden	2001	18.9	8.1
UK	1999	11.8	3.3

Note: Most recent year available – as of June 2004.

Eating Disorders

Eating disorders are amongst the most debilitating psychiatric disturbances that affect young women. Knowledge about the two main eating disorders – anorexia nervosa and bulimia nervosa – has increased in recent years; however much remains unknown. Many girls in adolescence are preoccupied with weight and dieting, and may be considered 'at risk' for developing a clinical eating disorder. While depression is sometimes present, the causes of these disorders are now known to be quite complex, implicating genes involved in decision-making.

According to Makino *et al.*[48] the prevalence rates in western countries for anorexia nervosa in female subjects ranges from 0.1% to 5.7%, and for bulimia it ranges from 0.3% to 7.3% in women and from 0% to 2.1% in males. In one study examining Central and East European epidemiological data of eating disorders the authors demonstrate that eating disorders are not exclusively characteristic to western societies.[49] The wide range of variation in published prevalence rates can be understood in light of the many methodological problems inherent in this type of research.

F. Sexual Health

Sexually Transmitted Infections

According to Fenton and Lowndes[51] sexually transmitted infections are a major public health problem across Europe. The Van Lancker Report[10] concludes that rates of sexually transmitted infections (STIs) are still unacceptably high in Europe, mainly because sexual education for young people is unsatisfactory. For example, Estonia, Latvia and Lithuania had high rates of gonorrhoea in 2000[52] but there are downward trends in gonorrhoea in England and Wales, France, the Netherlands and Sweden.[53]

HIV/AIDS

It would appear that the number of newly diagnosed AIDS cases is decreasing in the EU, but there is an upward trend to be observed in the number of newly reported HIV infections.[54] Men are still more affected by HIV/AIDS than women but the proportion of women in new HIV/AIDS cases has constantly increased since 1985. We can see from Tables 13 and 14 that the percentage of women newly diagnosed with HIV was over 44% in Belgium and the UK in 2003.

Table 13. Share of women in newly reported HIV infections[54].

	1990	1995	2000	2003
EU25	15.5	20.1	23.6	26.6
Belgium	18.4	28.1	40.8	44.8
Czech Republic	0.0	0.0	14.3	11.1
Denmark	8.6	13.6	31.0	26.8
Germany	10.3	14.0	17.1	14.7
Estonia	-	0.0	0.0	30.0
Greece	11.9	13.0	13.4	18.1
Spain	17.7	20.2	22.6	20.2
France	16.5	20.5	27.5	27.4
Ireland	27.9	11.3	23.1	25.0
Italy	18.6	24.3	24.1	26.2
Latvia	0.0	0.0	26.1	29.3
Lithuania	0.0	0.0	14.3	11.1
Luxembourg	0.0	6.7	10.0	37.5
Hungary	10.5	9.7	7.4	15.4
Netherlands	8.6	16.2	14.3	n/a
Austria	18.3	25.6	36.1	39.5
Poland	0.0	16.5	23.3	32.9
Portugal	11.6	16.9	17.5	21.0
Slovenia	0.0	18.7	14.3	16.7
Slovakia	0.0	50.0	25.0	0.0
Finland	6.7	9.8	47.1	26.9
Sweden	9.8	17.4	23.7	36.5
United Kingdom	7.8	15.9	29.5	44.4

Table 14. HIV infections newly diagnosed in persons infected through mother-to-child transmission[55].

Country	2003	Country	2003
Belgium	12	**Luxembourg**	0
Czech Republic	1	**Hungary**	0
Denmark	3	**Malta**	0
Germany	11	**Netherlands**	n/a
Estonia	1	**Austria**	n/a
Greece	1	**Poland**	11
Spain	n/a	**Portugal**	16
France	23	**Slovenia**	0
Ireland	12	**Slovakia**	0
Italy	n/a	**Finland**	1
Cyprus	n/a	**Sweden**	4
Latvia	2	**UK**	90
Lithuania	0		

The problem of preventing HIV/AIDS is very different for each Member State, since the distribution of HIV/AIDS cases by mode of infection varies considerably from one country to another. For example, in Denmark, Germany, and the Netherlands, AIDS sufferers are mostly homosexuals. Whilst in the southern countries, particularly Italy and Spain, drug addicts who administer drugs intravenously form the largest group. The incidence of HIV/AIDS is generally lower in the ten new Member States but there are signs of some increase. Much of the research conducted on HIV/AIDS is gender blind; however, important data has been collected on HIV infections through mother-to-child transmission.

Sexual Violence

Generally violence against women is often carried out by a known person or partner, and it can occur across all social, economic and cultural barriers and in varied settings such as the home, community or workplace.[56] Violence against women can be physical, sexual and emotional, yet large scale studies of violence against women are sparse and violence goes under-reported and under-estimated[56] resulting in a deficiency in comparative and official data.[57]

Abuse and coerced sex are the two most regular forms of violent acts carried out against women by intimate male partners. Furthermore, in the EU female genital mutilation is performed amongst some immigrant communities in Denmark, Germany, France, Italy, the Netherlands, Sweden and the UK.[58]

Table 15. Sexual Violence.

Country	Sexual Violence
France[a]	• 25,000 raped per year
Ireland[a] (2002 study)	• 20.4% of women have reported a sexual assault as adults
	• 6.4% reported rape as adults
Latvia[b] (1998 study)	• 5.2% women reported being sexually assaulted in last five years
Lithuania	• 26.5% of women reported sexual abuse by a stranger after age 16
	• 18.2% of women reported sexual abuse by a known man after age 16
Hungary[b] (1999 data)	• 2.2% of women over 16 reported being raped
	• 9.4% reported almost being raped
	• 7.4% raped by their partner
England and Wales[b] (2000 data)	• 4.9% of women have reported rape or sexual assault on at least one occasion since the age of 16

a European Women's Lobby, 2001.
b E, London Metropolitan University, 2003.

The consequences of being a target of violence are varied and women who find themselves victims of violence are at increased risk of depression, suicide attempts, chronic pain syndromes, psychosomatic disorders, physical injury, gastrointestinal disorders, irritable bowel syndrome and reproductive health consequences.[59] Tables 15 and 16 are reproduced from Amnesty International (2004).[58]

Table 16. Violence within the family.

Country	Violence within the family
Spain[a,b]	• 1.88 million women assaulted – only 43,000 reported it to the police
	• One woman every five days killed by her partner
Lithuania[c]	• 42.4% of all married/cohabiting women victims of physical/sexual violence by present partner
	• 10.6% women reported most serious incident to police
Hungary[d]	• 13% in/have been in a relationship reported being beaten by husband/partner
	• 18% afraid of being beaten by partner
	• 22% said partner had threatened to beat them
Netherlands[e]	• 21% of all women aged between 20 and 60 reported an act of physical abuse
	• 11% reported an act of severe physical assault
Poland[f,g]	• 60% of divorced women reported being hit at least once by their ex-husbands
	• an additional 25% reported repeated violence
	• 58.31% of cases police called to at home concerned women being attacked by intimate members of the family
UK[b,f]	• 25% women had been punched or slapped by partner or ex-partner in their lifetime
	• Approximately two women per week killed by their partners

a Women's Institute of Spain, 2002;
b E, Joni Sager, 2003;
c Women's issues Information Centre, "Women in Lithuania" Vilnius, 1999;
d TARKI Research Institute national survey, 1999;
e A, WHO 2002;
f A, UNICEF 2000;
g Police data 2002.

G. Selected Chronic Disabling Disorders

Many believe that population ageing and the increasing survival rates from disabling accidents and illness, will lead to an increase in the proportion of the population with disabilities. With increasing life expectancy, the prevalence for example, of hearing and visual impairments rises, as well as mental health conditions such as dementia.

The Euro-REVES Project aimed to harmonise health expectancy calculations across Europe and Table 17 demonstrates life expectancy without disability in selected European countries at age 65.

Chronic physical or mental health problems can hamper participation in daily life. The EU has developed a human-rights based approach to disability in recent years and allows European actions to combat discrimination based, amongst other things, on disability. Disability may be enhanced by gender-related problems such as access to transport and poverty.

Diabetes

Diabetes is now one of the most common non-communicable diseases globally. The International Diabetes Federation[61] estimate that there are currently about 150 million people with diabetes worldwide. The prevalence of diabetes is increasing in every country across Europe. The International Diabetes Federation have examined the latest figures and estimated the prevalence of this condition in 2025.

For both men and women, the proportion of people with diabetes increases with age. Various studies also suggest that the prevalence of diabetes is higher amongst low socio-economic groups, and is higher amongst some ethnic minority communities than in the general population. For example, in the UK prevalence of diagnosed diabetes is much higher for Pakistani, Bangladeshi and African Caribbean women than in the general population. Figure 19 presents data from the International Diabetes Foundation who estimate the prevalence of diabetes in Europe in 2025. Every single country of the EU is predicted to have a higher rate.

Diabetes is associated with a higher coronary heart disease (CHD) mortality in women compared with men. In subjects with diabetes receiving medical care, women had poorer control of blood pressure and a significantly higher mean systolic blood pressure compared with men. These findings might partially explain the excess CHD mortality in women with diabetes[62]

Figure 19. Estimated prevalence of diabetes, 2003 and 2025[61].

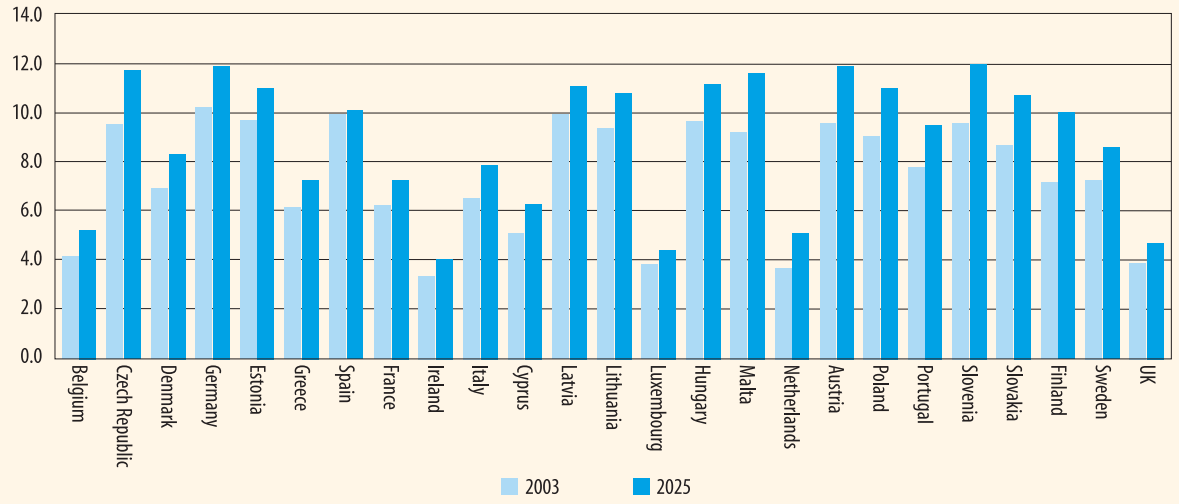


Table 17. Life expectancy without disability or in good health at age 65[60].

Country	Age Group		Life Expectancy	Health Expectancy	HE/LE in %
Bulgaria					25.6
Disability-free life expectancy	From age group 50–59		7.8	28.0	6.9
Denmark	At age 66	*Method 1*	17.2	14.0	81.4
Expected years without disability, 1986–1987		*Method 2*	17.2	13.6	79.1
		Method 3	17.2	7.6	44.2
		Method 4	17.2	8.3	48.3
		Method 5	17.2	15.7	91.3
		Method 6	17.2	9.2	53.5
		Method 7	17.2	16.3	94.8
Federal Republic of Germany	At age 60		78.4	68.4	87.2
Expectation of Active Life, 1983	At age 65		21.7	15.2	70.0
France, 1982 Life expectancy without disability	At age 65		18.5	9.9	53.5
Italy	At age 60				
Life expectancy in different health conditions, 1980		*In good health*	21.2	12.7	59.9
Remaining life expectancy in different health statuses, 1983		*In good health*	21.7	16.7	77.0
The Netherlands					
Life Expectancy without disability, 1981–1985	At age 65	*Method 1*	18.6	6.9	37.1
		Method 2	18.6	9.4	47.8
Health expectancy: Method 2: poor perceived health free, 1990			19.0	9.1	47.9
Health expectancy: Method 1: disability-free, 1990			19.0	8.0	42.1
Spain					
Expectancy of life free from disability, 1986			18.4	6.5	16.9
				35.3	
Life expectancy free from permanent disability, 1986			18.4	6.9	16.9
				37.5	
Sweden					
Expectation of life without disability, 1987	Between 65 and 84		16.0	7.9	49.4
United Kingdom	*Method of calculation :*				
Expectation of life without disability, 1980	*Double decrement*		17.4	15.4	88.5
	Double decrement (adapted)		17.4	15.9	91.4

Adapted from Table 1, Euro REVES website: http://euroreves.ined.fr/reves/database/2pres.html

Fibromyalgia

FMS (fibromyalgia syndrome) is a widespread musculoskeletal pain and fatigue disorder for which the cause is still unknown. Fibromyalgia means pain in the muscles, ligaments, and tendons – the soft fibrous tissues in the body. Its prevalence in the wider European region is estimated to be between 0.1 and 3.3%, even reaching 8 to 10.5% in women aged between 20 and 49 years of age according to one Norwegian study.[63] Women are more frequently affected (75–80% of cases) than men and it has significant repercussions on everyday life, such as sexual difficulties, inability to work and disability.

Migraine

In Europe 30 million people suffer from migraine (20 million women and ten million men). With twice as many women than men suffering from migraine hormonal influences are suspected. It is thought that both sexes are equally *prone* to migraine attacks, but from the menarche onwards female hormones make women more vulnerable to attack. One study of eight European countries[65] found substantial migraine-related impairment of productivity at work and school, as well as of family and leisure time among young women. Again as migraine impacts so much on the quality of life of women, this is also an area that would merit further research.

Endometriosis

Endometriosis is a common disorder in women affecting an estimated 14 million women in Europe. The cause is unknown. Tissue similar to the lining of the uterus is found in other areas of the body. The tissue responds to the hormonal cycle, it bleeds and forms lesions, blood-filled cysts and adhesions. The result is inflammation, pain, and for some, infertility and potentially other medical problems.

The symptoms are painful menstruation, ovulation, intercourse, bowel movements and urination; heavy bleeding, fatigue, immune system defects and possibly a susceptibility to develop other diseases, including some cancers. The impact on work, relationships and quality of life is significant. 36% have had their job affected. It costs the EU an estimated 30 billion euros a year in days taken off work[71].

Table 18. Prevalence of Fibromyalgia in Europe (total numbers)[64].

Country	Extrapolated Prevalence	Country	Extrapolated Prevalence
Belgium	140,766	**Lithuania**	49,078
Czech Republic	16,951	**Luxembourg**	6,293
Denmark	73,638	**Hungary**	136,469
Germany	1,121,217	**Malta**	n/a
Estonia	18,250	**Netherlands**	221,975
Greece	144,837	**Austria**	111,200
Spain	547,937	**Poland**	525,431
France	821,947	**Portugal**	143,159
Ireland	53,997	**Slovenia**	27,361
Italy	789,752	**Slovakia**	73,776
Cyprus	n/a	**Finland**	70,932
Latvia	31,372	**Sweden**	122,241
		UK	819,858

Pain

There is no comprehensive European epidemiological survey describing the extent of the pain problem across Europe. The International Association for the Study of Pain[66] has summarised the incidence of various chronic pain syndromes and their cost to society. Chronic pain patients can endure psychosocial as well as physical hardship including poor nutrition and weight loss, decreased activity, sleep disturbances, social isolation, marital problems, unemployment and financial problems, anxiety, fear and depression.

According to the *Pain in Europe* survey[67] the typical chronic pain sufferer is a middle-aged married woman whose children have left home. This survey states that in most European countries slightly more women (56%) than men (44%) suffer pain.

In the MERI project[16] the following key points in relation to pain were presented:

- Pain, related to paid and unpaid work, is more common among older women than older men.
- Arthritis is more common among older women than older men.
- Osteoporosis is more common in older women than older men.
- Older women are more often affected by disorders caused by injuries and falls.

Lupus

Little comparative data is available on Lupus across the EU. However, it is known that women are about ten times more likely to have or to develop lupus than men. A chronic inflammatory disease that can target joints, skin, kidneys, blood cells, heart and lungs, it is known that people from different racial and ethnic minority groups are at higher risk of developing lupus.

For reasons that aren't clear, lupus develops when the immune system turns against the body and harms the body's own tissues and organs. Some of the most common symptoms of this autoimmune disease include extreme fatigue, painful or swollen joints, unexplained fever, skin rashes, and kidney problems. More intensive research is needed that could lead to better diagnosis, treatment and cure.

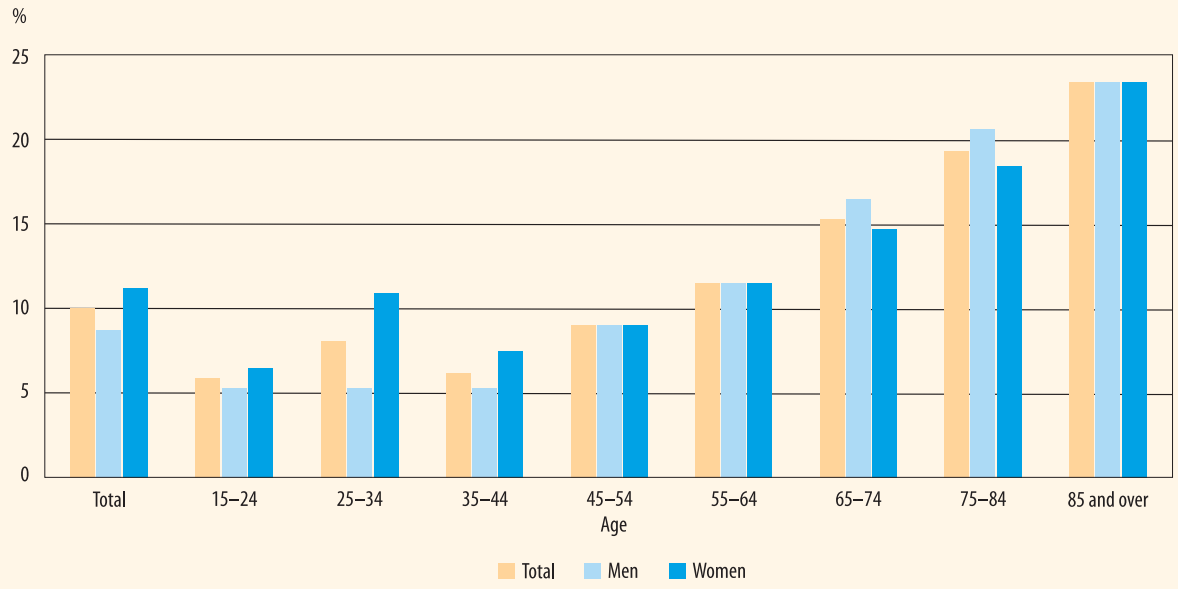
H. Healthcare

Utilisation of Healthcare Services

Men and women use healthcare services in different ways. The use of healthcare services can be substantial at several stages of life; explanations for these differences include differences between men and women in healthcare-seeking behaviour and biases in the provision of care to male and female patients. Because women tend to have a dominant role in caring for children, arranging for the healthcare needs of children often brings them into contact with healthcare professionals, leading to increased opportunities for the use of services.

Women are more likely than men to engage in health-seeking behaviour, including perceiving and reporting symptoms, and experiencing discomfort and disability, and thus are more likely than men to practice health prevention and promotion. Differences in health status between men and women are often a consequence of differences in opportunities and resources in all aspects of daily life.

Figure 20. Percentage of population hospitalised during the last 12 months by age, EU-15[69].



There is very little data available on health care utilisation for all EU-25 countries that is also broken down by gender. The data that exist tend to focus on the provision of services and include for example, numbers of physicians, dentists and nurses; number of available hospital beds; in-patient hospital admissions; childhood vaccinations and health expenditure. Alternatively, some data is available that is disease-specific but is beyond the brief of this report to present it all. Instead, two brief examples are given below – hospitalisation and drug use – that illustrate aspects of women's utilisation of healthcare services.

Hospitalisation

According to Eurostat (2002:144) *The life of women and men in Europe*[68] older women's self-perception of health is worse than that of older men. In EU-15, up to and including the age group 45–54 years, women have higher hospitalisation rates than men; after that men tend to have higher rates, especially in the age group 65–74.[69] Data is available from the 2001 European Community Household Panel examining the percentage of the population in EU-15 hospitalised during the last 12 months across different age groups and by gender. With caution it can be said that figures are somewhat lower in southern countries than in the other Member States.

Hospital discharge rates represent the total number of patients per 100,000 discharged from all hospitals during the year (including through death), categorised by the principal diagnosis. The comparability of hospital discharge data is limited owing to the differences in how hospital data collection systems are organised in different countries, and the differences in health care systems in general. Caution should therefore be exercised when discharge data are used as an estimate of morbidity.

Drug Use

Key findings from a European report in 2005 entitled *Differences in patterns of drug use between men and women*[70] suggest:

- Males outnumber females among drug users and clients attending drug treatment services.
- Male to female ratios vary in magnitude across different countries in the EU.
- The number of females in relation to males tends to increase as prevalence of drug use increases.
- The number of females in relation to males is generally lower for the more illegal drugs and recent or frequent patterns of drug use
- Most of the care provided by drug treatment services is for opiate, cocaine and cannabis problems, for which male clients far outnumber females.
- The proportions of females among clients receiving drug treatment are highest among young (under 20) clients with problems relating to amphetamine-type stimulant drugs and among older (over 39) clients with problems resulting from the use of sedative (pharmaceutical) drugs.

The next section presents some of the conclusions drawn from this research on women's health in the European Union. It also contains recommendations and an outline of some priorities for the future.

CONCLUSIONS AND RECOMMENDATIONS

A wide range of statistics from European and international sources has been assembled for this booklet. There are a number of disease-specific areas in which research on women's health has advanced significantly, e.g. cardiovascular diseases and cancer, but it is also apparent that considerably more research is needed in the coverage of important topics regarding women's health.

For example, determining the prevalence of certain diseases and conditions is difficult. Studies on prevalence often have to rely on either self-reports of a diagnosis or on extracting data from general practitioners or hospital records. Both these methods are limited because they omit cases of undiagnosed conditions and the criteria used by healthcare professionals in making diagnoses can vary.

Generally, considerably more research is necessary regarding women's access to, and utilisation of, health services and health-seeking behaviour.

There were a number of issues pertaining to women's health for which we were unable to locate any comprehensive statistics, and these ought to become research priorities. For example, there are no EU-wide studies on migraine and its effects on women. Data on diabetes, diet and nutrition and violence against women is patchy for all EU countries. Health surveys are limited on musculoskeletal diseases but would be a valuable source of information.

Reporting on HIV infections is also incomplete although considerable progress is being made. Some of the countries with the largest HIV/AIDS epidemics, such as Italy and Spain, do not yet have national reporting systems; and this problem is common across a range of conditions and for both older and newer Member States.

One problem with 'official' reporting systems, such as those for drug or alcohol use, is that not all cases are diagnosed and reported, thereby leading to a misrepresentation of the situation. Tackling cases of under-reporting and improving the collection and collation of data across national and Community systems ought to become a research priority.

It is hoped that this booklet will act as a guide for stimulating debate, encouraging policy development and further research that takes account of both gender differences and the specific situations of men and women, as well as comparisons over time and comparisons between countries.

Despite considerable progress in recent years at both national and international levels, gender inequalities in health remain in many areas across Europe. Strategies for promoting the health of women at the community level have not yet been introduced in any systematic way to the enlarged European Union. Neither has a systematic analysis been undertaken of how the healthcare sector could, or should, respond with greater sensitivity to the varying healthcare needs of women across all 25 Member States.

Determinants of women's health stem from both sex and gender differences and interdisciplinary research into both these aspects is necessary to tackle inequalities. The first and simplest step is the disaggregation of all health and healthcare statistics by sex to provide a more complete picture of women's health. Interdisciplinary collaborations to analyse existing data sources are also necessary.

There is a growing understanding of gender as a key determinant of health, and an appreciation that gender is as important as the social, economic or ethnic background of any individual. Crucially, we all seem to have moved on from the idea that women's health is considerably more than just reproductive health. Health and social care policy-makers and planners have traditionally seen women primarily in the context of their reproductive role. As a result, policies for women's health have largely been restricted to expanding and improving maternal and child health systems.

As women are important in relation to all aspects of society, and on average may live more than 30 years after the menopause, there needs to be a major shift in direction to take account of the health needs of women across the lifespan. It is important that the increasing longevity of women is considered in conjunction with population change and economic and social development; mid-life, older and elderly women will benefit from this approach.

There are still a number of conceptual barriers to overcome to get across this message, particularly in the new Member States, but our experiences to date should help us make progress. All healthcare services in every country of EU-25 need to be sensitive to women's health needs. To ensure gender

mainstreaming in health it is necessary to make explicit how women's physical, psychological and social health should be addressed at every stage of their lives.

We know that health policy and research priorities are shaped by the prevailing social and political climate, as much as the availability of resources. Different influences also guide the evolution of 'men's health' and 'women's health' as political issues. Good health is an integral part of life and an important resource for the quality of life of citizens across the European Union, the success of the economy and social cohesion.

We all, however, have a role to play in terms of advancing the cause of women's health across the enlarged European Union, both in terms of providing encouragement for change and lobbying those with the power and influence to effect real and long-lasting change.

Recommendations and Priorities

The European Institute of Women's Health (EIWH), together with its European Advisory Council and network members, calls on all policy makers and health stakeholders to support the recommendations of this report, and urges all sectors concerned to take action in these critical areas of women's health:

The recommendations are as follows:

- Determine the causes of good health in women and acknowledge that health is not merely the absence of disease;
- Fund biomedical research and research into the socio-economic determinants of health across the lifespan of women;
- Examine health inequalities within and between Member States under the current Public Health programme and the new Health and Consumer Strategy and Action programme and suggest strategies to minimise these disparities;
- Introduce gender-sensitive strands in those programmes in relation to access to information, health education, prevention and screening programmes;
- Collect gender-specific data in Member States and set gendered health indicators at Community level;
- Target information and education campaigns about smoking specifically at young girls in all EU Member States;
- Encourage new Member States to make greater use of structural funds for investing in the health sector, such as supporting implementation on the Council Recommendation on Cancer Screening;
- Channel EU funds into conditions which have low prevalence but high levels of disability in women, under the EU Framework Research programmes;
- Allocate more EU research funds under the Framework Research Programmes to disorders which are of little interest to the pharmaceutical and health technology industry because of their poor financial performance;
- Encourage the Commission to include women's health groups in the EU Obesity Initiative as an acknowledgement that women play key roles as family nutritionists and care givers;
- Encourage the new European Gender Institute in collecting gender-specific socio-economic data;
- Call on the Commission on a regular basis to produce reports on the state of women's health across the EU that include comprehensive data from the Member States and Accession Countries.

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