Young Women's Health Priorities in Europe

INTRODUCTION

Gender equity is increasingly cited as a goal of health policy at national, European and international levels, as it is associated with a number of positive outcomes such as increased population health (King et al., 2018) and economic growth (Maceira, 2017). According to the WHO (WHO, 2022b):

Equality in health means that women and men have equal conditions for realizing their full rights and potential to be healthy, contribute to health development, and benefit from the results. Gender equity means fairness and justice in the distribution of benefits, power, resources, and responsibilities between women and men.

To work towards gender equity, it must first be recognised that women's health to date has not been allocated the same level of resources as compared to men's health; equal research has not been conducted on women's health issues; and women are notoriously under-represented in clinical trials. Thus, less is known about diseases that are unique to women; diseases that disproportionately affect women; and women's health in general. Women's anatomy and physiological processes differ compared to men's and thus drugs and treatments can have different interactions and outcomes in women's bodies. Women have different psychosocial needs and their experiences in healthcare settings can vary. They can face discrimination based on their sex and gender which can affect their health. Furthermore, uneven power dynamics between men and women have led to men exercising a level of control over women's health (Sen & Östlin, 2008).

The term 'young women' can encompass a broad and diverse group. For the purpose of this scoping review, 'young' will be defined as those in the 18 – 34 years age bracket. This range was chosen as it represents those who have entered adulthood and are often seen to be in relatively good health. It is often viewed as the prime of life and thus, the health problems, issues and topics relevant to this group are less often examined. Additionally, mortality can sometimes be utilised as a key indicator when assigning priority to various sociodemographic groups (Anikeeva et al., 2015; Saxena, 2018), and in this sense young people's health does not compare with that of children and older adults. 'Women' is used in this review to refer to all who identify as female. However, some results may also relate to those who do not identify as female but were assigned female at birth, and to those who have higher levels of female hormones.

This review will analyse young women's health priorities in Europe. The continent of Europe consists of 44 countries by traditional convention, the WHO considers 53 countries to be a part of the European Region, and the European Union is made up of 27 member states. The WHO definition of Europe will be used herein to allow the inclusion of as many voices as possible,

while covering a large area with much diversity and disparity. There are 749 million people in Europe, 52% of which are female (WorldOMeter, 2023). Around 156 million people are aged between 18 and 34 (Statista, 2023).

To better achieve equality in health, the gaps must first be identified. The purpose of this scoping review is to sum up the evidence surrounding young women's health in Europe so that the key issues and areas for action, as defined by women themselves, can be identified. These areas are further explored, and inequalities across European countries are discussed, as well as social factors and implications, and congruent policies or lack thereof.

METHODS

The following databases were searched: PUBMED; MEDLINE; EMBASE; CINHAL; and PsychInfo using key words such as women, health issues, perspectives, Europe and their variations and related terms. The inclusion criteria for this review was peer-reviewed articles published between 2000 – 2023, in English, with female participants aged 18 – 35, set in Europe. Articles that mostly included female participants in this age range as well as some outliers were included. Additionally, articles that discussed Europe together with other continents were included.

RESULTS

1,414 articles were extracted. Duplicates were removed and the titles and abstracts of the remaining articles were screened for the inclusion criteria. 26 articles were included in this review. The reference list of articles were scanned to identify other relevant articles, which were subsequently read and included in the discussion.

DISCUSSION

A broad range of topics regarding young women's health were identified from the literature. These were placed under five broad headings: non-communicable diseases (NCDs); mental health; sexual and reproductive health; gender-based violence; and access to healthcare. The current social, political and policy contexts were explored.

Non-Communicable Diseases (NCDs)

NCDs of the heart, lung problems, allergies, hypertension, back pain, arm pain, leg pain, stomach problems, skin conditions, headaches and cancer are more common in women compared to men across Europe (Huijts et al., 2017). Smoking, diet, physical activity and alcohol

all present as risk factors to particular NCDs such as cancer, lung problems and heart disease. Studies show that most female smokers in Europe (over 80%) begin smoking before the age of 20 (Oh et al., 2010). A group mentality was observed in the study by Oh et al. (2010), whereby most women took up smoking because their friends smoked. As smoking behaviours can differ between men and women, this information presents an important opportunity for health promotion and disease prevention. Study participants should be disaggregated by both gender and age to get a better understanding of how harmful behaviours can be reduced to lower the risk of NCDs.

Cancer

From this scoping review, it was apparent that cervical cancer is the most topical malignancy for this cohort through the number of articles identified on this cancer type. In Europe, approximately 33,000 women are diagnosed with cervical cancer annually and 15,000 die of the disease (Arbyn et al., 2020). Europe represents only 9% of the world's population, however, it is over-represented in cervical cancer prevalence, accounting for 23.4% of cancer cases (Arbyn et al., 2021). Eastern Europe has a higher incidence rate of cervical cancer compared to Western Europe (Jansen et al., 2021); Romania, Latvia, Lithuania and Bulgaria have the highest rates of cervical cancer mortality (European Commission, 2021).

Incidence, screening and HPV vaccination rates vary widely across Europe. Around 70% of cervical cancer cases are caused by HPV 16 and HPV 18 (European Commission, 2021). Awareness of HPV, the modes of transmission and its health effects should be appropriately communicated and discussed with both women and men, preferably during adolescence. However, this is not always the case. Both within and between countries there are disparities in knowledge around cervical cancer and the benefits of cervical screening (Jovanovic et al., 2017). Additionally, not all European countries conduct population-based screening (IARC, 2017). A socio-economic gradient is often observed with opportunistic screening compared with population-based screening, giving rise to health inequalities. This is important as lower socio-economic groups have a higher incidence of HPV (Walsh et al., 2011).

Taken together, a greater focus on cervical cancer prevention and diagnosis is needed for young women across Europe. Further research, intervention and sound policies are needed to eliminate cervical cancer in line with Europe's Beating Cancer Plan (EC, 2021).

Iron Deficiency Anaemia (IDA)

In Europe IDA is common in pregnant, non-pregnant and pre-menopausal women (Robalo Nunes et al., 2020). The prevalence of this condition in women of reproductive age is estimated to be 18.8% (range 14.5 – 49) (WHO, 2019b). Consequences of IDA include weakness, fatigue,

headaches, alopecia, xerostomia and menometrorrhagia. IDA also carries a risk of certain diseases such as gastritis, peptic ulcer, oesophagitis, Crohn's disease and many others.

DA is likely under-diagnosed and thus, under-treated in women (Levi et al., 2016). Screening for IDA is contended due to the low evidence-base of its efficacy; the absence of quick, simple and cheap screening tools; and the presence of other causes of anaemia separate to iron deficiency, for which it would be inappropriate to treat as IDA (Pasricha, 2012). Thus, a more concerted effort is needed to raise awareness of the prevalence of anaemia, the symptoms, the consequences of IDA; to encourage women to seek help from healthcare professionals (The Lancet, 2022); and for services on this issue to be accessible and available to women.

Mental Health

Internalising Disorders

Internalising disorders, characterised by anxiety, depression, somatic symptoms and suicidal ideation (Liu et al., 2011), are consistently higher for women in Europe compared to men; in fact, depression is almost twice as common in women (Hopcroft & Dana Burr, 2007; Van De Velde et al., 2010). During the COVID-19 pandemic, literature found that women were more prone to the secondary effects of the pandemic and lockdown restrictions. This included digestive disorders, anxiety, headaches, fear of contracting the virus and depression (Bäuerle et al., 2020; Özdin & Bayrak Özdin, 2020; Patrono et al., 2022).

The higher prevalence of poor mental health among women compared to men is likely due to social differences (Cabezas-Rodríguez et al., 2021). Issues such as the gender pay gap; the greater responsibility for unpaid domestic and care work placed on women; gender-based violence and intimate partner violence which disproportionately affects women; and the under-representation of women in positions of power, among many other factors contribute to mental health problems. Gender differences in depression are more prevalent in Eastern and Southern European countries which is associated with socioeconomic status (Van De Velde et al., 2010).

In times of stress adolescent girls often experience a multitude of symptoms such as anxiety and depression as well as low self-image and bodily discomfort (Strömbäck et al., 2015). From their early teenage years, girls are subjected to gender inequality, sexism, sexual harassment, gender-based cyber-bullying, unrealistic body ideals and traditionally feminine expectations (Hartas, 2021). The adversity experienced by adolescent and young women is heightened for those of lower socio-economic status.

When considering mental health problems, it is pertinent that we include not only cisgender

females, but also transgender women who have been shown to have more psychosocial problems which can present as mental health problems, loneliness, poor satisfaction with life, and suicidal ideation. Young transgender women are at a heightened risk of social stigma, bullying, harassment and discrimination (Anderssen et al., 2020). Challenges and injustices are omnipresent for this group and can affect women's experience of, and interaction with, the healthcare system.

Eating Disorders

Eating disorders are a type of mental health condition that occurs when severe changes in dietary intake and body mass are evident. They are relatively common in adolescents and young adults, and they can result in severe morbidity and even mortality. The three most common types of eating disorders are anorexia nervosa, bulimia nervosa and binge eating disorder. Eating disorders affect more women than men (Galmiche et al., 2019).

Due to the social stigma attached to bulimia nervosa, women often binge and purge (e.g. vomit or take laxatives) in private (Broussard, 2005). The secrecy and shame associated with this mental health condition can cause women to feel like they're leading two separate lives – a private one with bulimia and a public one without bulimia. Many women living with this condition perceive their behaviours as normal but know that others would label them as abnormal (Broussard, 2005). There remains a societal pressure on young women to have a specific body type which can change according to the latest trend. Women's bodies are still regularly discussed in the media and body-shaming is popular on social media. With the emergence and popularity of social media, young women are bombarded with images of celebrities, peers and strangers, resulting in a constant comparison of body types. Additionally, technical advances such as the Fitbit can facilitate purging in the form of compulsive or excessive exercise (Derenne & Beresin, 2018). More needs to be done to prevent disordered eating in an ever-changing society.

Loneliness

Loneliness is an under-estimated public health problem. Whilst it is often associated with older persons, studies show that loneliness peaks at two stages of life and that young adults can have the highest rates of loneliness (Luhmann & Hawkley, 2016). A study of college and university students in Norway aged between 18 – 35 years found that loneliness was positively associated with being female, single, living alone and studying abroad (Hysing et al., 2020). Rates of loneliness in women increased during the COVID-19 lockdown restrictions and were associated with an increase in depression (Lee et al., 2020). Eastern European countries showed the highest levels of loneliness for 18 – 29 year olds, with some countries reporting loneliness levels as high as 15.4% (95% CI 12.0 – 19.3) (Surkalim et al., 2022).

Sexual and Reproductive Health

Contraception

In 2020 there was an average birth rate of 1.5 children per woman in the EU. The average age at the birth of a first child has been increasing over the years from 29 in 2001 to 30 in 2020 (Eurostat, 2022). This shows that more women are using contraceptives and are having children later in life.

Contraception use is 56.1% (ranging from 50.2% in Eastern Europe to 68.4% in Northern Europe). The pill and the male condom are the most commonly used contraceptive methods in Europe, and 6.7% of those using contraception choose traditional methods (UN, 2019). While barrier methods such as condoms can protect against pregnancy and STIs, they are considered less effective than hormonal methods such as the pill and the IUD (ESHRI, 2014). 10% of couples have unmet need for contraception (UN, 2016).

In many countries in Europe, the responsibility for contraception largely falls on women. Barriers to effective and appropriate contraception disproportionately affect low income women. Increasing access to contraception and providing factual, reputable and thorough information using language that can be easily understood by laypersons on the options available are important to address the many facets of this problem. Europe must go further and reduce or eliminate financial costs, provider bias, stigma and misinformation (Campbell et al., 2006).

Many contraceptives available come with a number of side effects and risks. Women's methods of choosing the right method of contraception vary and involve individual preferences and priorities. Amenorrhea is one such side effect. There are cultural and personal aspects to the perception of amenorrhea and its acceptability ranges from 0% to 65% among women (Polis et al., 2018). The consequences of these side effects are often not well explained. As a result, some women perceive amenorrhea to be associated with infertility and choose to forgo this method of contraception for this reason (Polis et al., 2018).

Abortion rates fell from 52 per 1,000 women of reproductive age to 30 per 1,000 with increased access to contraception in Europe between 1990 and 2014 (Sedgh et al., 2016). Evidence shows that the rate of abortion does not decline in areas where abortion is restricted. Instead, women seek abortions from illegal, unregulated and potentially unsafe methods (Bearak et al., 2020). There are 7 European countries where there are still either total bans or severe restrictions on abortion (Countries where abortion is illegal, 2023).

These statistics highlight the need for comprehensive and effective family planning clinics which are available to all women regardless of age, race, income, geographical location and sexuality. In 2012 it was estimated that 34% of all pregnancies in Western Europe and 54% in Eastern Europe were unplanned (Sedgh & Hussain, 2014).

Unsafe Sex

The WHO identified unsafe sex as a risk factor for unintended pregnancies and sexually transmitted infections. The long term health effects and the wide range of health risks associated with unsafe sex can be significant (WHO, 2019a). Populations with the highest rates of sexually transmitted infections include sex workers, people who inject drugs, prisoners and mobile populations (WHO, 2022c).

Infections

While the true prevalence of recurring vulvovaginal candidiasis is unknown due to a lack of high quality studies, it is estimated to affect up to 25% of women (Foxman et al., 2013). This ubiquitous health problem affecting countless women can cause abnormal vaginal discharge, pruritus, dyspareunia or dysuria (Rosati et al., 2020) and requires more research and intervention.

Endometriosis

Endometriosis is caused by the presence of stroma and endometrial glands outside the uterine cavity. It can cause severe pain and infertility. Endometriosis affects up to 10% of women of reproductive age, and there is greater prevalence of endometriosis in infertile women which ranges between 25% and 50% (Meuleman et al., 2009). Endometriosis is widely under-diagnosed and those with the condition often experience a diagnostic delay of several years (Sims et al., 2021).

A lack of scientific and medical consensus on risk factors for endometriosis and effective treatment methods, contribute to women seeking information and support elsewhere such as via self-help books and internet sources (Seear, 2009). Women report that some alternative treatments such as Pilates help with the pain of endometriosis, however, classes can be expensive and they are not covered by medical insurance. This is true for other complementary treatments such as herbal remedies and dietary changes. Additionally, some women decrease their working hours or forgo employment altogether as the management of this chronic condition and working can prove to be too stressful. Some advice from healthcare professionals can be inappropriate for women with busy lives and caring responsibilities (Seear, 2009).

This highlights the need for research to be conducted with women to better understand this highly prevalent disease and co-create strategies and treatment regimes that are appropriate for women to help them prevent, treat and relieve the pain of this condition.

Menstruation

Dysmenorrhea describes pain that is felt before the onset of, or during, menstruation. This pain is usually felt in the abdomen. The prevalence varies widely in women of reproductive age, from 16% to 91%. In the past, dysmenorrhea was seen as a solely psychological and emotional issue. Physiological processes have since been identified, which cause the symptoms of dysmenorrhea. These can vary widely for women (Chen et al., 2018). Pain can be felt in other parts of the body separate to the abdomen, pain levels can range from 'not bad' all the way to 'excruciatingly painful', and other gastrointestinal symptoms can present, for example nausea and diarrhoea. Dysmenorrhea regularly changes for women from month to month. This shows how each woman's experience can be unique and thus a one-size-fits-all solution is inappropriate.

Dysmenorrhea can impact women's daily lives, preventing them from carrying out their regular activities. Treatment can include paracetamol, NSAIDs, aspirin and oral contraceptives (Proctor & Farquhar, 2006). Different medications and treatments such as heat pads are regularly used to manage symptoms with varying degrees of success. Other complementary treatments can be used such as herbal remedies, exercise and dietary changes but these have not been adequately researched (Proctor & Farquhar, 2006).

Societal attitudes to dysmenorrhea often do not treat it as a valid medical condition. Employers, healthcare professionals and women themselves often view these symptoms as a normal part of female experience. Thus, little sympathy, attention or resources are given to the issue.

Issues such as irregular menstruation patterns, or oligomenorrhea, are found to be correlated with lower lung function and higher rates of asthma, in particular allergy-induced asthma (Real et al., 2008). This requires further investigation.

LGBTQAI+

In a study of lesbian women's healthcare experiences, women reported a culture of heteronormativity which impacted the appropriateness of care they received (Bjorkman & Malterud, 2009). Women were given prescriptions for unnecessary contraception and asked to do a pregnancy test even after disclosing their sexual orientation. In moments of vulnerability such as during a pelvic exam, women felt they had to discuss their sexuality when healthcare

professionals assumed them as heterosexual. Some doctors showed discriminatory attitudes to lesbian women, pathologising their sexuality and creating an uncomfortable atmosphere. While not all experiences in this study were negative and many reported satisfactory relationships with healthcare providers, empathy, respect and understanding, it is important that the quality of healthcare services is improved for all patients regardless of sexuality, gender, ethnicity or any other identifiers.

Sexuality is an important determinant of health and should be understood by healthcare providers. Lesbian, gay, bisexual or other orientation can be associated with certain diseases and determine the most appropriate and effective treatment option (Komlenac et al., 2019). At the same time, disclosing one's sexuality can increase the vulnerability of a patient and can be distressing. Heteronormativity in healthcare can have dangerous consequences and exacerbate inequalities.

In a study by Komlenac et al. (2019), surveys of Austrian medical students revealed that they did not feel that they received adequate education on sexual health. Students reported that they did not receive any training on sexual medical history-taking. This critical health aspect should be included in all medical professionals' training to ensure that sexual health is incorporated into health assessments in a manner which is appropriate, sensitive and respectful.

Pregnancy

Postnatal depression is an important health condition that affects 10 – 13% of women within the first year of giving birth. There is stigma associated with postnatal depression and women fear being labelled as bad mothers. Too often care is focused on the infant rather than incorporating the mother's mental health also (Slade et al., 2010). If left untreated, postnatal depression can have devastating consequences such as infanticide or suicide (Almond, 2009).

Gender-Based Violence (GBV)

Intimate Partner Violence (IPV)

GBV stems from patriarchal societies, power structures and gender norms, and disproportionately affects women. IPV, one form of GBV, is defined as the physical, sexual or psychological abuse from a current or previous partner or spouse. On average 22% of women in Europe experience intimate partner violence (FRA, 2014; WHO, 2021). In one study from Ukraine, IPV was positively associated with witnessing parental violence, externalising disorders and marital problems (O'Leary et al., 2008). IPV can lead to short and long term health consequences for women such as injuries, STIs, unintended pregnancies, psychological trauma, anxiety and depression among many other sequelae.

Due to the omnipresent nature of IPV, ambivalence from the media and the low conviction rates of abusers, most incidences of IPV go unreported. As IPV generally occurs in private settings, many do not seek professional help. Stigma, victim blaming and a lack of understanding around the topic is prevalent with victims receiving questions such as “Why didn’t you leave?”, contribute to a fear of reporting incidents, shame and guilt. This indicates that IPV is not treated as a societal and public health and safety problem, but rather an issue which is treated on an individual basis (Lloyd et al., 2017). Furthermore, the national and international media outlets have endorsed victim-blaming and the sexualisation of abuse through their headlines, details, interviews and story angles, which further distorts the narrative around IPV, its causes and consequences (Lloyd & Ramon, 2017).

Reproductive Coercion and Abuse

In a global qualitative synthesis of evidence on this topic, a range of forms of reproductive coercion and abuse were reported (Moulton et al., 2021). Women experienced contraception sabotage; verbal and emotional abuse to have a child early; psychological or physical abuse in order to terminate a pregnancy, or keep a pregnancy; rape and sexual assault; and were forced to have permanent procedures such as tubal litigation against their will. In many cases men held access to money and transport, and so women were unable to attend family planning clinics or purchase contraceptives. Women experienced anger, distress and trauma as a result of this.

Reproductive control was not only felt by partners for some women, but also by extended family members who coerced women into pregnancy, prevented women from accessing contraception or forced the termination of pregnancies.

While reproductive coercion is a problem for many individuals and communities in Europe, it would be beneficial to understand whether sexual and reproductive health services are capable, committed and designed to tackle this issue. Healthcare professionals should be trained on screening practices so that early intervention and support can be provided to affected women. Services should be adapted for women in this situation, as many report using covert contraception as a management strategy (Moulton et al., 2021).

Female Genital Mutilation (FGM)

FGM affects half a million women in Europe. FGM “involves the partial or total removal of external female genitalia or other injury to the female genital organs for non-medical reasons” (WHO, 2022a), and is associated with many short and long term health effects that negatively impact women. These go beyond the physical to include the psychosocial. Healthcare professionals in many European countries are ill-equipped to support women who have

undergone FGM and the side effects that accompany it (Abdulcadir et al., 2011), and thus it should be prioritised in young women's health in Europe.

Healthcare Access

Across Europe, females have greater unmet need for healthcare compared to males, and unmet need is often associated with financial strain (Fjær et al., 2017). As more women compared to men have low income, part-time and temporary jobs, they may be unable to take time off work for a healthcare appointment without risking a loss of income, or they may lack sufficient leave allowance. As women undertake the burden of domestic and care duties, they may have less free time to take care of themselves and their own health needs. Women in these positions may have less disposable income to spend on healthcare, medicines and services.

CONCLUSION

While the age group of 18 – 34 year olds share many commonalities such as being of reproductive age and legal adults, they are rarely analysed as a whole. Instead, they are more often split into adolescents and young adults, beginning as young as 10 up to 25 years of age, and adults, middle aged and older people. This scoping review provides valuable insight into the health needs and issues of this group and an important starting point for future research and intervention.

This scoping review shows that insufficient research has been conducted on young women's health priorities. There are staggering gaps in knowledge regarding highly prevalent women's health issues that have not been given adequate attention both in research and in public discourse. There is shame, guilt and stigma attached to women's health conditions that both prevents women from speaking openly and honestly on the subject, and the development of effective and appropriate actions and policy changes. Dysmenorrhea is a prime example of this. Women are encouraged to take over-the-counter medications and carry on with daily activities. Absenteeism from work and school due to this condition is common (13% – 51% of women have been absent from work or school at least once due to this) which illustrates the severity of the issue (Proctor & Farquhar, 2006).

The inclusion of young women's voices in health research, policy and programmes is critical to ensure that their priorities are taken into consideration and their needs are met. The health of this subgroup of the population affects the health of current and future generations. Women, due to social and biological factors, have specific health needs. Treatments and interventions may interact differently for women and the efficacy of health products or services may differ for these same reasons. Thus, women should be consulted at every stage of health needs analyses and during the designing and testing stages of new or improved treatments and

interventions.

Working towards gender equity in health benefits society as a whole in a myriad of ways such as improved public health, economic growth, scientific research, innovation and climate resilience.

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