# GENDER PERSPECTIVE OF THE HEALTHCARE SECTOR OF UKRAINE

MOVING FORWARD TOGETHER

UNFPA

WE ACT

The research and report publication was produced within the WE ACT: Women Empowerment Action programme, implemented by the United Nations Population Fund, UNFPA, and funded by the European Union. Materials, conclusions and recommendations reflect the views of authors and do not necessarily reflect the official views of UNFPA and the European Union.

The research "Gender Perspective of the Healthcare Sector of Ukraine" was conducted to identify opportunities for closing gender gaps in the healthcare system; to increase potential of decision-makers of the government, local authorities and civil society organisations to advance gender equality, counter gender stereotypes and provide quality services in the healthcare domain for various groups of population. Materials of the research will complement the country's gender profile with a focus on the gender dimension of the implementation of AA/DCFTA (The Deep and Comprehensive Free Trade Area) cooperation/EU assistance in Ukraine.

**Research company:** Razumkov Center

**Coordination and methodological support:**

Nataliia Koshovska, Program Analyst, Gender Equality and Women's Empowerment, UNFPA

Maksym Liushan, Programme Coordinator, WE ACT: Women's Empowerment Action

**Expert support:**

Marianna Kolodii, Director, Center for Gender Studies, Uzhhorod National University

Please use QR code to download research text and infographics:

**May, 2022**

# TABLE OF CONTENTS

# ACRONYMS AND ABBREVIATIONS

WEF – World Economic Forum

IDP – Internally displaced person(s)

GBV – Gender-based violence

CSDH – Commission on Social Determinants of Health

ICPD – International Conference on Population Development

ILO – International Labour Organization

CSO – Civil society organizations

SDG – Sustainable development goals

# INTRODUCTION

Equal rights of women and men are one of the fundamental principles of the Charter of the United Nations.[1] Achieving gender equality is essential for ensuring tangible positive changes in subjective and objective indicators of well-being, and increasing the efficiency of the use of financial resources.

Ukraine identifies gender equality as one of its priorities and sets a national gender policy. Ukraine acceded to the Beijing Declaration and Platform for Action adopted at the Fourth World Conference on Women on September 15, 1995; the country ratified the main human rights treaties, including the Convention on the Elimination of All Forms of Discrimination against Women (1980)[2] and its Optional Protocol.[3]

In 2020, Ukraine formally became a full member of the Biarritz Partnership – an international initiative for equal rights and opportunities for all. Under this partnership, Ukraine committed to a range of actions at the legislative and regulatory levels. As a full member of the Biarritz Partnership, Ukraine undertook commitments in five key areas, namely developing of barrier-free public space friendly to families with children and groups with limited mobility; teaching children the principles of equality between women and men; preventing violence; reducing the pay gap between women and men; and creating greater opportunities for men to care for children.

The Association Agreement between the European Union and the European Atomic Energy Community and their Member States, of the one part, and Ukraine, of the other part, signed in 2014,[4] aims at achieving gender equality and ensuring equal opportunities for women and men in employment, education, training, economic and social activities, and in decision-making.

Shaping and improving public understanding of the objectives of public policy on gender equality contributes to the achievement of the Sustainable Development Goals,[5] proclaimed by the United Nations[6] and supported by Ukraine. 53 of the 230 SDG targets and indicators directly or indirectly relate to gender equality aspects. In addition to SDG 5 *Achieve gender equality and empower all women and girls*, other goals also address a range of gender issues, including in health, water, climate change and others.

Despite the recent significant progress, Ukraine still faces various challenges in gender equality and the elimination of all forms of discrimination against women. Ukraine's gender policy is somewhat fragmented. There is a widespread misconception that gender topics only concern women. One can see a rather strong women's movement and women's organisations in Ukraine, but very few organisations focus on protecting men's rights, which may be due to the total absence of male discrimination issues in public discourse. Men are also discriminated against in the exercise of certain rights, though to a lesser extent.

1 Charter of the United Nations and Statute of the International Court of Justice, https://zakon.rada.gov.ua/laws/show/995_010

2 Convention on the Elimination of all Forms of Discrimination Against Women, https://zakon.rada.gov.ua/laws/show/995_207#Text

3 Optional Protocol to the Convention on the Elimination of all Forms of Discrimination Against Women, https://zakon.rada.gov.ua/laws/show/995_794#Text

4 The Association Agreement between the European Union and the European Atomic Energy Community and their Member States, of the one part, and Ukraine, of the other part, https://zakon.rada.gov.ua/laws/show/984_011#Text

5 Decree of the President of Ukraine No. 722 of 30 September 2019 "On Sustainable Development Goals of Ukraine until 2030", https://zakon.rada.gov.ua/laws/show/722/2019#Text

6 UN General Assembly Resolution of 25 September 2015, No.70/1

Gender inequality is largely ignored in the development of health reforms, while the issues of measuring it in healthcare are rarely raised. The experience of mainstreaming a comprehensive gender approach into healthcare reforms, gained by some countries and international organisations, remains unclaimed by Ukraine.

Gender equality in healthcare often has purely formal interpretation – equal opportunities for women and men to exercise their rights to healthcare enshrined in legislation. Currently, only a few strategies to support gender equality identify health as a top priority. Gender equality initiatives are also insufficiently addressed in existing health reporting and strategic documents.

**The goals of the study are to:**

- Identify opportunities to address gender gaps in the healthcare system; build capacity of key members of central executive bodies, local governments and civil society (CSOs) to promote gender equality, counter gender stereotypes and provide quality healthcare services to citizens of different categories .
- Prepare materials that will complement the country's gender profile with an emphasis on the gender dimension of the implementation of AA/DCFTA (The Deep and Comprehensive Free Trade Area) cooperation/EU assistance in Ukraine.

# METHODOLOGY

## GENDER ANALYSIS

Gender analysis of health and healthcare policy is intended to identify the different needs of women and men in healthcare, as well as to determine ways to meet these needs based on the principles of social justice and non-discrimination on the grounds of gender. In the latter case, the emphasis is on equal opportunities for women and men in healthcare, rather than on equal outcomes.

## DESK REVIEW

Desk review includes an analysis of Ukraine's international and national commitments to gender equality and empowerment of women, with a special focus on the gender dimension of AA/DCFTA (*The Deep and Comprehensive Free Trade Area*)[7] cooperation/assistance programmes in Ukraine.

The data for this study originate from the latest published statistics, as of the end of 2021, and from global, regional and national monitoring mechanisms. Sources include publications and databases from WHO, other UN agencies and groups, international organisations, national ministries and scientific publications. References to sources are duly provided in the text.

To assess gender impact, primary data are collected, including information that Ukraine regularly collects as part of the state statistical analysis. Data reported in monitoring agreements with international organisations or through public sources, such as national census data or demographic and medical surveys, were also used in the review.

Whenever possible, priority was given to primary data. The mapping was made by reviewing specialised literature and studying standard datasets (such as UN INFO). A review of the professional literature and an analytical review of national strategic policies and policy documents related to healthcare were conducted.

Methods also included a quantitative study of national data, as well as interviews with national health experts to identify areas of progress, gaps and challenges in addressing gender equality.

The analysis was limited by the lack of up-to-date data and poor standardisation of sampling schemes, as well as significant gaps in data collection since 2014. There is still no such data on people living in non-government-controlled areas of eastern Ukraine and Crimea.

## NATIONWIDE SOCIOLOGICAL STUDY

To achieve the study goals, a nationwide face-to-face survey of the adult population of Ukraine was conducted in respondents' places. The survey sample represented the adult population aged 18+ in all regions of Ukraine excluding Crimea and non-government-controlled areas of Donetsk and Luhansk oblasts, in line with the main socio-demographic indicators (region, type of settlement, gender, and age).

Statistical source of the sample: the data of the State Statistics Committee of Ukraine on the socio-demographic structure of the population of Ukraine. During the field stage, 2,018 completed questionnaires were collected. The survey sample was constructed as stratified, multi-staged, randomised at the initial stage of selection, and quota selection of respondents at the final stage

7 Both Moldova and Ukraine signed Association Agreements with the EU in 2014. This marked a new stage in the development of the EU's bilateral relations with both countries, aiming at political association and economic integration. EU-Ukraine Deep and Comprehensive Free Trade Area, https://ukraine-eu.mfa.gov.ua/en/2633-relations/torgovelno-ekonomichne-spivrobitnictvo-ukrayina-yes/zona-vilnoyi-torgivli-mizh-ukrayinoyu-ta-yees

(selection by gender and age quotas). The survey involved 133 interviewers (112 women and 21 men). The sample was structured in a way that all members of the general population had the same statistical probability of being included in the sample. A comparison of demographic distributions with statistics to assess representativeness shows the maximum discrepancy at 0.2%.

**An online expert survey** was conducted to identify stereotypes, barriers and obstacles faced by men and women in healthcare. 59 experts were interviewed, including primary and secondary care physicians, urban and rural health professionals in both public and private health facilities. The combined information survey (a combination of online surveys and face-to-face interviews) was used.

# I

# REGULATORY AND LEGAL FRAMEWORK

# INTERNATIONAL HEALTH INITIATIVES: A GENDER PERSPECTIVE

Gender factors affect the design of healthcare systems and their ability to effectively meet people's needs in healthcare services. However, existing tools for assessing gender equality, including the WEF Global Gender Gap Index[8] (Ukraine ranks 74th with an index value of 0.714), the UNDP Gender Inequality Index (Ukraine has an inequality-adjusted HDI of 0.728, a Gender Development Index of 1,000, and an overall 74thrank),[9] the European Institute for Gender Equality's Gender Equality Index[10] shows that women in the WHO European Region continue to suffer from discrimination on the grounds of sex, and that some women face multiple discrimination on the grounds of age, ethnicity, disability, socio-economic status, sexual orientation or gender identity.

## GENDER (SOCIO-CULTURAL) DETERMINANTS OF HEALTH

*People's inherent right to the highest attainable standard of health is enshrined in the Constitution of the World Health Organisation and international human rights law.*[11] Preamble to the WHO Constitution clearly states that "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".[12] According to the WHO, health inequities are differences in health status or in the distribution of healthcare resources between different population groups, arising from the social conditions in which people are born, grow, live, work and age.

In 2005, WHO established a *Commission on Social Determinants of Health* (CSDH)[13] to gather evidence on possible ways to reduce the social causes of health inequities? The CSDH produced a report containing three main principles that affect the social determinants of health, specifically:

a) Improve the conditions of daily life – the circumstances in which people are born, grow, live, work and age;

b) Tackle the inequitable distribution of power, money and resources – the structural drivers of those conditions of daily life, globally, nationally and locally;

c) Measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health.

However, the selection, development and organisation of services often disregard gender norms, roles and the balance of rights and opportunities, thus creating obstacles to the optimal satisfaction of women and men's health needs.

The accessibility and quality of healthcare in developing countries is declining due to the deterioration of healthcare systems' overall condition and its privatisation with no adequate guarantees of access for the general public. This situation not only affects women's health, but also

8 Global Gender Gap Report 2021, https://www.weforum.org/reports/global-gender-gap-report-2021

9 Gender Inequality Index (GII), New York: United Nations Development Programme; 2021 https://www.hdr.undp.org/en/countries/profiles/UKR

10 Gender Equality Index 2020 [https://eige.europa.eu/gender-equality-index/2021/country]. Vilnius: European Institute for Gender Equality; 2020

11 Leading the realization of human rights to health and through health. Report of the High-level Working Group on the Health and Human Rights of Women, Children and Adolescents. Geneva: World Health Organisation; 2017 (https://apps.who.int/iris/bitstream/handle/10665/255540/9789241512459-eng.pdf?sequence=1, accessed 30 May 2019)

12 Constitution of the World Health Organisation. https://www.who.int/governance/eb/who_constitution_en.pdf

13 Commission on social determinants of health: note by the Secretariat. https://apps.who.int/iris/handle/10665/20230

places disproportionate responsibilities upon them. Women's reproductive (care) work, both within a family and in society, is often unrecognised, preventing women from receiving the necessary social, psychological and economic support.

To achieve a higher level of health for men and women and improve their opportunities in the field of healthcare, the WHO in 2007 adopted the strategy for integrating gender analysis into the work of the organisation and recommended to incorporate gender perspective in planning and developing programmes and activities in healthcare.[14]

As a basis of the Strategy on women's health and well-being in the WHO European Region, *Health-2020 – The European policy framework for health and well-being*,[15] adopted in September 2012, considers gender as one of health determinants among other social and environmental factors, and prioritises gender mainstreaming as a mechanism for achieving gender equality.

*The historic Programme of Action of the International Conference on Population and Development (ICPD) (Cairo, 1994)*[16] clearly calls for the exclusion of demographic targets and birth control indicators from national population and family planning programmes. Since policy-making should still take into account the dynamics of demographic processes, the Programme of Action includes a strong call to put women's needs and rights at the heart of population and development policies. In April 2019, UN member states of the UN Commission on Population and Development adopted a Political Declaration calling for "full, effective and accelerated implementation of the ICPD Programme of Action and the 2030 Agenda for Sustainable Development".[17] This process has intensified political and financial incentives, and also established and strengthened partnerships to complete all of the ICPD Programme of Action clauses.

## NON-DISCRIMINATION

Non-discrimination and equality are key factors for eliminating social determinants that negatively affect the realisation of the right to health. Functioning national health information systems and disaggregated data are needed to identify the most vulnerable groups and diverse needs.

Commitments to ensure non-discrimination require adherence to certain health standards and their application to such groups as women, children or persons with disabilities.

The *International Covenant on Economic, Social and Cultural Rights* and the *Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)* include provisions to eliminate discrimination against women in healthcare and ensure access to healthcare services on the basis of equality of men and women.

*CEDAW* further requires the states to ensure appropriate services to women in connection with pregnancy, confinement and the postpartum period, including family planning and emergency obstetric care, which requires the state to ensure safe motherhood, reducing maternal mortality and reducing the number of medical complications.

14 Integrating gender analysis and actions into the work of WHO: draft strategy https://apps.who.int/iris/handle/10665/22021

15 About Health 2020. WHO, https://www.euro.who.int/en/about-us/regional-director/regional-directors-emeritus/dr-zsuzsanna-jakab,-2010-2019/health-2020-the-european-policy-for-health-and-well-being/about-health-2020

16 Programme of Action. Adopted at the International Conference on Population and Development Cairo, 5–13 September 1994 20th Anniversary Edition, https://www.unfpa.org/sites/default/files/pub-pdf/programme_of_action_Web%20ENGLISH.pdf

17 Accelerating the Promise: The report on the Nairobi Summit on ICPD25, https://www.unfpa.org/publications/accelerating-promise-report-nairobi-summit-icpd25

1. State Parties shall take all appropriate measures to eliminate discrimination against women in the field of healthcare in order to ensure, on a basis of equality of men and women, access to healthcare services, including those related to family planning.

2. Notwithstanding the provisions of paragraph I of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the postpartum period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

**Article 12**

2. States Parties shall take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure, on a basis of equality of men and women, that they participate in and benefit from rural development and, in particular, shall ensure to such women the right:

To have access to adequate healthcare facilities, including information, counselling and services in family planning.

**Article 14**

**Convention on the Elimination of All Forms of Discrimination against Women**

Pursuantt to the *Committee on Economic, Social and cultural Rights General Comment,* health facilities, goods and services must be available, accessible, and acceptable and be of good quality for everyone without discrimination.

Main components of the right to health

*Availability* – functioning public health facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party.

*Accessibility* – health facilities, goods and services have to be accessible to everyone without discrimination. This also includes information accessibility – the right to seek, receive and impart information concerning health issues.

*Acceptability* – health goods and services must be culturally appropriate and respectful of medical ethics.

*Quality* – health facilities, goods and services must be scientifically and medically appropriate and of good quality.[18]

**General Comment No. 14, Ref. 7, Para. 12**

## SEXUAL AND REPRODUCTIVE HEALTH

Women and men's right to health is directly linked to sexual and reproductive health. Implementing the concept of reproductive health is a worldwide priority, as it significantly affects the demographic situation in the country, reduces maternal and child mortality, and decreases pregnancy and childbirth complications.

According to key international instruments and regulations on the protection of reproductive health, family planning is considered the main method of preserving the health of women and men; it is also one of the fundamental human rights. Women's special reproductive status is reflected in declarations directly related to women's rights.[19]

*The 2001 WHO Regional Strategy on Sexual and Reproductive Health*[20] provides for everyone's right to:

- highest attainable standard of sexual health, including access to sexual and reproductive health protection;
- search, receipt and dissemination of sexuality-related information;
- sex education;
- respect for physical integrity;
- freedom in choosing a partner;
- independent decision on being sexually active or not;

18 Ref. 7, Para. 12. General Comment No. 14 on the Right to sexual and reproductive health. https://www.escr-net.org/resources/general-comment-no-22-2016-right-sexual-and-reproductive-health

19 Reproductive Rights are Human Rights. Center for Reproductive Rights https://reproductiverights.org/wp-content/uploads/2020/12/%D0%9F%D1%80%D0%B0%D0%B2%D0%B0-%D1%8D%D1%82%D0%BE-%D0%9F%D1%80%D0%B0%D0%B2a.pdf

20 WHO Regional Strategy on Sexual and Reproductive Health. 2001. https://www.euro.who.int/__data/assets/pdf_file/0004/69529/e74558.pdf

- sexual intercourse upon the consent of both partners;
- marriage upon the consent of both partners;
- independent decision on having children or not, and when;
- satisfying and safe sex life.

*The Fourth World Conference on Women (1995, Beijing Platform)* stressed the need to ensure that reproductive rights remained an integral part of human rights.

The Beijing Platform also emphasises the right of men and women to be informed and to have access to safe, effective affordable and acceptable methods of family planning of their choice, and the right of access to appropriate health services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

Sexual and reproductive health is closely interlinked. *Article 12 of the International Covenant on Economic, Social and Cultural Rights* enshrines the right to health, of which the right to sexual and reproductive health is a part. The state must guarantee the protection and enhancement of the right of citizens and couples to control their reproductive life and access family planning information and services. Freely deciding on the number, spacing and timing of the children is a fundamental human right recognised by the entire international community.

According to the *2030 Agenda for Sustainable Development*, the states, among other things, are committed to ensuring universal access to sexual and reproductive health services, including for family planning, information and education. However, the states must step up preventive and other measures to protect people from harmful practices, including gender-based violence, that includes female genital mutilation, child and forced marriage; domestic and sexual violence including rape in a marriage, which violate the right of people to make own decisions on matters relating to their sexual and reproductive health, without violence, coercion or discrimination.

## UKRAINE'S INTERNATIONAL COMMITMENTS

*Convention on the Elimination of All Forms of Discrimination against Women, CEDAW:*[21] Ukraine made a significant progress in policy and at the level of institutional mechanisms, but many problems persist. Ukraine's main achievements in implementing the Convention are the creation of a system to reduce gender inequality in all spheres of society through gender mainstreaming. Major factors hindering the effective implementation of the Convention in Ukraine include war on its territory; underestimating the role of women in conflict prevention; lack of mechanisms for coordinating authorities and female representatives of civil society, including underestimating the role of women activists. There has been an increase in violence against women and restrictions on the rights of women and girls, particularly affecting IDP women, women from rural areas, Roma women, LGBTI+, other minorities. There are still no effective measures to ensure the rights of older women, women with disabilities and IDP women, whose living conditions are deteriorating.

*Sustainable Development Goals (SDGs).* By endorsing the goals of sustainable development, Ukraine recognised the inseparability of economic, social and environmental development, thus creating a unique opportunity to ensure gender equality and at the same time to improve the health and

21 Convention on the Elimination of all Forms of Discrimination against Women was signed by Ukraine in 1980 and ratified in 1981. In 1999, the UN adopted the Optional Protocol to CEDAW that allowed the Committee on the Elimination of Discrimination against Women to hear individual complaints. Ratified by the Verkhovna Rada of Ukraine in 2003.
UN Convention on the Elimination of all Forms of Discrimination against Women. https://zakon.rada.gov.ua/laws/show/995_207#Text

well-being of all. Taking into account the specifics of national development and seeking to ensure its national interests, Ukraine adapted SDGs until 2030 and initiated the inclusive process of their national localisation.[22] By approving the 2030 Agenda, Ukraine accepted the global measures to improve the health of women.

Gender equality is a separate target in SDG 5, but at the same time it contributes to ensuring progress towards all other goals and targets, including SDG 3 – *Ensure healthy lives and promote well-being for all at all ages*. Reducing gender inequality will significantly accelerate the achievement of SDG 3, at the same time a number of SDG 3 targets would be unattainable without implementing the related SDG 5 targets. SDGs have become the basis of government policies to preserve and maintain reproductive health.

In May 2019, Ukraine's Ministry of Health signed the *Global compact for progress towards universal health coverage*,[23] which will help achieve SDGs and build a safer and healthier world by 2030.[24] Universal Health Coverage (UHC) covers many aspects of healthcare and promotes security and equity in this sphere.

On September 23, 2019, an ambitious *Political Declaration on Universal Health Coverage*[25] was adopted by the UN General Assembly. Member States have committed to the UHC development, including mechanisms to ensure universal access for all without financial hardships caused by the need to pay for healthcare, highly effective medical measures of disease prevention and maternal and child health. By joining the Declaration, the government of Ukraine confirmed that primary healthcare was the basis for developing the healthcare system, with UHC guaranteed and provided by the state.

**Main dimensions of the Universal Health Coverage** include:

*Increased coverage*, aimed at ensuring access to healthcare services for all people, particularly for those who are vulnerable.

*Expansion of healthcare services*, accessible to all and at all times. These services must be accessible at all tiers of healthcare (prevention, diagnostics, treatment, rehabilitation, and palliative care).

*Financial protection.* Medical care should not constitute a financial burden.

22 Ukraine supported the global sustainable development goals proclaimed by the resolution of the United Nations General Assembly on 25 September 2015 No.70/1. 2030 Decree of the President of Ukraine on sustainable development goals, 30 September 2019, No. 722/2019. https://zakon.rada.gov.ua/laws/show/722/2019#Text

23 Ministry of Health of Ukraine develops a system of universal coverage in health, https://www.kmu.gov.ua/news/moz-ukrayini-rozvivaye-sistemu-universalnogo-pokrittya-v-ohoroni-zdorovya

24 Global compact for progress towards universal health coverage, https://www.uhc2030.org/fileadmin/uploads/uhc2030/Documents/About_UHC2030/mgt_arrangemts___docs/UHC2030_Official_documents/UHC2030_Global_Compact_WEB.pdf Universal health coverage (UHC) https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc)

25 Political Declaration of the High-level Meeting on Universal Health Coverage "Universal health coverage: moving together to build a healthier world", https://www.un.org/pga/73/wp-content/uploads/sites/53/2019/07/FINAL-draft-UHC-Political-Declaration.pdf

In collaboration with the World Bank, the WHO developed a framework for monitoring the UHC progress by tracking these dimensions, taking into account both the overall level and the equity of UHC, service coverage and financial protection to all people within the population, especially women, low-income and individuals living in remote rural areas.

Improving health coverage and outcomes depends on the availability, accessibility and capability of health professionals to provide quality, comprehensive and people-centred care.[26]

*The EU-Ukraine Association Agreement*.[27] Ukraine's commitment to gender equality is also enshrined in the Association Agreement.[28] Ukraine is committed to taking into account the issue of equality between men and women in developing and implementing laws, regulations, administrative provisions, policies and measures, primarily by enshrining gender equality principles in legal instruments and their further implementation.

In particular, the Association Agreement envisiones implementating a number of directives in the fields of labour, anti-discrimination and gender equality, and ensuring healthy and safe working conditions. It should be recognised that gender equality is rarely mentioned in the Agreement – in particular, in Article 419 (Chapter 21) "Cooperation on employment, social policy and equal opportunities". Article 420 further states that the Agreement shall "aim at gender equality and ensure equal opportunities for women and men in employment, education, training, economy and society, and decision-making.

17 regulations in the Agreement directly relate to healthcare. Ukraine has committed to update national health legislation by 2026, particularly focusing on infectious diseases, cancer diseases, the circulatory system, human tissues, cells and organs, mental health (including drug addiction), injury prevention, tobacco and alcohol consumption control, promotion of a healthy lifestyle, and work towards:

- reducing the number of cardiovascular diseases through a comprehensive approach to combating their causes;
- reducing the number of infectious diseases through the creation of a standardised network of epidemiological surveillance and control over their spread;
- reducing the cancer mortality with the help of an effective screening programme;
- reducing injuries and arranging better safety conditions for citizens;
- regulating the rules of conduct in the market of producers and sellers of tobacco products in order to protect the health of citizens;
- reducing the level of alcohol consumption among adolescents and young people by standardising the labelling of products that fall into this category.

The development of a single strategy on nutrition, physical activity and mental health is a key condition, as it, among other things, should determine indicators for objective assessment of

26 Universal health coverage (UHC) https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc)

27 Association Agreement between the European Union and its Member States, of the one part, and Ukraine, of the other part, https://trade.ec.europa.eu/doclib/docs/2016/november/tradoc_155103.pdf

28 A key component of the Association Agreement is the approximation of Ukrainian legislation and administrative procedures to the relevant EU norms and procedures. In particular, the Agreement includes a list of more than 350 directives and other EU regulations with which Ukrainian legislation should be gradually harmonised

citizens' health condition and the effectiveness of the health system.[29] A single system for assessing the effectiveness of healthcare will enable monitoring of its dynamics in Ukraine and compare its achievements with European ones.

# NATIONAL REGULATORY AND LEGAL DOCUMENTS OF UKRAINE AND MEETING NATIONAL COMMITMENTS

## NATIONAL COMMITMENTS ON GENDER EQUALITY

Ukraine's state policy nowadays focuses on creating equal opportunities for women and men; it is being implemented taking into account international documents signed by Ukraine.

As part of the *Biarritz Partnership* initiative,[30] the government of Ukraine has committed itself to reducing the pay gap between women and men, developing inclusive and gender-sensitive public spaces (friendly to families with children and low-mobility groups), and countering gender-based violence.

The government of Ukraine as a member of the *Action Coalition on Economic Justice and Rights* of the international initiative "Generation Equality Action Coalitions" has undertaken to ratify the ILO Convention on Eliminating Violence and Harassment in the World of Work No. 190 (2019), to adopt the Law of Ukraine "On Equal Remuneration for Work of Equal Value", and to reduce the pay gap between women and men to 16% until 2026.

To raise awareness of employers about the ways to ensure equal rights and opportunities for women and men in employment (reducing the pay gap, combating discrimination on the grounds of sex, combining family and professional responsibilities) the Ministry of Social Policy approved guidelines[31] on introduction of provisions in collective agreements aimed at ensuring equal rights and opportunities for women and men in labour relations.

In 2021, the government adopted the *Second National Plan for the implementation of the UN Security Council Resolution 1325 on women, peace and security for the period until 2025*,[32] which takes into account the special needs of women and girls, including from vulnerable groups (female refugees, IDPs, victims of gender-based violence and conflict-related sexual violence), as well as female military personnel and veterans in the provision of healthcare, psychological and humanitarian assistance.

*State strategy on ensuring equal rights and opportunities for women and men until 2030.* Seeking to implement unified state policy aimed at achieving equal rights and opportunities for women and

29 Commission Directive 2005/61/EC of 30 September 2005 implementing Directive 2002/98/EC of the European Parliament and of the Council as regards traceability requirements and notification of serious adverse reactions and events (Text with EEA relevance) https://eur-lex.europa.eu/legal-content/EN/ALL/?uri=CELEX:32005L0061&qid=1426191104154

30 Biarritz Partnership: Ukraine appreciated the achievements in creating equal opportunities for all citizens. Government portal, https://www.kmu.gov.ua/news/partnerstvo-biarric-v-ukrayini-ocinili-dosyagnennya-na-shlyahu-stvorennya-rivnih-mozhlivostej-dlya-vsih-gromadyan

31 Ministry of Social Policy. On approval of Methodical recommendations concerning introduction in collective agreements of the provisions aimed at ensuring equal rights and opportunities for women and men in labour relations. Order No. 56 of 29 January 2020, https://www.msp.gov.ua/documents/5627.html?PrintVersion

32 Cabinet of Ministers of Ukraine Directive "On approval of the National Plan of Action for the implementation of the UN Security Council Resolution 1325 on women, peace and security for the period until 2025" No. 1544-r of 28 October 2020, https://zakon.rada.gov.ua/laws/show/1544-2020-p#Text

men in all spheres of society, improving the mechanisms of its implementation, the Ministry of Social Policy has developed a draft Strategy on ensuring equal rights and opportunities for women and men until 2030. The strategy builds on fundamental international documents on equal rights and opportunities for women and men, and also takes into account strategic documents in the field of human rights and already approved national gender equality plans.[33]

In September 2016, Ukraine approved the *European strategy on women's health and well-being in the WHO European Region*.[34] It contains recommendations for the introduction and implementation of women's health programmes, both within the health system and beyond.

The strategy aims to promote progress in reducing gender and socio-economic inequalities in women's health. The goal of the Strategy is to assist health planners in their work to promote health and well-being of women and girls and ensure that policies and health systems are gender responsive.

The strategy offers four important recommendations directly related to women working in the health sector. They not only address the impact of gender factor and social, economic, cultural and environmental determinants of health, but also seek to increase the effectiveness of measures taken by the healthcare system to promote women's health and improve their well-being, in particular:

- Promoting and strengthening gender equality in the workplace at all levels.
- Reducing the negative impact on health and well-being from precarious employment and working conditions.
- Ensuring that women's work is not only appreciated but valued equally to that of men, and that women's paid and unpaid contributions as care providers are recognised, valued and compensated.
- Supporting models of care that do not increase the pressure on women and put them at risk of social exclusion; examples include policies that increase men's participation in caring for their families.

## GENDER EQUALITY IN HEALTH SYSTEM

Ukrainian law guarantees the right to healthcare and free medical care to men and women. Currently there are more than 340 laws related to healthcare directly or indirectly, including health guarantees. In addition to legislative acts, international treaties, consented by the Verkhovna Rada of Ukraine as binding, are of major importance, as they also form an integral part of the national legislation of Ukraine.[35]

*The right to motherhood and fatherhood*. The right to reproductive choice and family planning is interlinked with the right to motherhood and fatherhood, enshrined in Articles 49 and 50 of the Family Code of Ukraine. This right allows the couple to decide on the number, spacing and timing of the children in or out of wedlock, as well as family planning responsibilities.

33 OnapprovaloftheStatestrategyonensuringequalrightsandopportunitiesforwomenandmenfortheperioduntil 2030 (draft), https://www.msp.gov.ua/projects/709/?fbclid=IwAR1FVo8KtabLHY99Sc31UTG8dpJGsEI4mAbR4i1XeiuHlYC-yEy36xyLa0U

34 Strategy on women's health and well-being in the WHO European Region. https://www.euro.who.int/__data/assets/pdf_file/0003/333912/strategy-womens-health-en.pdf

35 Article 9 of the Constitution of Ukraine, http://zakon5.rada.gov.ua/laws/show/254к/96-вр

The rights of women in labour are set out in detail in the MoH documents.[36] During their stay in the maternity hospital, expectant mothers have the right to a high culture of medical care. All staff members of the obstetric hospital must know modern methods of psychological support for pregnant women and women in labour.

*The right to delivery with a birth partner is fully supported*.[37] Expectant parents should contact the maternity hospital administration (chief physician, head of the department) in advance and inform them about their willingness to involve a birth partner. No more than 2 people can be present during the labour and birth, which should only take place in an individual delivery room.

The right to motherhood includes the provision of full motherhood support, as well as proper conditions for the health and life of a mother and a child during pregnancy, childbirth and the postnatal period. A woman is recognised as having the right to freely decide on the number of children and the interval between births.

The right to fatherhood is also a natural right of a man. However, this right means the man's right to direct his behaviour towards conceiving a child or to refrain from it. A man may not be deprived of this right, and the restriction of this right is possible only in cases provided by law.

*Current goal of the state is to ensure maternal and child safety.* Childbirth and the entire complex of medical care for infants are free of charge. During 2020-2021, the Medical Guarantees Programme prioritised obstetric care and assistance in complex neonatal cases.[38] Health facilities providing these services must meet the increased requirements for the availability of necessary equipment and a team capable of providing round-the-clock medical care. The National Health Service offers higher rates[39] for these services (the tariff for childbirth assistance is UAH 10,382; the tariff for assistance to children with body weight below 1,500g at birth – UAH 98.5 thousand; and the tariff for the provision of medical care to new-borns in complex neonatal cases is defined as the rate for the treated case at UAH 113,725). A new package "Pregnancy in an outpatient setting" has also been introduced.

36 Order of the Ministry of Health No. 782 of 29 December 2005 "On approval of clinical protocols for obstetric and gynaecological care", Order of the Ministry of Health No.152 of 4 April 2005 "Protocol of medical care for a healthy new-born child"

37 The Ministry of Health has cancelled its Order No.698, which imposed restrictions on health facilities during the quarantine, including on birth partners

38 Medical Guarantees Programme 2021: motherhood and childhood protections of main priority,https://www.kmu.gov.ua/news/programa-medichnih-garantij-2021-ohorona-materinstva-i-ditinstva-zalishatsya-prioritetnimi-napryamkami

39 In 2020, the National Health Service of Ukraine has contracted 399 health facilities for the provision of medical care during childbirth. These facilities have already received more than 1.8 billion hryvnias

In its Medical Guarantees Programme, the National Health Service has increased and improved services available to women. In particular, the free package of obstetric care and assistance includes:

- medical care for non-complicated and complicated delivery, including caesarean section;
- opportunity for the presence of birth partners;
- reduction of pain in women during childbirth, including epidural anaesthesia;
- round-the-clock laboratory tests and instrumental examinations;
- intensive care of a mother and a new-born, their round-the-clock transportation in case of complications;
- vaccination of a new-born, according to the calendar of preventive vaccinations;
- provision of medicines from the National List and disposables, as well as medicines centrally procured by MoH;
- meals during the hospital stay.

Legislation requires the opportunity to exercise one's own reproductive function in a natural (biological) way or with the use of assisted reproductive technologies permitted in Ukraine. The constitutional right to personal liberty does not take into account coercion to intimacy or abortion.

However, only a woman has the right to induce termination of pregnancy. In particular Part 6 of Article 281 of the Civil Code of Ukraine clearly states that abortion may be carried out at the request of a woman with a gestational age of up to 12 weeks,[40] and in cases provided by law –up to 22 weeks. This provision is also enshrined in Article 50 of the Law of Ukraine "Fundamentals of Health Legislation of Ukraine".

The Law of Ukraine "On Amendments to Certain Legislative Acts of Ukraine on Ensuring Equal Opportunities for Mothers and Fathers in Child Care"[41] entered into force in 2021, effectively equalising the rights of men and women to parental leave. The law is designed to provide equal opportunities for a man and a woman in reconciling work with family responsibilities. In particular, it eliminates legal gaps restricting the father's right to parental leave. Previously, such leave was granted to a child's father, grandparents or other family members who actually cared for the child on the basis of a certificate from the mother's place of work or study confirming her return to work (classes) before the end of her maternity leave. The new provision eliminates the discriminatory approach, according to which the father's right to leave to care for a child until 3 was understood as derived from the mother's right to such leave, when only a mother could delegate the right to leave to a father or other relatives.

Now a man and a woman can take parental leave on equal terms, independently of each other.

40 Cabinet of Ministers of Ukraine Resolution No.144 of 15 February 2006 "On the realisation of Article 281 of the Civil Code of Ukraine" establishes the grounds on which abortion can be performed in the period from 12 to 22 weeks of pregnancy

41 Law No.1401-IX of 15 April 2021, https://zakon.rada.gov.ua/laws/show/1401-20#Text

The law also encourages men to spend more time caring for their children together with mothers and introduces a new type of leave in Ukraine –an additional one-time leave of two weeks, paid for by the employer. It can be taken any time during the first three years after birth by the child's father, grandparents, or even another adult relative who cares for a child. More importantly, the law creates preconditions for strengthening the role of a father in raising children and developing responsible parenthood in Ukraine.

The Civil Code of Ukraine (Part 3 of Article 284) determines that the *provision of medical care to an individual who has attained 14 years of age is carried out upon his or her consent*. Persons under 14 receive medical care with the consent of their legal representatives. This also applies to abortion and family planning services.

*Accessibility and quality of maternity care services*. Health facilities and health professionals in the field of assisted reproductive technologies must meet certain requirements. Improved access to services for non-working women, students, women registered with the employment centres, women fired in connection with the liquidation of business is ensured through government decisions that simplify the procedure for receiving maternity benefits for women not insured in the system of obligatory state social insurance.[42] To assign maternity benefits, information on the issuance of medical certificate of temporary incapacity for work due to "Pregnancy and Childbirth", generated electronically in the Register of Medical Conclusions will be used instead of the paper-based certificate.

To date, Ukraine has not approved the State Programme on Reproductive and Sexual Health. In the absence of a new state programme and relevant action plan in this area, Ukraine's previous achievements may be lost, jeopardising the country's prospects of meeting its international commitments in this area.[43]

State control over the implementation of reproductive health and family planning legislation is also largely ineffective, as insufficient and unstable funding hinders the achievement of the desired results.

42 Cabinet of Ministers of Ukraine Resolution No.1751 of 27 December 2001 "On approval of the Procedure for assignment and payment of state assistance to families with children". https://ips.ligazakon.net/document/KP011751?utm_source=buh.ligazakon.net&utm_medium=news&utm_content=cons12&_gl=1*k7rvn6*_ga*MTM5NjEzMjEyMS4xNjE1NTQ2NjQ3*_ga_DTFQWX6QG5*MTY0MzIwNDY4NS43LjAuMTY0MzIwNDY4NS4w&_ga=2.98380255.1780449114.1643204686-1396132121.1615546647

43 There is currently a Cabinet-initiated moratorium on the development and adoption of state targeted programmes addressing public health issues, including reproductive health. MoH representatives support the idea of elaborating a national reproductive health programme. The parliamentary committee decided to send an appeal to the Cabinet to instruct the Ministry of Health to develop a draft concept of the state targeted programme on preserving the reproductive health of the nation until 2030 and submit it for government consideration. See Resolution of the Cabinet of Ministers on the effective use of public funds No. 710 of 11 October 2016,https://zakon.rada.gov.ua/laws/show/710-2016-%D0%BF#Text

II

# GENDER PARITY IN HEALTHCARE: OVERVIEW

*The war caused by the invasion of the Russian Federation to Ukraine* triggered an immediate and sharp rise in humanitarian needs as the supply of basic goods and services has been suspended and the civilian population is fleeing hostilities. The conflict's humanitarian consequences for the population are devastating. 12 million people in Ukraine need help and protection, while more than 4 million Ukrainian refugees, mostly women and children, may need protection and assistance in neighbouring countries.[44] The lives of civilians and civilian infrastructure need to be protected and preserved in accordance with international humanitarian law.

The war has significantly affected Ukraine's healthcare system. Most hospitals work "shorthanded", and not everyone can get to the right specialist. As a result of mass migration, medical logistics, that is, the path from a family doctor to a specialist, have been disrupted. Necessary services are mostly available online or in a medical chat.

Joint statement from UNICEF, UNFPA and WHO[45] emphasises that attacks on healthcare facilities in Ukraine are killing and causing injuries to the most vulnerable patients, including women and children, as well as health workers, destroying vital health infrastructure and forcing thousands to forgo accessing health services despite catastrophic needs.

Since the start of the full-scale war in Ukraine, 135 hospitals have been shelled and 43 ambulances damaged,[46] and the WHO has confirmed 49 attacks on hospitals and nine on medical transport units. Seven hospitals were completely destroyed and 104 damaged. Six health workers have been killed in shellings.[47] The most critical situation with healthcare can be seen in Mariupol, Kharkiv, as well as in the Donetsk and Luhansk agglomerations.

Health and sanitary needs of pregnant women, women in labour, young children and the elderly are growing, and violence is restricting access to care. More than 4,000 children were born in Ukraine, and 80,000 Ukrainian women are expected to give birth shortly. The country's health system is under significant strain and its collapse will have devastating consequences.

## SOCIO-ECONOMIC DETERMINANTS OF GENDER PARITY

***Demographic situation***. Typical for Ukraine are disparities in the gender structure of the population, with women making up 54%, and men – 46% of the total population. On average, there are 1,158 women per 1,000 men. But the men-women ratio varies with age: if at birth there are 938 new-born girls per 1,000 boys, then at the age of 40-44 years, there are already 1,033 women per 1,000 men. At the age of 70-74, this difference further increases to 1,810 women per 1,000 men.[48]

The distribution of the Ukrainian population by place of residence (urban and rural areas) shows the proportions of 67.8% and 32.2%, respectively. However, the ratio between urban and rural population may fluctuate very distinctly depending on regions. Specifically, the rural population in the South-Eastern oblasts has the lowest share – 9.8% in Donetsk oblast, 13.6% in Luhansk oblast, and 16.6% in Dnipropetrovsk oblast. At the same time, the western region is dominated by the rural population at 60% or more.

44 The UN needs $1.7 billion as humanitarian needs in Ukraine and neighbouring countries grow. UN High Commissioner for Refugees. https://www.unhcr.org/ua/43013-оон-потребує-17-мільярда-доларів-сша-ос.html

45 Stop attacks on healthcare in Ukraine. https://www.who.int/ru/news/item/13-03-2022-stop-attacks-on-health-care-in-ukraine

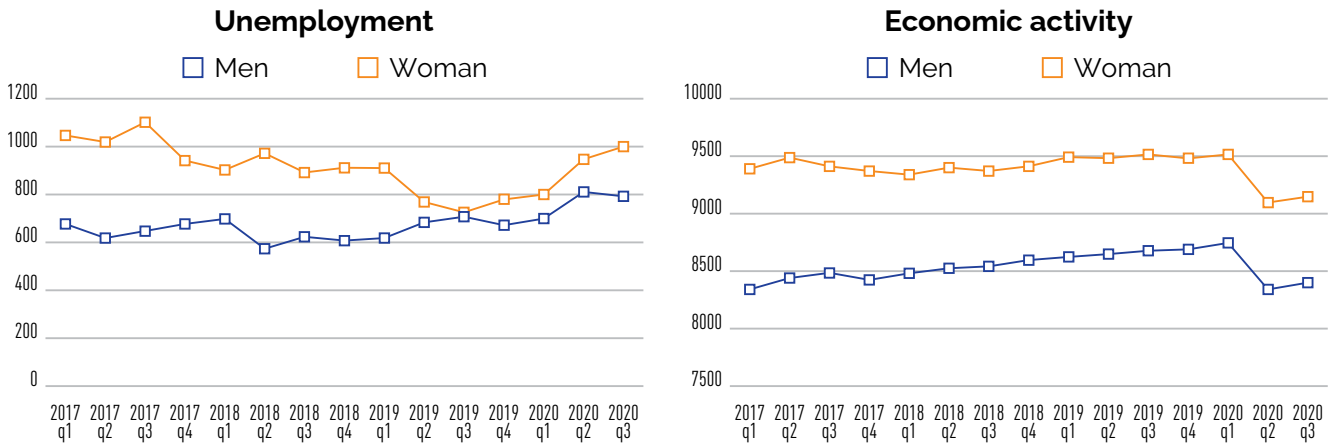
46 Attacks on Ukraine's Hospitals Will Cause Long-Term Harm to Health https://www.directrelief.org/2022/03/attacks-on-ukraines-hospitals-will-cause-long-term-harm-to-health/

47 Russian aggressors have destroyed 7 hospitals and damaged 104, some doctors killed https://www.pravda.com.ua/eng/news/2022/03/13/7331084/

48 http://database.ukrcensus.gov.ua/PXWEB2007/ukr/publ_new1/2021/dem_2020.pdf

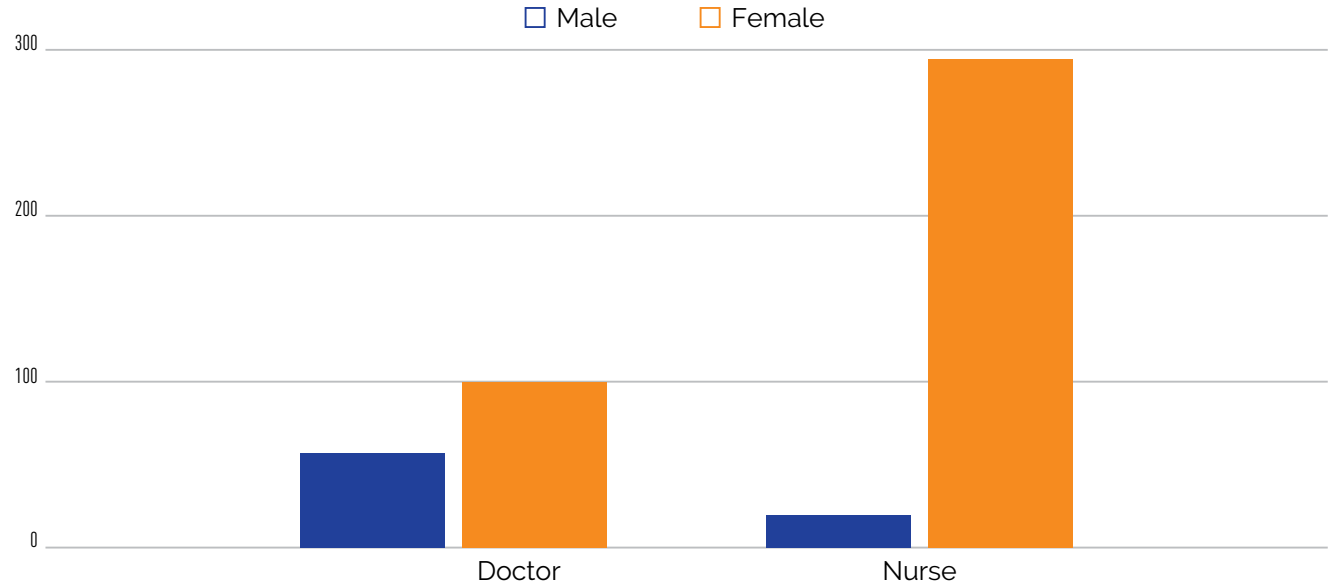
***Employment and unemployment***. Economic activity of men is higher than that of women, and women's unemployment is lower than men's.

**The level of economic activity and unemployment of men and women, % of the workforce (ILO methodology)**




Ukraine's official statistics show that 83% of health workers are women.[49] Among doctors, the share of women is 62%, but their proportion in the nursing staff increases to 94%.[50] According to the national records, there were 57.6 thousand male doctors, 99.3 thousand female doctors, 294 thousand female nurses, and 19 thousand male nurses. Today, about a quarter of doctors and more than 10% of nurses are working pensioners. Therefore, Ukraine's health sector has a distinct gender imbalance and sectoral gender segregation.

**Disaggregation of medical personal by age, thousands**




49 State Statistics Service. Women and men in Ukraine. Statisticalbook, Kyiv, 2019, https://ukrstat.org/uk/druk/publicat/kat_u/2019/zb/09/zb_gch2018.pdf

50 D.Bohdanetal. Human resources of Ukraine's health system. Situation analysis, https://www.skeptic.in.ua/wp-content/uploads/HRH-situational-analysis-2019.pdf

The healthcare system itself contributes to the persistence of many existing gender biases and social inequalities between and within the medical profession. There are significant differences between male and female health workers in their choice of specialty (horizontal segregation), as women are underrepresented in management positions and in such well-paid occupations as surgery. Instead, women are overrepresented in general practice and paediatrics – those healthcare areas that are less paid and less prestigious.

Gender segregation also exists in the medical hierarchy (vertical segregation), as women are much more represented in such professional services as nursing and midwifery, while men are much more likely to work in higher-paying occupations.

Health sector has one of the highest unemployment rates. Against the total number of registered unemployed in the sector in 2021 (21.1 thousand persons), the number of vacancies was only 3.9 thousand, or 5 applicants per vacancy. This suggests the reduction in health facilities.[51] Women make up 67.3% of the total number of registered unemployed in the health sector.

The massive wave of written warnings about significant changes in working conditions and/or future dismissals, received by health workers, was a critical issue in ensuring their employment in the system. In the total number of people warned of mass layoffs by economic activity, the healthcare sector is second only to public administration and defence.[52] In 2020-2021, the number of women warned about the planned mass dismissals in the health sector ranged from 65% to 72%.

## HEALTH INDICATORS IN GENDER DIMENSION

*Life expectancy (LE)* is an integral indicator of the population's health and well-being, as well as a final assessment of a standard of living and an indicator of the health system's effectiveness.

Unsatisfactory socio-economic conditions, aggravated by a difficult and unfavourable environment, including due to the long-term consequences of the Chernobyl disaster, contribute to low life expectancy, both expected and actual.[53] By LE indicators, Ukraine lags behind most developed countries, and this lag is growing, sometimes exceeding 10 years, and for men – almost 15 years. Such a reduction is observed both in terms of place of residence and gender, which, at the same time, creates contradictory consequences in terms of vital activities.

*On the one hand*, the availability of health services, their timeliness and quality in rural areas is noticeably lower than in cities, which is usually associated with different accessibility of medical care.

*On the other hand*, urbanisation is a recognised negative factor for a healthy environment and is associated with environmental degradation, which in turn exacerbates health problems in urban settings. And one of the consequences is the continuation of relatively low (as for a European country) life expectancy.

51 Data of the State Employment Centre on the number of registered unemployed, number of vacancies and number of applicants per vacancy, as of 1 January 2021

52 Data of the State Employment Centre on the number of persons warned about the planned release, by type of economic activity in 2020-2021

53 Global age-sex-specific fertility, mortality, healthy life expectancy (HALE), and population estimates in 204 countries and territories, 1950–2019: a comprehensive demographic analysis for the Global Burden of Disease Study 2019. – https://www.thelancet.com/journals/lancet/article/PIIS0140-6736 (20)30977-6/fulltext

**Average life expectancy,** *years*

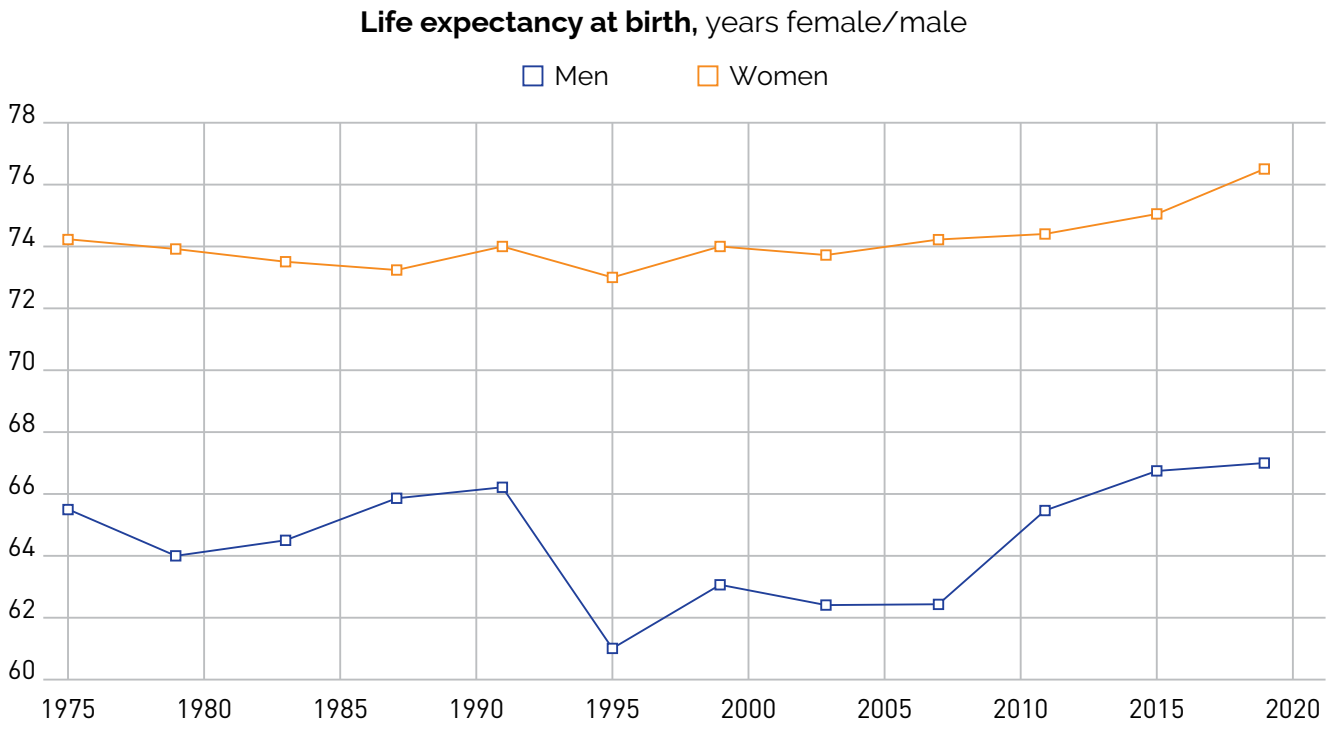
| | At birth | | | At 15 years | | | At 45 years | | |
|---|---|---|---|---|---|---|---|---|---|
| | total | men | women | total | men | women | total | men | women |
| 2018 | 71.76 | 66.69 | 76.72 | 57.48 | 52.43 | 62.42 | 30.10 | 25.90 | 33.85 |
| 2019 | 72.01 | 66.92 | 76.98 | 57.72 | 52.65 | 62.66 | 30.28 | 26.04 | 34.06 |
| 2020 | 71.35 | 66.39 | 76.22 | 57.01 | 52.06 | 61.87 | 29.46 | 25.27 | 33.24 |

LE indicators in Ukraine also have quite significant regional peculiarities that can be divided into three groups, depending on the level and structural characteristics of life expectancy:[54]

- Regions with a relatively favourable situation – mostly western oblasts of Ukraine (Ivano-Frankivsk, Lviv, Ternopil and Chernivtsi), where there are smaller differences in LE between men and women, urban and rural populations. This region is characterised by the highest level of survival to old age.
- Regions with an extremely unfavourable situation in terms of life expectancy (Dnipro, Zhytomyr, Kyiv, Kirovohrad, Kherson and Chernihiv), where the life expectancy is lower than the country average, and the share of those who live to old age is the lowest.
- Other regions.

Life expectancy at birth in Ukraine is 10 years lower than in most developed countries in the European region. Over the past decade, the maximum LE value at birth was reached in 2019 – 72.01 years, and 76.98 years for women. However, the 2020 indicators are already significantly worse, which is probably due to the COVID-19 pandemic. Moreover, these are not only its short-term, but also medium-term consequences due to the increase in incidence of cardiovascular and pulmonary diseases.

54 Annual report on health of the population, sanitary and epidemiological situation and results of the health system of Ukraine 2016 / Ministry of Health of Ukraine, State Institution "UISD of the Ministry of Health of Ukraine" - Kyiv, 2017 - 516 p




The gap between women and men in life expectancy has multifactorial components and is explained by multiple factors, such as the environment, nutrition, lifestyle, personal hygiene, bad habits, medical care and more. Moreover, the contribution of individual components to life expectancy is different.

Also, LE is directly linked to gender differences, as according to the WHO, the biological difference in life expectancy between women and men is about 2-3 years. In particular, the diseases in the terminal stage are more likely to be diagnosed among men due to their reluctance to visit doctors or undergo medical examinations.[55] This attitude towards one's own health is traditionally associated with stereotypical concept of masculinity, which includes fear of losing control of the situation, fear of showing weakness or embarrassment.

LE of both men and women is also affected by the neglect of preventive measures, including secondary prevention that contributes to the early detection of diseases and preceding ailments. This is especially true for oncology. The WHO predicts an increase in cancer in the next 10-20 years by more than 60%.[56] The highest (about 81%) growth will be observed in low- and middle-income countries. The COVID-19 pandemic and its restrictions lowered the number of oncology screenings; thus, stimulating an additional increase in cancer in the following years.

*Healthy life expectancy (HALE) in Ukraine* is also the shortest in Europe. This indicator is used to estimate the expected years that a person at a certain age should live healthy, that is, with no serious health problems limiting daily activities. The Lancet magazine estimated HALE in Ukraine at 61.7 years[57] and ranked the country last among all European countries.

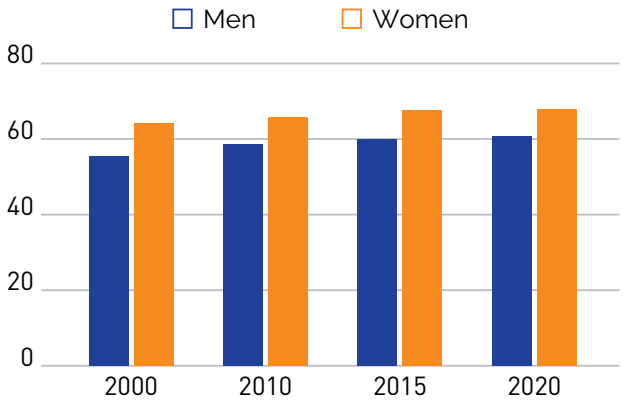
55 Gender-oriented budgeting in Ukraine: theory and practice. Methodological guide _ Kyiv, FOP Klymenko, 2016 – 92 p., https://library.fes.de/pdf-files/bueros/ukraine/12562.pdf

56 Cancer. World Health Organisation, https://www.who.int/news-room/fact-sheets/detail/cancer

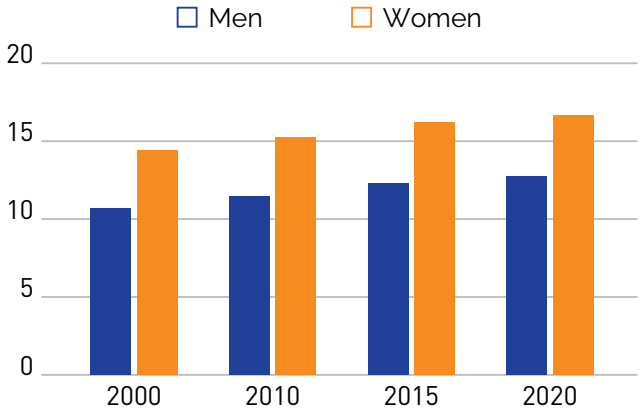
57 Global Health Metrics. Global Burden of Disease Study 2019. https://www.thelancet.com/action/showPdf?pii=S0140-6736%2820%2930977-6

The WHO considers HALE a priority indicator and uses it for international calculations. HALE is practically not used in Ukraine. According to the WHO, men in Ukraine begin to first suffer from chronic diseases at the age of 55-60. Women live an average of 65-67 years without chronic diseases.

**Healthy life expectancy at birth[58]**




**Healthy life expectancy of those who reached 60 years**




*One of Ukraine's most pressing problems is the steady decline in the birth rate,* which today has fallen to the level of the late 1990s, when Ukraine was in a deep transformational crisis.[59] Moreover, this deterioration is primarily due to a decrease in the number of women who give birth to children in the age of 20-29 years.

**Birth rate by mother's age,[60]**

*live births per 1,000 women of relevant age*

| Age | 15-49 | 15-19 | 20-24 | 25-29 | 30-34 | 35-39 | 40-44 | 45-49 | Total fertility rate |
|---|---|---|---|---|---|---|---|---|---|
| 2018 | 36.9 | 19.7 | 73.3 | 80.3 | 54.3 | 26.4 | 6.1 | 0.7 | 1.301 |
| 2019 | 34.3 | 16.9 | 68.1 | 76.5 | 52.4 | 25.3 | 5.9 | 0.8 | 1.228 |
| 2020 | 33.4 | 15.8 | 66.4 | 76.3 | 52.2 | 25.7 | 6.2 | 0.8 | 1.217 |

Although the adolescent birth rate in Ukraine is declining, Ukraine is still well ahead of European countries in this respect. Girls from rural areas prevail among those who gave birth in adolescence.

*The maternal mortality rate* is an integrated indicator of women's reproductive health, which not only reflects the general health, the quality of medical care for pregnant women and the level of organisational work of maternity hospitals, but also describes the combined interaction of these factors with economic, environmental, cultural, social and hygienic and other factors.

58 Ukraine - Healthy life expectancy. https://apps.who.int/gho/data/node.main.HALE?lang=fr.

59 For more detail, see Ukraine: 30 years on the European path / Y. Yakymenko et al, the Razumkov Centre – Kyiv, Zapovit, 2021 – 392 p

60 However, this process of reducing birth rate in Ukraine mirrors the European trends; it was observed in the country since the mid-1960s. As a result, the number of children born does not provide for the replacement of generations: the total fertility rate is 1.2 children per woman, although for simple reproduction of the population it should be 2.1

According to the United Nations Maternal Mortality Estimation Interagency Group *(UN MMEIG)*, the situation with women's mortality during pregnancy in Ukraine remains unsatisfactory.[61] Despite the fact that the maternal mortality decreased from 35 per 100,000 live births in 2000 to 19 in 2017, Ukraine by this indicator sits between economically developed countries with a well-established system of safe motherhood and developing countries with insufficient healthcare.

According to official statistics of Ukraine, the number of pregnancy-related deaths continued to rise in 2020.[62] The number of maternal deaths per 100,000 population in 2020 was 18.7 (12.5 in 2018).[63] In rural areas, this figure rises to 23.0. In total, more than 2,000 deaths of young mothers were recorded during Ukraine's independence since 1991. Currently, the maternal mortality rate in Ukraine (19 per 100,000 live births) is 3.8 times higher than in the European Union (5 per 100,000 live births).[64]

**Number of pregnancy-related deaths**

| | 2018 | | 2019 | | 2020 | |
|---|---|---|---|---|---|---|
| | Total | Per 100,000 live births | Total | Per 100,000 live births | Total | Per 100,000 live births |
| Pregnancy-related deaths | 58 | 17.3 | 50 | 16.2 | 62 | 21.1 |
| Maternal deaths | 42 | 12.5 | 46 | 14.9 | 55 | 18.7 |
| Deaths from direct obstetric causes | 25 | 7.4 | 25 | 8.1 | 20 | 6.8 |
| Deaths from indirect obstetric causes | 17 | 5.1 | 21 | 6.8 | 36 | 11.9 |
| Maternal deaths from external causes | 16 | 4.8 | 4 | 1.3 | 7 | 2.4 |

The high neonatal and maternal mortality rates have prompted the National Health Service of Ukraine (NHSU), which distributes money among health facilities for the treatment of patients, to put forward an additional requirement regarding the number of births starting from 2022. If there are fewer than 150 births a year in this facility, the NHSU will not sign a funding contract. The NHSU officials believe that with the small number of births, doctors lose the necessary practice and skills. Therefore, according to the NHSU, the minimum rate of births per year, at which maternity hospitals can operate, is 300.

*Family planning and family policy*. Family policy in Ukraine remains in line with the traditional model.[65] Such family policy largely focuses on the traditional family model, which mainly supports motherhood and childhood. The Concept of the State Targeted Social Programme of Family

61 Maternal mortality in 2000-2017. UN Maternal Mortality Estimation Inter-Agency Group https://cdn.who.int/media/docs/default-source/gho-documents/maternal-health-countries/maternal_health_ukr_en.pdf

62 Men and women in Ukraine. Statistical book 2021. http://ukrstat.gov.ua/druk/publicat/kat_u/2021/zb/09/zb_gch2020.pdf

63 The data of the State Statistics Service are different from the UN MMEIG data

64 Maternal mortality in 2000-2017, https://www.who.int/publications/i/item/9789241516488

65 The traditional family policy model implies the preservation of traditional gender roles, which does not include creating the necessary conditions for women to combine motherhood and employment. Under such conditions, the system of family services does not develop

Support[66] is aimed at implementing these tasks. It identifies the following main problems – low birth rate, mass unigeniture of Ukrainian families, instability of marriages.

Speaking of the modern family policy in Ukraine, some obstacles to its implementation deserve special attention. In Ukraine, the practice of parental leaves by fathers has not yet become widespread. Ukraine does not keep track of the number of men who have exercised their right to parental leave to care for children until the age of three. According to rough estimates by NGOs, there are approximately 25 thousand men, or 3-4% of all fathers who took such leaves.[67] According to the 2018 UNFPA survey, less than half of the respondents (46%) knew a father had the same right to take parental leave as the child's mother. At the same time, 8% of men were convinced that such legislation did not exist in the country altogether.[68] In the EU, approximately 20% of men use their right to parental leave.

*Abortions* in Ukraine are legal upon request during the first twelve weeks of pregnancy. Between 12 and 28 weeks, termination of pregnancy is possible on medical, social, or personal grounds and is performed with the consent of the medical commission.

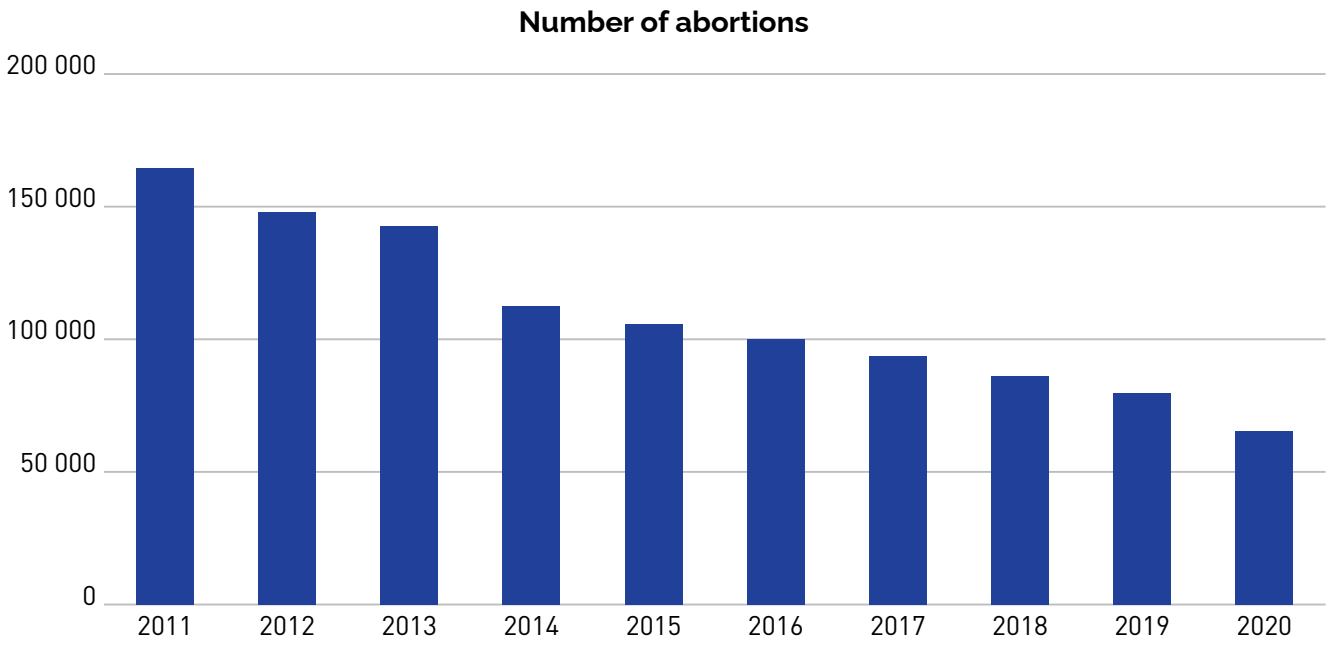
Before the 12th week, abortions are performed by curettage, vacuum aspiration and medication. It is worth noting that the abortion statistics are improving every year, with the number of abortions and the number of deaths from post-abortion complications decreasing. In addition, the number of abortions among minors has also decreased.

Medical statistics on abortions include both spontaneous abortions (miscarriages) and medical legal abortions performed according to medical indications or at the woman's request. A total of 1,096,415 abortions have been registered in the last 10 years. Of these, 1,048,974 were performed in public health facilities, and 47,441 – in private institutions.

66 Concept of the State Targeted Social Programme of Family Support in Ukraine until 2016. Approved by the Cabinet of Ministers of Ukraine Directive No.325 of 31 May 2012,http://zakon4.rada.gov.ua/laws/show/325-2012-%D1%80

67 International Renaissance Foundation. Status of implementation of national labour legislation in terms of ensuring gender equality in the field of labour. https://bureau.in.ua/images/docs/State.pdf

68 Modern understanding of masculinity: men's attitudes to gender stereotypes and violence against women. https://bit.ly/3bdnxvw




*Infertility.* According to the WHO, a marriage is considered infertile in which the wife fails to achieve pregnancy after 12 months of regular unprotected sex, provided that the couple is of childbearing age. Both male and female factors can almost equally be the cause of infertile marriage, and a combination of these factors is observed in a significant number of married couples.

Recently, there has been an increase in the number of infertile couples in Ukraine. According to the MoH, there are about 1 million infertile couples in the country.[69] This problem is particularly relevant in Ukraine, as the birth rate continues to decline every year, with ever-increasing number of childless families and families with few children. In Ukraine, the incidence of infertile marriages among couples of childbearing age exceeds 15%, reaching 20% in some regions – a level that is defined as critical and has a negative impact on demographic indicators.

According to statistics, the frequency of female infertility in Ukraine reaches 60%, and that of male – up to 40%.[70]

## RESTRICTED ACCESS

*In Ukraine, there is a tendency of increasingly difficult access to health services.* According to official statistics, almost all (98%) households in 2020 had members who needed medical care, purchase of medicines and medical supplies, and 24.4% of them could not meet such needs (in 2016 this figure was 23,1%, and already 31.7% in 2021).[71] Moreover, 25.3% of female-headed households could not meet the needs, compared to 19.6% of male-headed households.

*Limited access to health services for the elderly, most of whom are women,* can be described as one of the most common forms of discrimination. According to the State Statistics Service, 35.4% of households headed by women aged 59+ cannot receive medical care, purchase medicines and

69 www.moz.gov.ua, 2015

70 Explanatory note to the draft Law of Ukraine "On Assisted Reproductive Technologies". https://moz.gov.ua/uploads/ckeditor/.pdf

71 Population's self-perceived health status and availability of selected types of medical aid in 2017 (household sample survey conducted in October 2017). Statistical book. The State Statistics Service of Ukraine. http://www.ukrstat.gov.ua/

medical supplies.[72] Given that the age group of 50 to 69 years in Ukraine is dominated by women, they represent a risk group in terms of getting timely and qualified care.

*Women with disabilities also face obstacles to receiving medical care*. 2.8 million people with disabilities live in Ukraine, including more than 1 million women of working age. Only about one-third of them have a job, while others need employment. 65% of women with disabilities visit a doctor less than once a year, 11% self-medicate, and 76% cannot visit a gynaecologist simply because the doctor's office is above the ground floor and there is no elevator in the building.[73]

*The number of single mothers and fathers raising children with disabilities grows every year in Ukraine*. There are more than 162,000 single mothers and fathers with children with disabilities in the country,[74] and the number of such mothers is almost 9 times higher than the number of fathers. For example, in the Bakhmut community there were almost 396 children with disabilities, 70 of whom are raised by single mothers and 9 by single fathers.[75] Nonetheless, such data do not reflect the full picture, because a woman who gave birth to a child in marriage and then divorced is not considered a single mother by law.

## "GENDER MEDICINE" AND GENDER-SPECIFIC HEALTH FEATURES

From a gender perspective, gender-specific features of diseases are important for identifying the different health needs of women and men, as well as finding ways to meet those needs. Such special needs of men and women are considered by gender medicine, which shows that, in addition to external differences in the structure and functioning of the reproductive systems of the male and female body, there are also gender characteristics of the origin[76] and development, as well as prevention and treatment of "identical" diseases.

*Morbidity and mortality from malignant neoplasm*. Women are at higher risk of getting one of the cancers compared to men.[77] In recent years, the share of women in the total number of patients with a newly diagnosed malignancy was 52-53%. 52.3 thousand male and 57.4 thousand female patients of this kind were registered in 2020. A significant proportion of all cases occur in women aged 35-49 – the most productive age in social, economic and societal terms.

72 Population's self-perceived health status and availability of selected types of medical aid in 2019. The State Statistics Service of Ukraine. http://www.ukrstat.gov.ua/

73 Annual report of Ukrainian Parliament Commissioner for Human Rights. On observance and protection of human rights and freedoms of citizens of Ukraine. 2020. zvit_za_2019.pdf (dpsu.gov.ua)

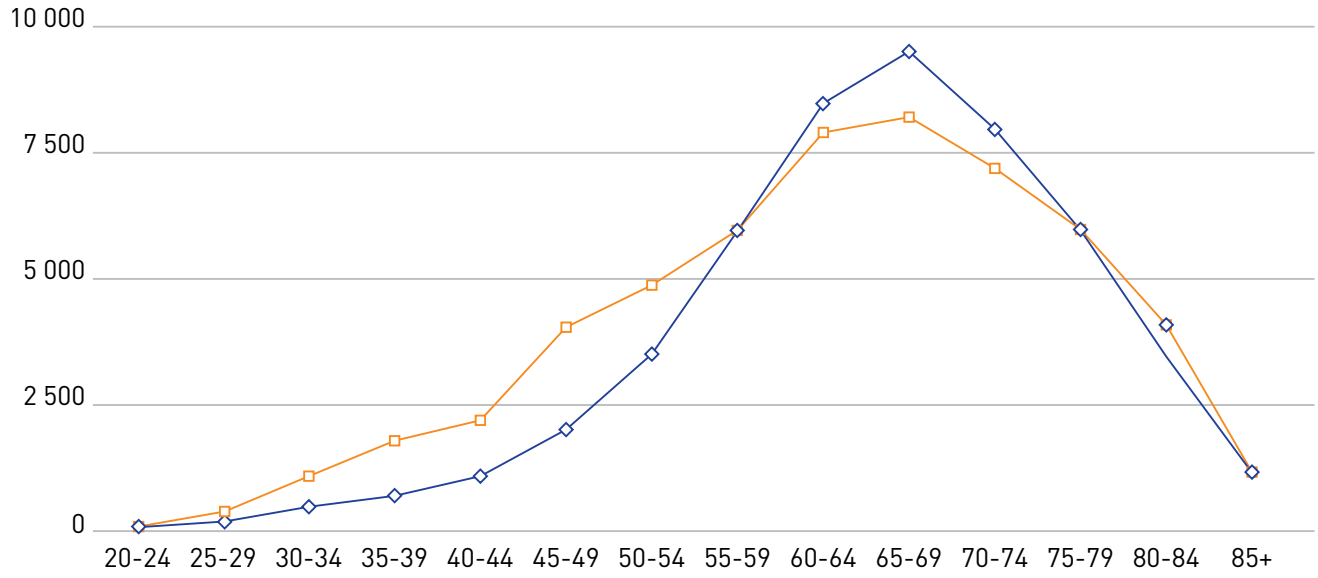
74 Verkhovna Rada of Ukraine. Parliamentary hearing on the prevention and response to discrimination against women from vulnerable social groups, http://static.rada.gov.ua/zakon/new/par_sl/sl1010118.htm

75 Lonely upbringing: why do men abandon families with seriously ill children?https://bahmut.in.ua/novosti/v-artemovske/3230-odinoke-vikhovannya-chomu-z-rodin-vazhkokhvorikh-ditej-idut-choloviki

76 Age and Gender Variations in Cancer Diagnostic Intervals in 15 Cancers: Analysis of Data from the UK Clinical Practice Research Data link. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0127717

77 Obviously, many of these diseases have a "natural" female specificity, which further emphasises the task of protecting the health of women

**Malignant neoplasm, by gender and age,** person




*COVID-19*. Women represent 60% of people diagnosed with coronavirus. At the same time, mortality from this disease is higher among men, compared to women (53% and 47%, respectively). This is explained by the peculiarities of both physiological and behavioural nature.[78]

*HIV/AIDS*. The sixth stage of HIV development, which began in 2020, is currently underway in Ukraine. This stage is closely associated with the COVID-19 pandemic caused by SARS-CoV-2 and is characterised by reduced access to HIV services (primarily testing) due to lockdowns, as well as conversion of many health facilities into hospitals providing care to COVID-19 patients. As a result, the number of persons tested for antibodies to HIV, compared to 2019, decreased by almost a quarter from 2.5 million to 1.9 million.[79] Most HIV-positive people had limited access not only to inpatient but also to outpatient care due to heavy involvement of infectious disease specialists in infectious diseases hospitals. All these factors could not but affect the development of the epidemic. The negative consequences will be felt later, primarily manifesting themselves in the growth in new HIV cases and the deterioration of the clinical course of the disease in HIV-positive people.

*Medical Gaslighting.* Modern European research operates the term "medical gaslighting"[80] that describes the situations where health workers underestimate or explain symptoms with non-medical or emotional reasons that make people doubt themselves or think they are exaggerating. Medical gaslighting delays the correct diagnosis, which, in turn, delays appropriate treatment. According to sociological studies, medical gaslighting is more common in relation to women than to men.[81] When this problem with diagnosis surfaced in Europe thanks to the attention from women's rights movements, it resulted in changes in approaches to learning and updated protocols, so that women's symptoms that are different from men's were finally taken into account in practice and were no longer considered "atypical".

78 Crises Collide: Women and Covid-19. Examining gender and other equality issues during the Coronavirus outbreak. Women's Budget Group, April 2020. - p.7. https://wbg.org.uk/wp-content/uploads/2020/04/FINAL.pdf

79 National evaluation of the HIV/AIDS situation in Ukraine. Public Health Centre, 2021. https://phc.org.ua/sites/default/files/users/user90/Natsionalna_otsinka_sytuatsyi_z_VIL_SNIDu_v_Ukraini_na_pochatok_2021.pdf

80 Medical Gas lighting. How to Recognize It and What You Should… | byDiannaCarney | ILLUMINATION | Medium https://medium.com/illumination/medical-gaslighting-3c7d6c4de00a

81 Paige L. Sweet. The Sociology of Gas lighting. https://www.asanet.org/sites/default/files/attach/journals/oct19asrfeature.pdf

According to statistics, men are twice less likely than women to visit doctors, which is confirmed by statistics on the payment for outpatient care.[82]

## GENDER POLICY AT THE COMMUNITY LEVEL

The process of transferring the property previously jointly owned by villages, towns and liquidated rayons from the district to the community level is currently underway in Ukraine; at the same time, local communities are launching primary and secondary care services. Every community, every hospital is now self-governed and autonomous. According to the Deputy Minister for Communities and Territories Development, 95.5% of facilities were handed over to communities as of 6 February 2022. These include primary and secondary care facilities. The government also proposed to transfer funding of 29 facilities under MoH – including hospitals with highly specialised services (radiation protection, telemedicine) – from the state to local budgets.

Gender equality policy is formulated at the national level but implemented at the regional level. Decentralisation reform provided communities with broader powers, allowing them to independently determine the direction of their economic and social development, provide relevant services, study and respond to the needs of their residents – women and men from different social groups.

As a result of decentralisation reform, local governments can now use gender analysis tools, including analysis of service accessibility for women and men, gender sensitive strategic planning, and gender responsive budgeting that require gender disaggregated data. It is clear that this would help address the differences in the needs of women and men and better meet them through local programmes, but at the moment there is a lack of knowledge that does not allow broad use of these tools.

Along with the progress in implementing gender policy in "older" communities, there are also challenges that are typical of the newly created communities. These include organisational and, above all, financial challenges related to the lack of capacity to work on gender issues, as well as limitations of local budgets in further support of institutions that can be financed from the state budget subvention to create a network of specialised support services for women.

82 See Section 3

III

# SOCIOLOGICAL DIMENSION OF GENDER ASPECTS OF HEALTH SERVICES

Gender-specific health issues are attracting attention and are increasingly the subject of public debate. Given the complexity and ambiguity of socio-economic, demographic and other processes and their questionable impact on men and women, such attention is quite logical.

The goal of the survey was to investigate whether there were any gender biases in healthcare that could potentially affect the general health of the population.

## OPINION OF CITIZEN[83]

### SOCIO-DEMOGRAPHIC PORTRAIT OF RESPONDENTS

The study was carried out in all regions of Ukraine in urban and rural areas, excluding Crimea and the occupied areas of the Donetsk and Luhansk regions, using a formalised face-to-face interview. 2018 citizens of Ukraine aged 18+ were interviewed, including 1,089 women and 929 men. The benchmark for the selection of demographic characteristics was the documents of state statistics that helped formulate a representative sample.

### ASSESSMENT OF OWN HEALTH

54.7% of adults in Ukraine describe their health as good and 18.5% as very good. 18.7% consider their health weak. Women are less positive about their health compared to men. The most significant differences in health assessment are age-related. Subjective assessment of own health worsens with age.

Men tend to assess their health better despite being less likely to adhere to healthy lifestyles. 25.3% of men consider their health to be very good, compared to 12.9% of women. Meanwhile, more women view their health as poor (20.9% vs. 16% of men). The lowest assessment of own health is found in women of the oldest age groups.

Younger age group (18-35 years) gives the highest rate to its health status, as 46.7% of men and 31.8% of women assess their health as good. Speaking of people of 56 and older, only 5% of men and 2.9% of women report having good health. Among women, assessment of own health depends on the place of residence. 14.4% of women living in urban areas consider their health to be better, compared to 9.9% of women living in rural areas.

Men smoke twice as much as women and tend to drink more. At the same time, only 29.8% of men admit the existence of chronic diseases, compared to 43.6% of women.

### ACCESSIBILITY AND QUALITY OF HEALTH SERVICES

When assessing the accessibility and satisfaction from health services, both men and women tend to give medium grades. For example, accessibility scored 6.5 and 6.2 points in men and women, respectively. Similarly, quality scored 6.3 and 6.1 points. The survey found no significant differences in the assessment of quality and accessibility of health services by place of residence.

The accessibility assessment is directly affected by the respondents' age and their financial status. The highest level of satisfaction is found in men (7.1) and women (6.81) aged 18-35. The lowest level is shown by the age group of 56 years and older – men (5.86) and women (5.43).

83 The survey was carried out on 3-8 December 2021 in all regions of Ukraine, excluding Crimea and the occupied areas of Donetsk and Luhansk oblasts. 2,018 respondents aged 18+ were interviewed. Theoretical sample error does not exceed 2.3%

It should be noted that about 22,700 villages and townships in Ukraine have, at best, only health posts (so-called FAPs) with a minimum set of medicines and equipment for primary healthcare. In order to undergo a full examination and treatment or visit a specialist, a person must go to the rayon or oblast hospital. Health reform is aimed, among other things, at improving the quality of healthcare in rural areas at the primary level. The reform implies signing an agreement with a doctor for the provision of health services, which requires at least a computer with Internet access to enter the person's data in the database. Funds allocated from local budgets for medicine are often only enough for minor repairs and basic necessities. There is a shortage of doctors, who are mostly concentrated in oblast and rayon centres or serve residents of several villages.

Nonetheless, rural residents, both men and women, assess the accessibility and satisfaction from health services slightly better than urban residents. Such accessibility and quality assessments of healthcare can be explained by subjective perceptions, as the quality of health services in cities is objectively much higher.

## GETTING MEDICAL CARE

The average level of satisfaction with doctors is quite high, and even slightly higher among men. Also, the satisfaction of men and women living in cities is lower compared to rural residents.

When visiting a doctor, 49% of women and 47.7% of men report receiving enough information to make informed decisions about their health and treatment. 37.5% of women and 27.4% of men consider such information insufficient. 7.5% of men and 5.5% of women from older age group claim not to receive any information at all to make informed decisions about their health and treatment.

Women are more likely to undergo medical examinations and seek medical assistance. Instead, men are more likely to delay a visit to the doctor in case of symptoms. 17.2% of men have not seen a doctor for a long time, compared to 6.8% of women. Middle-aged men particularly decide not to visit doctors. People with low levels of education are more likely to avoid examinations.

Women are much more likely than men (the difference is more than 10%) to seek assistance from both general practitioners at primary care level and narrow medical specialists in the case of exacerbations / health problems. Instead, 15% of men did not go anywhere at all in case of health problems compared to 6% of women.

The vast majority of men and women use state medicine. Specifically, 73.1% of women and 61.7% of men go to a general practitioner, therapist or family doctor at a public clinic; 27.3% of women and 18.5% of men go to a specialist. Only 8.4% of men and 7.9% of women turn to private doctors. Women are much more likely than men to use the services of a private specialist (10.3% vs. 6.5%).

Also, women tend to trust the so-called alternative medicine and traditional healers more than men. The study does not specify the reasons for turning to alternative medicine.

8.1% of men living in rural areas versus 6% of those living in cities engage in self-medication; the same is true for women (5.9% and 4.1%, respectively). The analysis of age-specific data shows that self-medication is most popular among men of 35-55 years and women of older age groups (7.8% and 5.8%, respectively).

Among rural residents, only 5.2% of men and 3.9% of women sought non-dental care at a private clinic. Meanwhile, urban residents in need of medical care were much more likely to use paid health services (10.1% of men and 9.7% of women, respectively). Regardless of gender and place of residence, paid services are most popular with young and middle-aged Ukrainians.

The main reasons for not seeing a doctor if necessary is the same for women and men. 29% of women and 20% of men know how to treat themselves; 26.4% of women and 22% of men do not consider their diseases serious. 12% of men and women alike simply do not trust doctors.

## CARE AND UNEQUAL DISTRIBUTION OF UNPAID WORK

Only 7% of couples with minor children equally share their childcare responsibilities. In other married couples, only 3% of men accept the duty of taking a child to the doctor if necessary. In most cases, the responsibility for caring for minor children in married couples lies with women.

When answering the clarifying question of why a woman (or a man) in the couple is taking a child to the doctor, the distribution of answers is almost even for both women and men. 55.4% of women and 56.1% of men answer that the one who has more free time takes the child to the doctor. 38.2% of women and 33.7% of men agree that this is done by the one who is more versed in childhood diseases. 22% of men and women believe that a woman should be responsible for a child in a married couple, because it was decided so in a family. Instead, the family's decision about a man taking a child to the doctor was found in less than 1% of married couples.

## DOCTOR-PATIENT RELATIONS

The study addressed the issue of "medical gaslighting", in particular the relations between doctors and patients of both genders. Disrespectful behaviour on the doctors' part was rare for both men and women, but there were isolated cases of disregard, contempt and refusal of treatment.

The study found no significant gender differences in doctors' attitudes toward patients. If the respondents (both male and female) ever encountered a disrespectful attitude on the part of the doctor, this equally applied to men and women.

48.9% of men and 41.1% of women were never dissatisfied with the doctor, either male or female. Women are more likely to have a negative experience of communication with female doctors – 15.8% of women and 10.6% of men reported female doctors' unpleasant behaviour. Similar behaviour on the part of male doctors was reported by 4.4% of men and 6.9% of women. At the same time, almost equal shares of men (23.2%) and women (24.7%) experienced disrespectful doctor's attitudes regardless of their gender.

78.4% of men and women don't really care who receives a patient – a male or female doctor. Only 11.6% of respondents preferred women, and 6.3% - men. Also, 17.1% of women noted that it would be better for them to see a female doctor. 3.5% of women and 2% of men have less trust in female doctors and their recommendations; similarly, 5% of women and 1.5% of men do not trust medical examinations conducted by male doctors.

## GENDER PECULIARITIES OF A HEALTHY LIFESTYLE

83.2% of women and 76.1% of men want to have a healthy lifestyle. Also, 44.8% of women and 37.8% of men associate a healthy lifestyle with having money; 30% of men and women are ready to have a healthy lifestyle only if they have more free time. 15.6% of women and 13.7% of men will embrace a healthy lifestyle upon medical indicators. Men, especially under the age of 35, go in for sports more often both at home and outside the home. Men also prefer sports sections and professional facilities.

18.8% of men and 13.2% of women have never had a primary medical examination; 30.3% of men and 23% of women have never had a cardiovascular examination; 67.3% of men and 55.4% of women

have never taken cancer screening. 35 % of women have never had a mammogram.

Speaking of the reasons affecting the irregularity of preventive medical examinations, 50.1% of men and 37.9% of women mentioned the absence of health problems. A quarter of women (24%) reported having no money for such preventive examinations. For men, the lack of money to undergo medical examinations is a much smaller obstacle (14.4%).

According to women and men alike, the main responsibility for one's own health lies with an individual (60.4%) and is affected by the low standard of living in the country (43.9%). One-third of men and women believe that the state does not pay enough attention to healthcare. 5.5% of men and 6.1% of women indicate the absence of preventive medicine in the country.

Giving up bad habits (53.9%) and following a healthy lifestyle (50%) are the most important preconditions for maintaining good health, according to both men and women. For 54.8% of women and 49.6% of men, it is important to have enough money for a healthy diet and the ability to lead a healthy lifestyle. Compared to men, women place more emphasis on regular diagnosis of health (36.5% vs. 29.5% for men) and consultation and treatment with a qualified physician (36.5%).

## REPRODUCTIVE HEALTH[84]

Not only are women more concerned about their own health, but they are also more aware of reproductive health. 78.4% of women and 67.4% of men know what reproductive health is. The awareness is influenced by age. Therefore, the least knowledgeable are men of the older age group (60.2%), and the most knowledgeable are women under 60 (81.8%). Also, higher level of education means better awareness (from 57.5% among those with secondary or incomplete secondary education, to 85.1% among people with higher or incomplete higher education).

Awareness of all aspects of women's and men's reproductive health ranges from 54% to 80%. It is higher among younger and middle-aged respondents compared to older respondents, and also increases with their educational level.

Speaking of reproductive health, men mostly lack information about safe pregnancy, childbirth, survival and health of the child (23%), maternal well-being (20.6%), family planning capabilities and prevention of unwanted pregnancies (17.5%). This lack of information is especially characteristic of men of the older age group.

Men's inattention to own health is also reflected in the fact that they almost never use reproductive health services, regardless of age. Among men of reproductive age, only 3.3% regularly use such services. For comparison, 15.8% of women aged 18-35 and 13.3% of those aged 36-55 turn to reproductive health services.

The study found no statistically significant differences in the level of reproductive health use between urban and rural residents. People with secondary or incomplete secondary education (78.1%) and secondary special education (77.1%) are more likely to avoid these services compared to people with higher or incomplete higher education (62.6%). Also, the use of reproductive health services decreases with the level of well-being: the share of non-users increases from 67.6% among those who "live well" to 91.2% among those who "barely make ends meet".

84 According to the World Health Organisation, reproductive health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so

The difference in intentions to use reproductive health services in the future depending on age is much more pronounced among women than among men. 57.7% of women aged 18 to 35 are planning to use such health services compared to only 10.0 % of women aged 56+. The shares of men in respective age groups are 28.0% and 6.1%.

The practice of talking with children and grandchildren about reproductive health has not become widespread. 32% of women and 37% of men never raised the issue with their children and grandchildren. 25% of women and 21% of men believe that children (grandchildren) know more about reproductive health, and only 6.2% of women and 2.5% of men communicate with their children (grandchildren) on this topic. Conversations with children about reproductive health are most common in the middle age group (35-55 years), where many respondents talk about it often (8.2%) or rarely (19.8%). Such communications depend on educational level – men and women with higher education are likely to discuss these issues with their children (grandchildren) more often.

14% of women and men who have children or grandchildren of school-age believe that they talk enough about reproductive health at school. Women are generally unhappy with the extent to which children are taught about reproductive health at school. 12% of women and 8% of men agree that at school they hardly talk to students about reproductive health. Almost half of women and men (40.9% and 51.7%, respectively) who have children or grandchildren of school age have no idea whether they talk enough about reproductive health at school. Almost one in five women of childbearing age who has a child knows nothing about whether reproductive health is included in the school curriculum. The level of awareness among men is even lower.

## ATTITUDE TO FAMILY PLANNING AND THE USE OF CONTRACEPTION

Attitudes toward termination of pregnancy are generally positive. Only 9.1% of women and 12.4% of men believe that abortion without medical indications should be prohibited. The most conservative in this regard are men (16.5%) and women (13.1%) of the older age group. The level of abortion rejection is particularly high among men living in rural areas (20.4%). The smallest share of those who support the ban on abortion (4.7%) was found among young girls. 24.3% of men and 21.9% of women believe that abortion can be allowed only in certain situations such as medical indicators or cases of rape. Older people (14.4%) are somewhat more in favour of a total ban on abortion.

Compared to the country average, residents of the western region, are more likely to support a total ban on abortion (19.2%) and to believe that abortion can be allowed only in certain situations, including on medical grounds or rape (36.0%). With lower educational level, the respondents increasingly support a total ban on abortion. The share of such respondents increases from 7.5% among those with higher or incomplete higher education, to 15.8% among those with secondary or incomplete secondary education.

One-third of women (31.6%) believe that a woman herself has the right to decide whether to have an abortion or not. Among men, only 16% are ready to agree that abortion is purely the woman's right. Also, 52.5% of women and 63.6% of men believe that both a man and a woman together should decide on unwanted pregnancies.

42% of men and women have full access to contraceptives. Contraceptives are not available for 2.3% of men and 1.9% of women. 3.4% of men and 4.4% of women reported some restrictions on access to safe and effective family planning methods, with more limited contraceptive use in rural areas.

There is a significant difference in accessing safe and effective family planning methods for women and men of the youngest age group – 70.6% of women and 57.5% of men have full access to safe methods.

77% of men and women believe that the responsibility for preventing pregnancy lies equally with both partners. Meanwhile, women are slightly more likely than men (12.1% and 9.2%, respectively) to say that women bear the primary responsibility for preventing pregnancy. Compared to respondents with secondary special or higher education (10.1% and 9.1%, respectively), people with low education (e.g., not higher than the general secondary level – 15.0%) are more likely to place the responsibility on women.

71.0% of women and 75.3% of men at least occasionally use contraceptives to prevent unwanted pregnancies. 18.6% of men and 21.5% of women have never used any method of contraception. The level of contraceptive use depends on age, education, income and type of settlement (urban or rural).

Respondents, especially men, report some difficulties in obtaining advice on the use of methods of contraception. 49.4% of women and 73.8% of men (themselves or their partners) received no counselling on contraception. Similarly, rural women (55.8%) are less likely to receive such counselling than their urban counterparts (46.3%).

Most women (33.8%) receive counselling mainly in antenatal clinics. Consultations in the OBGYN's office of the polyclinic are more popular with urban residents (13.8%) than with women living in the countryside (6.5%).

Women are generally positive about the quality of contraceptive counselling, especially regarding modern methods. 50% of women confirm receiving useful advice from a doctor and having comprehensive information about modern medicines. Men are significantly less likely to seek professional counselling, and only 31.4% of them are satisfied with the level of counselling on the use of modern contraceptives. 11% of women and 8.8% of men faced situations when a doctor recommended a specific expensive drug. The latter are more offered to urban (48.0%) than to rural residents (37.9%), and to younger men and women.

The most common method of contraception for men and women is a condom, as indicated by 49.3% of men and 29.3% of women, referring to their sexual partners. The second most popular method with respondents is a withdrawal method – its use was reported by 6.8% of women and 6.5% of men. The third method is the IUD[85] use, as reported by 6.0% of women and 1.6% of men. Only 14.1% of women use and 11.6% of men report the use of hormonal contraceptives to prevent pregnancy.[86]

The most common reason for non-use of contraceptives (except for the absence of sex life) is the partner opposing the use of contraception (3.7%). Also, 2.4% of men and 1.9% of women do not use contraceptives due to their religious beliefs. 5.3% of men and 3.5% of women mention their willingness to have a baby as an argument for refusing to use contraceptives.

85 Intrauterine device

86 Male oral contraceptives exist, but most of these drugs are currently in various stages of development. There are drugs that affect hormones, thus preventing sperm from maturing. Other male oral contraceptives may, for example, inhibit the sperm production itself, leading to temporary infertility. However, male oral contraceptives are less common.

### ACCESSIBILITY AND QUALITY OF CHILDBIRTH-RELATED HEALTH SERVICES

The accessibility and quality of childbirth-related health services, services in the prenatal and postnatal periods, as well as the quality of necessary information provided to women during and after the childbirth are highly or very highly appreciated by women and men. The evaluation ranges from 44% to 56%.

Births with partners[87] are gaining popularity and importance. Almost one-third of men and women among those who (or whose wife or partner) have given birth in the last 3 years have had such an experience. So far, this opportunity is only available to couples living in the city. No respondent from the rural area has had an experience of birth with partners. Also, given only recent popularity and spread of this practice, it is natural that the presence of a man at childbirth was only mentioned by respondents from the younger age group.

91.8% of women and 94.7% of men confirm the absence of cases of rude treatment, physical violence, coercion, medical actions without the patient's consent during childbirth and stay in the maternity hospital (ward). However, 8.2% of women and 5.3% of men (their partners) experienced rudeness. Cases of such ill-treatment are more common in city hospitals. Not a single surveyed woman living in a rural area mentioned coercive or disrespectful actions by medical staff during childbirth and when in the maternity hospital.

## OPINIONS OF HEALTH WORKERS[88]

### ACCESSIBILITY OF HEALTH SERVICES

74.6% of health professionals consider the accessibility of health services for men and women as equal for both genders. 79.7% of doctors also confirm that the needs of men and women are equally taken into account in the provision of health services in Ukraine. Also, 86.4% of doctors deny different approaches to the provision of emergency medical care to men and women. The only difference in such approaches concerns pregnancies.

Speaking of the lack of access to health services for citizens of Ukraine, health workers mention financial incapacity to pay for such services (81.4%), the absence of necessary specialists in the area (62.7%), and poor quality of services in Ukraine (52.5 %).

When asked about unequal access to healthcare for men and women, 18.6% of health workers explain it by widespread social stereotypes that prevent men from seeking medical attention, and 13.6% mention differences in the income level of men and women.

### GENDER-SPECIFIC AGGRAVATION[89]

Women generally assess their health condition worse than men.40.7% of health workers explain this by the fact that women pay more attention to their health, undergo diagnosis more frequently, and therefore are better aware of their diseases.

87 Childbirth in which, in addition to obstetricians and doctors present in the delivery room, there is a person(s) who helps and supports a woman in labour. The main task of such a birth partner is to create psychological and physical comfort, providing both physical and moral support

88 Expert survey was carried out from 25 January through 7 February 2022, involving 59 experts – primary care physicians and specialists working in rural and urban health facilities

89 Aggravation is an exaggeration of any symptom or disease by patients

Both female and male patients tend to exaggerate the symptoms by attributing diseases or morbid conditions that are not really present. Many health workers have seen cases of exaggeration of symptoms, attribution of illness or alleged morbid conditions both in women (62.7%) and in men (45.8%).

65.8% of health professionals take into account women's exaggeration of their medical condition when prescribing treatment and 71.4% of health workers do the same in relation to male patients.

### COMPETENCES OF HEALTH WORKERS

Health workers need to improve their knowledge about providing services to people living with HIV/AIDS (52.5%), persons with mental illness (50.8%), members of the LGBTI+ community (39%), pregnant women (35,6%), people with disabilities (27.1%), elderly men and women (11%).

### ENCOURAGING MEN TO USE HEALTH SERVICES

Risks of premature death among men are primarily related to their lifestyle (61%), insufficient attention to existing diseases (42.4%), peculiarities of men's typical occupations (42.4%), and insufficient attention to preventive measures 37.3%).

Measures to encourage men to actively seek medical care include annual preventive screenings and scheduled examinations (13.6%), awareness raising work with the population (11.9%), provision of free services (10.2%).

Men are less likely than women to follow doctors' advice on prevention (screenings, regular check-ups, etc.) and doctors' recommendations.

### HEALTHY LIFESTYLE

According to health workers, there are no particular differences in motivating women and men to lead a healthy lifestyle. Some factors, however, are still more important for women, such as the need to be more careful about own health (3.4%), greater burden associated with a woman's family responsibilities (3.4%), greater propensity of men to active leisure time (1.7%).

The main factors that will motivate citizens of Ukraine – both men and women – to lead a healthy lifestyle include higher income (72.9%), healthy lifestyle promotion and its prestige, including through the media (61%), healthy lifestyle promotion at the workplace by employers (52.5%), growth of the network of sports clubs, arenas, and playgrounds (45.8%).

### "MEDICAL GASLIGHTING" IN RELATION TO PATIENTS

Health professionals of both genders generally admit the existence of contempt and insult, breach of confidentiality, involuntary treatment, denial of the right to make independent decisions, non-compliance with the principles of voluntariness and informed consent. Specifically, health workers acknowledged cases of contempt and insults towards women (8.5%), non-compliance with the principles of voluntary and informed consent (6.8%) and physical violence (3.4%). The most common violation with regards to men is involuntary treatment (8.5%).

### SEXISM AND DISCRIMINATION IN HEALTH FACILITIES

Cases of discrimination and sexism sometimes occur in Ukrainian health facilities, against both men and women. The most common examples involving women include lower wages[90] (25.4%),

90 The principle of equal pay for equal work generally applies in Ukraine, but women are more likely to hold lower-paid positions

inappropriate jokes (13.5%), lack of formal employment contracts (10.2%), and problematic access to management positions (27%).

## GENDER-DIFFERENTIATED STANDARDS

The introduction of gender-differentiated drug prescribing standards is not popular in the medical community. Only 20.3% of health workers support the introduction of such standards. Gender sensitive organisation of preventive measures, including in reproductive health, needs to be reinforced.

## REPRODUCTIVE HEALTH

The main problems of ensuring the reproductive health system in Ukraine include insufficient funding for health services for the prevention and treatment of various reproductive health issues (72.9%), inadequate access to quality reproductive healthcare regardless of the patient's social and economic status (52.5%), shortcomings in overall organisation of health system (45.8%) and the lack of qualified medical staff with relevant specialisation (40.7%).

# CONCLUSIONS AND RECOMMENDATIONS

**The conclusions and recommendations of this study summarise the identified gender gaps related to the provision of health services or their usage by women and men. Given that a broader understanding of gender is more than just parity between men and women, the study also looked at other factors that determine the availability of health services to population groups that may have socio-economic vulnerabilities, including the elderly and people living in rural areas. The gender gaps identified in most cases relate to the level of awareness of women and men on various issues, from access to healthcare or attitudes towards their health.**

**The vast majority of these gaps are caused by a lack of gender sensitivity among healthcare workers, including at the managerial and political levels, and gender stereotypes and prejudices that determine the behaviour and attitudes of women and men. The recommendations are structured by topic and can be integrated into strategies, action plans, local development programs, and other documents at the national and local levels. The recommendations can also be used by NGOs working in the medical field and gender equality to sensitise their projects and respond to the needs of patients and healthcare workers.**

**GENDER EQUALITY IN HEALTHCARE IS OFTEN INTERPRETED PURELY FORMALLY:** as the equality of citizens of different sexes to exercise their rights to healthcare, enshrined in law. At the same time, considering the identified experience of patients, to determine the needs of women and men in health services, an approach based on the epidemiological profile is used, rather than the one based on the specific needs of women and men from different populations groups. To better address the needs in healthcare services, an in-depth gender analysis is needed to identify gender gaps in access to healthcare. Unequal distribution of household responsibilities, including caring for the sick and elderly, should be taken into account, as it increases the burden on women, augmenting the share of unpaid work and reducing earnings and access to healthcare as a result. Given that many payments come directly from patients' pockets, this raises the issue of access to healthcare for women, the elderly, and low-income groups. Therefore, it is essential to continue looking for and implementing solutions that would improve the actual access to healthcare for everyone.

**LEGISLATION GOVERNING HEALTHCARE REMAINS GENDER-BLIND MAINLY.** Although Ukraine's public policy is based on international documents signed by Ukraine, the existing policy papers do not fully consider the gender aspect. The insufficient practice of collecting data disaggregated by sex in consideration of other personal characteristics (age group, disability) hinders further gender sensitization in the healthcare sector. The availability of such data will allow conducting a comprehensive assessment of the nation's health, identify gender gaps, and better satisfy the needs in healthcare services. Data collection and analysis will also allow for a fair distribution of budget resources, taking into account the current needs of women and men. Experience with gender mainstreaming gained from EU countries, UN agencies, and international organisations should be used to sensitise NGOs in healthcare. It should be noted that the country has not yet approved the State Program for Reproductive and Sexual Health, which would define targeted measures and budget funds to be provided for the provision of preventive and curative services, and information activities to support reproductive health.

**A NOTABLE CHARACTERISTIC OF UKRAINE'S MEDICAL SECTOR WORKFORCE IS A GENDER IMBALANCE.** Even though most health workers are women (80% of primary care physicians and about 90% of nurses), they are disproportionately represented in healthcare decision-making as men occupy most management positions. It is necessary to introduce changes to promote women in leading roles in the medical field, from the management of medical institutions to higher levels of government in the Ministry of Health of Ukraine, to achieve gender equality.

**THE ABSENCE OF LEGAL BARRIERS OR DISCRIMINATORY DENIALS OF THE PROVISION OF MEDICAL SERVICES TO WOMEN AND MEN DOES NOT MEAN EQUAL ACCESS TO THEM.** Almost a third of Ukrainians did not visit doctors due to lack of funds, inability to get to the hospital, and distrust of doctors. Access to healthcare is equally difficult for men and women, but socially vulnerable groups - people with disabilities, the elderly, women, and girls living in remote rural areas - have fewer opportunities to overcome these factors. Given the medical infrastructure destroyed in the war in many places, especially in rural ones, building medical clinics and logistics systems from settlements to medical facilities should be a priority. While rebuilding destroyed infrastructure and improving existing ones, it is essential to apply principles of gender-responsive budgeting and consider the needs of women and men with disabilities as medical experts confirmed the lack of competencies and special equipment to provide services to patients with various disabilities. Building an effective information campaign for improving the level of trust (12.3% of respondents did not seek medical care because they do not trust doctors) between patients and doctors requires first identifying the causes of women and men of different ages from different parts of the country leading to the distrust of the system.

**THE LIFE EXPECTANCY GAP BETWEEN WOMEN AND MEN HAS A CLEAR GENDER COMPONENT.** Men are more prone to bad habits, less likely to see a doctor, especially for preventive purposes, and more likely to begin treatment in later and more severe stages of a disease. To reduce the gap in life expectancy, it is critical to combat existing gender stereotypes in society, such as men having to endure pain, risky behaviours that increase the level of trauma, or the fact that a man's visit to a doctor may be perceived as a weakness. At the same time, it is necessary to increase the awareness level of both men and women, but mostly men, on the issues of taking care of their health: giving up bad habits, regular preventive medical examinations, and healthy eating. In addition to national and local information campaigns, educators need to involve doctors who have direct contact with patients, as they can communicate information directly to men or through their partners.

**PUBLIC AWARENESS OF SEXUAL AND REPRODUCTIVE HEALTH IS INSUFFICIENT.** Women are more aware of these issues than men and more likely to use reproductive health services. However, most women and a critical majority of men have not used these services in the last five years. Improving women's and men's understanding of the need for regular check-ups of the reproductive system should be a key component of efforts to reduce male and female infertility. Events such as Men's and Women's Health Months, organised at the national or local levels, will help promote preventive care for one's reproductive health. Particular

attention should be paid to engaging and creating conditions for vulnerable groups - men, women, girls, and boys with low incomes, men and women with disabilities, rural residents, and representatives of the Roma community.

**ACCORDING TO THE STUDY, THE AVAILABILITY OF SAFE AND EFFECTIVE FAMILY PLANNING METHODS FOR WOMEN AND MEN IS HIGH.** The vast majority of women and men use barrier methods of contraception. Less than 2% of the population choose modern methods of contraception, such as hormonal pills. Primary care physicians, such as the ones visited by the vast majority of the people, should have sufficient knowledge to inform patients about existing methods of contraception and their effectiveness and advise further consultation with specialists on the specifics of their use. It is especially true for rural residents, where the source of verified medical information is limited to family doctors and paramedics. Not only do young people need additional information, but also informing older women and men about safe sex should not be overlooked. Particular focus should be placed on raising awareness of contraceptive methods, safe and effective contraception, and personal responsibility for family planning, especially among men who are currently transferring it to their partners.

**MEN'S EDUCATION ON SAFE PREGNANCY AND CHILDBIRTH, CHILD SURVIVAL AND HEALTH, MATERNAL WELL-BEING, AND PREGNANCY PLANNING REMAINS LOW.** Some women, in turn, also report a lack of knowledge on these issues. Increasing men's awareness of pregnancy and childbirth will increase the safety of women during pregnancy and foster healthy partnerships and greater involvement of men in caring for the child in the future. In turn, partner births are gaining importance among the population, although only women and men from urban areas had similar experiences in this study. Attention should also be paid to counteracting and eradicating ill-treatment, physical violence, coercion, and medical action without the patient's consent, which, although rare, are still happening in medical practice.

**SEX EDUCATION IS AN ESSENTIAL FACTOR IN SHAPING GIRLS' AND BOYS' ATTITUDES TOWARD THEIR HEALTH.** The level of communication on reproductive health between adults and their children or grandchildren is low. Such issues include conception and birth of children, the possibility of sexual intercourse without the threat of sexually transmitted diseases, safe pregnancy, childbirth, survival, and health of the child, the well-being of mothers, the possibility of planning pregnancies, and prevention of unwanted pregnancies. Thus, girls and boys are more likely to receive information from unverified sources, which can be unreliable and biassed. The process of overcoming the barrier to intergenerational communication on topics that society considers "inconvenient" is a long one. At the same time, the education system has the opportunity to implement change faster and pay attention to comprehensive sex education in the educational process and extracurricular activities.

**IT IS VITAL TO PRIORITISE GENDER SENSITIVITY AND IMPARTIALITY TOWARDS ALL PATIENTS** (regardless of their gender, age, income level, vulnerability, and other factors) in deontology courses for physicians (advanced training) of medical staff and medical students. Relevant provisions of European practices and the experience of relevant public organisations may be helpful, as they have a high level of competence and the necessary flexibility to respond to the demands of the medical system. As isolated cases of distrust in patients' symptoms and various types of violence by medical staff have been identified, there is a need for internal information work with medical staff to combat violence and minimise internal gender biases of health workers.