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ADDENDUM TO THE NOTE

from : The Permanent Representatives Committee (Part I)

to : Council (EPSCO)

Subject : **Review of the implementation by the Member States and the EU institutions
of the Beijing Platform for Action
- Draft Council Conclusions**

Delegations will find attached in the Annex a report concerning the three indicators on "Women and Health" put forward by the Austrian Presidency.

Report by the Austrian Presidency Indicators concerning women's health

Introduction

The Beijing Declaration and Platform for Action (PFA) adopted at the United Nations Fourth World Conference on Women in 1995 form the guidelines for European and national policies promoting equality between women and men and have been a catalyst for a large number of initiatives launched by governments to promote gender equality.

Following the Fourth World Conference on Women, the Madrid European Council (15 to 16 December 1995) requested an annual review of the implementation in the Member States of the PFA.

Already during its first presidency in 1998, Austria included the demand for the development of indicators to reach the goal of the Beijing Platform for Action. On 2 December 1998, the Council agreed that the annual assessment of the implementation of the PFA would include a proposal on a set of qualitative and quantitative indicators and benchmarks. Indicators are needed to enable the assessment of progress and usually require a set of quantitative data, comparable over time and between countries.

Starting in 1999 Member States, in cooperation with the European Commission, have developed indicators for the follow-up of the 12 critical areas of concern of the Beijing Platform for Action (Women and Poverty; Education and Training of Women; Women and Health; Violence against Women; Women and Armed Conflict; Women and the Economy; Women in Power and Decision Making; Institutional Mechanisms for the Advancement of Women; Human Rights of Women;

Women and the Media; Women and Environment; The Girl Child). In 2005, the 10th anniversary of the Platform, Member States committed themselves to continuing to develop indicators in the missing areas. So far the European Union has developed a set of indicators in order to fulfil five of the twelve strategic objectives of the Beijing Platform for Action (see Annex 2).

Until recently the work on indicators within one area was divided between 2 Presidencies: one collecting relevant data by developing and sending out questionnaires to Member States, the other Presidency analysing the collected data and presenting a report.

In the High Level Group on Gender Mainstreaming in September 2005, the European Commission asked for a different approach related to indicators. It was agreed to speed up the process by developing, whenever possible, one set of indicators during each Presidency. Moreover, as the availability and comparability of data is a crucial factor in the development of indicators, it was proposed that, based on existing data (see Annex 1) the Presidency could then look for indicators that seem crucial for the implementation of the PFA and which show a specific need for further analysis by the European Union.

The Austrian Presidency 2006 has now undertaken to focus on indicators for measuring progress on women's health (PFA, critical area of concern: women and health) since gender based data are the prerequisite for gender related health policies. It is important to bring attention to the current data within this area.

Socially constructed inequalities or gender differences between males and females play a central role in determining whether individuals are able to realize their potential for a long and a healthy life. The difference between the sexes has a direct impact on the health needs of women and men as well as affecting their access to care.

The "Roadmap for equality between women and men, 2006-2010" (COM (2006) 92 final) presented by the European Commission in March 2006 stresses the importance of the recognition of the gender dimension in health. "Women and men are confronted with specific health risks,

diseases, issues and practices impacting their health. Medical research and many safety and health standards relate more to man and male-dominated work areas. Knowledge in this field should be improved and statistics and indicators further developed. Social, health and care services should be modernised with a view to improving their accessibility, quality and responsiveness to the new and specific needs of women and men." The Commission also undertakes to " monitor and strengthen gender mainstreaming in health policies, including by updating the analysis of the gender dimension in health, further develop indicators where necessary; define a new composite Gender Equality Index in 2007; develop, by 2010 and together with Member States, new indicators for the 12 critical areas of the BPfA; support the development of EU comparable data on gender equality and statistics broken down by sex.”

The indicators on women’s health proposed by the Presidency are healthy life years, access to health care and cardio-vascular-diseases. The number of indicators has been restricted to three because this is the usual policy of the High Level Group on Gender Mainstreaming. Important elements for women’s health including smoking and life expectancy are already implicitly taken into account by these indicators.

- **Healthy life years**

The “Healthy Life Years” indicator is in the core set of the European Structural Indicators. This follows from the Conclusions of the Lisbon European Council, 20 to 23 March 2000.

- **Access to health care (unmet demand)**

In 2002, the Barcelona European Council recognised three guiding principles for the reform of health care systems, one of them being accessibility for all.

- **Cardio-Vascular Diseases**

Cardiovascular disease is the largest cause of death of men and women in the European Union. CVD is seen as a ‘male disease’ by the general public and, since women’s symptoms and disease progression trends differ from men’s. Women are under-represented in clinical trials and their CVD clinical manifestations are less charted and outlined to the medical professional. Gender-specific aspects of CVD must be taken into account in the future research of cardiovascular health.

1) **Healthy Life Years**

*Healthy life years indicator
measures the number of years that a person at
birth - woman or man – is supposed to live
without disability.*

The Healthy Life Years indicator (also called disability-free life expectancy) measures the number of remaining years that a person of a certain age is still supposed to live without disability. Healthy Life Years is a solid indicator to monitor health as a productivity/economic factor.

Healthy Life Years introduces the concept of quality of life into life expectancy. It is used to distinguish between years of life free of any activity limitation and years experienced with at least one activity limitation. The emphasis is not exclusively on the length of life, as is the case for life expectancy, but also on the quality of life. Healthy Life Years (HLY) is a functional health status measurement that is increasingly used to complement the conventional life expectancy measures. Chronic disease, frailty, and disability tend to become more prevalent at older ages, so that a population with a higher life expectancy may not be healthier.

Indeed, a major question within an ageing population is whether increases in life expectancy will be associated with a greater or lesser proportion of the future population spending their years living with disability. If HLY is increasing more rapidly than life expectancy in a population, then not only are people living longer, they are also living a greater portion of their lives free of disability.

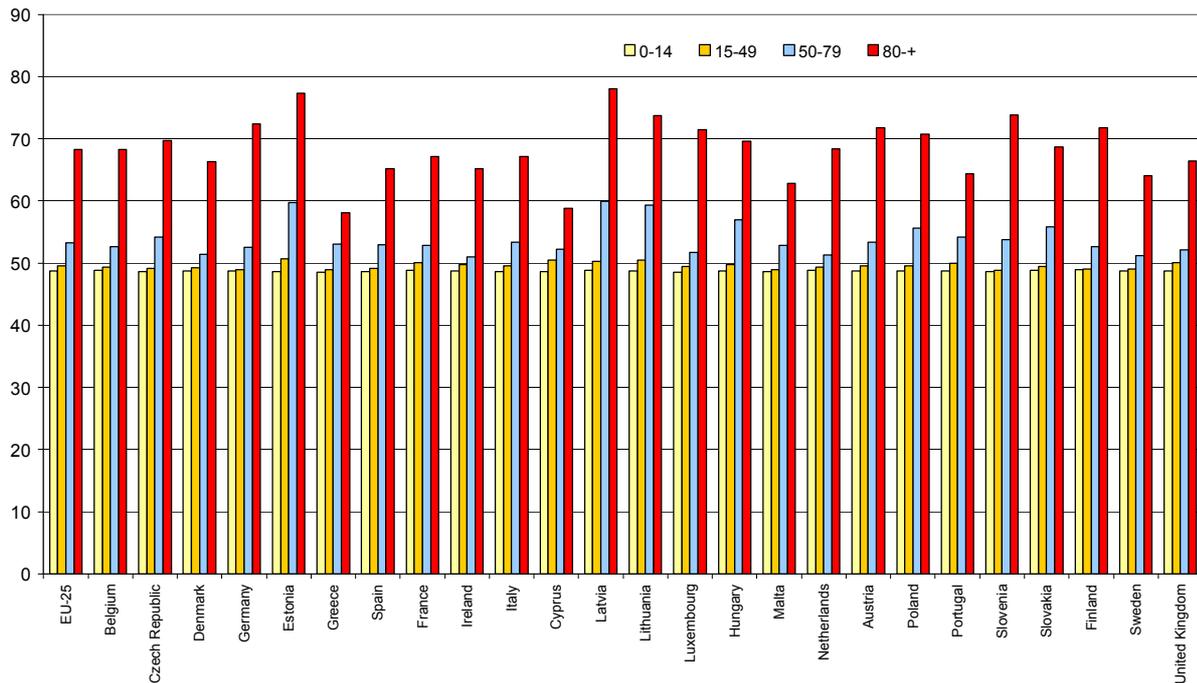
The two components of the calculation of the HLY in the EU are the mortality tables and the self-perceived disability assessed by health surveys. Life tables which give mortality data for calculating life expectancy are fully available as a demographic long-term series based on the standard procedures of causes of death registration harmonised at EU level.

A Healthy Life Years improvement must be the main health goal for the EU. At present HLY at birth in the former EU-15 was, on average, 12 years shorter than overall life expectancy in men and 17 years shorter in women.

Healthy Life Years is a functional health status measure that is increasingly used to complement the conventional life expectancy measures. The HLY measure was developed to reflect the fact that not all years of a person's life are typically lived in perfect health.

There are suggestions that life expectancy had reached its limits but the evidence suggests otherwise. Female life expectancy has risen for 160 years at a rate of 3 months per year. In 1840 the longest survivors were Swedish women who lived an average of 45 years while now the life expectancy of Spanish women is 83 years. Before 1950 most of the gain was due to a reduction in young deaths. In recent decades it is due to improvement in survival in people over 65 years. The old notions that even under favourable circumstances human beings have a characteristic lifespan are now under challenge. Continuing belief that the ceiling is about to be finally reached has been proved incorrect repeatedly over the last 100 years. These misleading forecasts have led to inaccurate calculations of the financial, medical and social needs of the elderly. If the current trend of life expectancy increasing 2.5 years per decade persists, the average lifespan may commonly be 100 years by 2070.

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



Source : Eurostat - Reference year : 2004 except EU-25, BE, EE, EL, IT and UK : 2003

Source: Eurostat, “Share of Women by age in 2004 (%)”

As regards self-perceived disability, from 1995 to 2001, data from the Eurostat European Community Household Panel (ECHP) survey have been used for the EU-15 Member States. The successor of the ECHP, the Eurostat EU-Survey on Income and Living Conditions (EU-SILC) was launched in various countries at different times in 2004 and 2005. During the transition between end-ECHP and start EU-SILC, for the EU-15 Member States, data were calculated by extrapolating

the data on the prevalence of disability from 1995 to 2001. As disability is a phenomenon which changes slowly in time, in the calculations for 2002 and 2003 an assumption was made that the evolution of the prevalence is linear. For the new Member States national sources are used when comparable (CZ, HU, CY, MT, and PL). From 2004/2005 onwards, data from the EU-SILC survey are used for EU-25.

The data calculated by Eurostat for the year 2003 shows clear differences in life expectancies with no disability between Member States with available data.

Country	Healthy life years at birth (Males)	Percentage of life expectancy without disability (Males)	Healthy life years at birth (Females)	Percentage of life expectancy without disability (Females)
EU-15 (2003)	64.5	85 %	66.0	81 %
BE (2003)	67.4	89 %	69.2	85 %
CZ (2002)	62.8	87 %	63.3	80 %
DK (2003)	63.0	84 %	60.9	76 %
DE (2003)	65.0	86 %	64.7	80 %
GR (2003)	66.7	89 %	68.4	85 %
ES (2003)	66.8	87 %	70.2	84 %
FR (2003)	60.6	80 %	63.9	77 %
IE (2003)	63.4	85 %	65.4	81 %
IT (2003)	70.9	92 %	74.4	90 %
CY (2003)	68.4	89 %	69.6	86 %
HU (2003)	53.5	78 %	57.8	75 %
MT (2002)	65.1	86 %	65.7	81 %
NL (2003)	61.7	81 %	58.8	73 %
AT (2003)	66.2	87 %	69.6	85 %
PL (2002)	62.5	89 %	68.9	88 %
PT (2003)	59.8	81 %	61.8	77 %
FI (2003)	57.3	76 %	56.5	69 %
SW (2003)	62.5	80 %	62.2	76 %
UK (2003)	61.5	81 %	60.9	75 %
NO (2003)	66.3	86 %	64.2	78 %

Source: Eurostat – NewCronos Database

Estimates of the years that individuals can expect to spend in healthy and unhealthy states can be valuable for estimating the demands for future care. Although many of the studies of health expectancy focus on measures such as physical impairment or disability in functional tasks or presence of a specific chronic disease, self-assessed health, being much more global and subjective in nature, can incorporate a variety of aspects of health including cognitive and emotional as well as physical status, and therefore provide insights into the needs of an ageing society. Hence, self-assessed health measures as HLY may be a particularly important indicator of the potential demand for health services and long-term care needs of the whole but especially for the elderly population.

The disability burden expressed in health care expenditure (in kind and in cash) and pensions are a main part of the expenditure facing the national finances. Increasing age and non-healthy life years brings greater medical needs especially in terms of pathologies such as the degenerative vascular diseases, cancer, Alzheimer and other neurodegenerative diseases. The sick elderly are a greater financial commitment than their healthy counterparts. If the retirement age is to be raised, people must be physically able to work and have healthy life years. Healthy Life Years is a measure of social and health needs in the population that is independent of resources and the use of social and health services. This makes it an optimum indicator for allocating resources.

As mentioned, the EU population is ageing and as the post-war generation reaches retirement the pace of that ageing will increase dramatically, with profound social effects – especially for women. One major difficulty in planning for future health and long term care needs, however, is the lack of agreed estimates of future numbers and needs. Healthy Life Years indicators could provide some of these estimations.

2) Ensuring access to health care

Access to health care indicator
measures the share of women and men in the total population
aged 16 and over who needed medical examination or
treatment during the last 12 months but did not receive it, and
reasons for this unmet need.

Access to health care implies that ability to pay is not a precondition to receiving care and that the need for care does not lead to impoverishment. As reviewed, consistent increases in expenditure, coupled with increasing population coverage over the years, have allowed Member States to generally ensure all residents access to basic health care as well as ensuring that the need for health care is not a major cause of poverty and financial dependence of patients and their relatives. Despite that, there remain important access inequities to address.

Access barriers include lack of coverage of certain types of care, high individual financial costs of care, geographical disparities of supply, waiting times and lack of information. Limiting access can save costs but if too high can result in belated and more costly treatment. Moreover, countries identify different experiences of care use across socio-economic groups (e.g. richer households make more use of preventive and specialist care than poorer households who make more use of emergency hospital care).

Hence, we need to identify the extent of the various barriers to access and use across socio-economic groups, gender and regions.

Social protection systems must ensure that people who need medical or social care can get it regardless of their income or wealth and that the cost of such care does not cause poverty to the care recipients or their relatives. In 1999, the Commission and the Council stressed that ensuring high quality and sustainable health care was one of the key areas of social protection in which a concerted modernisation effort should be undertaken.

On 29 June 2000, the European Council agreed on establishing the Social Protection Committee (SPC) in order to serve as a vehicle for cooperative exchange between the European Commission and the Member States of the EU about modernising and improving social protection systems. Under the mandate given to it by the Council, the Committee should *inter alia* work on the policy challenge "to ensure high quality and sustainable health care".

In 2002, the Barcelona European Council recognised three guiding principles for the reform of health care systems: accessibility for all; high quality care and long-term financial sustainability. Cooperation on this basis has started in the form of an analysis of health care and long-term care in the Member States by means of a questionnaire and a joint Commission/Council report. The Social Protection Committee established an Indicators' Sub-Group to work on the development of indicators and statistics in support of its tasks. The 2003 Spring European Council, based on this work, highlighted the need to intensify the cooperative exchange in the field and in April 2004 the Commission presented a communication which proposed to extend the "open method of coordination" to the area of health and long term care. This will establish a framework allowing for the exchange of experience and best practice and thus supporting Member States in their reform efforts.

This Sub-Group is currently working on assessing and analysing data from the EU Member States regarding access to health care.

As a starting point, one may wish to know if there are access issues and where they stem from. This can be addressed by looking at the two access indicators of EU-SILC: unmet demand and related reasons which encompass, albeit in general terms, the various access barriers identified. It may be relevant to look at unmet demand and its reasons by socio-economic measures: income groups, education level, activity status, occupation, household, type, or region or specific groups in society (e.g. children, disabled, unemployed, lowest quintile...).

The two EU-SILC questions related to access are:

1. *whether individuals faced **unmet need**, by age, gender, income groups, education level, activity status, occupation, household type, by region or urban /rural or specific group in society (e.g. lowest income decile)*
2. ***main reason for unmet need** including: could not afford to (too expensive), waiting list, could not take time because of work, care for children or for others, too far to travel/no means of transportation, fear of doctor/hospital/examination/treatment, wanted to wait and see if problem got better on its own, didn't know any good doctor or specialist, others, by age, gender, income groups, education level, activity status, occupation, household type, by region or urban /rural or specific group in society (e.g. lowest income decile).*

Given sufficient sample sizes and depending on the demographic questions asked, surveys can provide detailed information on the perceived access barriers. The advantage of such surveys is that they can also capture unofficial payments to care providers which would not be reflected in private health care expenditure (out-of-pocket spending). However, such information may be very subjective. Information from Member States on policies to facilitate access for certain groups should be considered alongside the survey results.

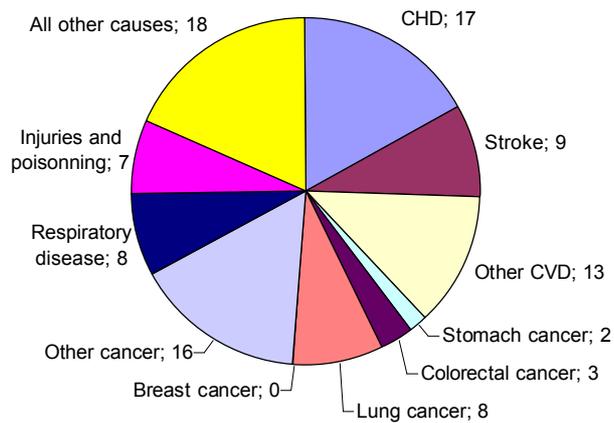
Access indicators are crucial to meet the public needs within a gender based medical system. It is necessary that the data analysed will provide a gender perspective.

3) Cardio-Vascular Diseases

***Cardio-vascular diseases indicator**
measures the share of deaths of women and men
caused by Cardio Vascular Diseases (coronary heart
disease (CHD), stroke and other CVD).*

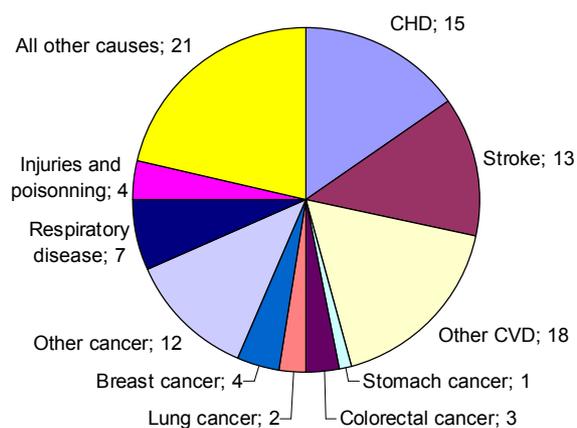
Diseases of the heart and circulatory system (cardiovascular disease or CVD) are the main cause of death in the European Union (EU): accounting for over 1.9 million deaths each year. Nearly half (42%) of all deaths in the EU (46% deaths in women and 39% deaths in men) are from CVD. The main forms of CVD are coronary heart disease (CHD) and stroke.

Deaths by cause of men for EU-25 (2001)



Source : Eurostat - Health data

Deaths by cause of women for EU-25 (2001)



Source : Eurostat - Health data

CVD is the main cause of death for women in all 25 countries of the EU.

CHD by itself is the single most common cause of death in the EU: accounting for over 744,000 deaths in the EU each year. Around one in six men (17%) and over one in seven women (16%) die from the disease.

Stroke by itself is the second single most common cause of death in the EU: accounting for just under 490,000 deaths in the EU each year. Around one in ten men (9%) and one in eight women (13%) die from the disease.

Unfortunately information on the existence of sex differences in the management of stroke patients is scarce.

Total number of deaths by cause and sex, latest available year

MEN		Deaths CVD		
COUNTRY	All deaths (including other causes)	CHD	Stroke	Other CVD
Austria (00)	35.211	7.724	3.136	5.399
Belgium (96)	52.514	6.732	3.892	7.125
Czech Republic (00)	54.882	12.034	6.991	7.443
Denmark (98)	28.750	5.379	2.090	2.939
Estonia (00)	9.265	2.576	1.112	608
Finland (00)	24.042	6.512	1.858	1.555
France (99)	274.764	24.969	16.537	34.569
Germany (99)	390.742	82.209	31.126	53.592
Greece (99)	54.121	7.951	7.699	9.050
Hungary (00)	70.475	14.656	8.559	8.612
Ireland (99)	16.961	3.989	1.163	1.705
Italy (99)	285.901	40.041	27.711	42.645
Latvia (00)	16.155	4.492	2.271	947
Lithuania (00)	20.408	5.685	1.764	1.628
Luxembourg (00)	1.857	263	158	230
Malta (99)	1.543	395	108	164
Netherlands (99)	68.872	10.432	4.811	8.754
Norway (99)	22.416	4.771	1.976	2.480
Poland (00)	195.390	30.972	17.867	34.839
Portugal (00)	55.346	4.914	9.110	4.651
Slovakia (00)	28.157	7.476	2.140	3.942
Slovenia (99)	9.671	1.361	879	1.168
Spain (98)	190.218	22.929	15.744	22.516
Sweden (99)	46.782	11.675	4.236	5.706
UK - England and Wales (99)	264.299	63.317	20.711	21.092
UK - Northern Ireland (99)	7.464	1.936	619	475
UK - Scotland (99)	28.605	7.122	2.494	1.990

Total number of deaths by cause and sex, latest available year

WOMEN		Deaths CVD		
COUNTRY	All deaths (including other causes)	CHD	Stroke	Other CVD
Austria (00)	41.569	8.518	5.733	9.601
Belgium (96)	51.856	5.503	3.701	10.219
Czech Republic (00)	54.119	11.350	10.352	10.022
Denmark (98)	29.329	4.650	2.908	3.308
Estonia (00)	9.138	3.364	1.792	530
Finland (00)	25.274	6.388	3.162	1.924
France (99)	262.695	20.101	23.275	45.468
Germany (99)	455.588	92.872	54.629	9.194
Greece (99)	49.092	5.792	10.815	11.721
Hungary (00)	65.126	15.143	10.380	11.523
Ireland (99)	15.647	3.070	1.644	1.809
Italy (99)	281.840	35.899	40.632	59.267
Latvia (00)	16.050	5.164	4.143	849
Lithuania (00)	18.511	6.928	3.133	1.792
Luxembourg (00)	1.852	203	268	319
Malta (99)	1.554	369	199	247
Netherlands (99)	71.615	7.872	7.598	10.127
Norway (99)	22.698	3.973	2.760	3.280
Poland (00)	172.638	24.603	23.576	43.550
Portugal (00)	50.467	4.104	11.885	6.330
Slovakia (00)	24.567	8.212	2.537	4.576
Slovenia (99)	9.214	1.266	1.271	1.722
Spain (98)	170.293	17.270	22.377	33.676
Sweden (99)	48.294	9.502	6.077	7.358
UK - England and Wales (99)	291.819	51.803	35.342	26.869
UK - Northern Ireland (99)	8.199	1.632	1.060	700
UK - Scotland (99)	31.676	6.215	4.291	2.675

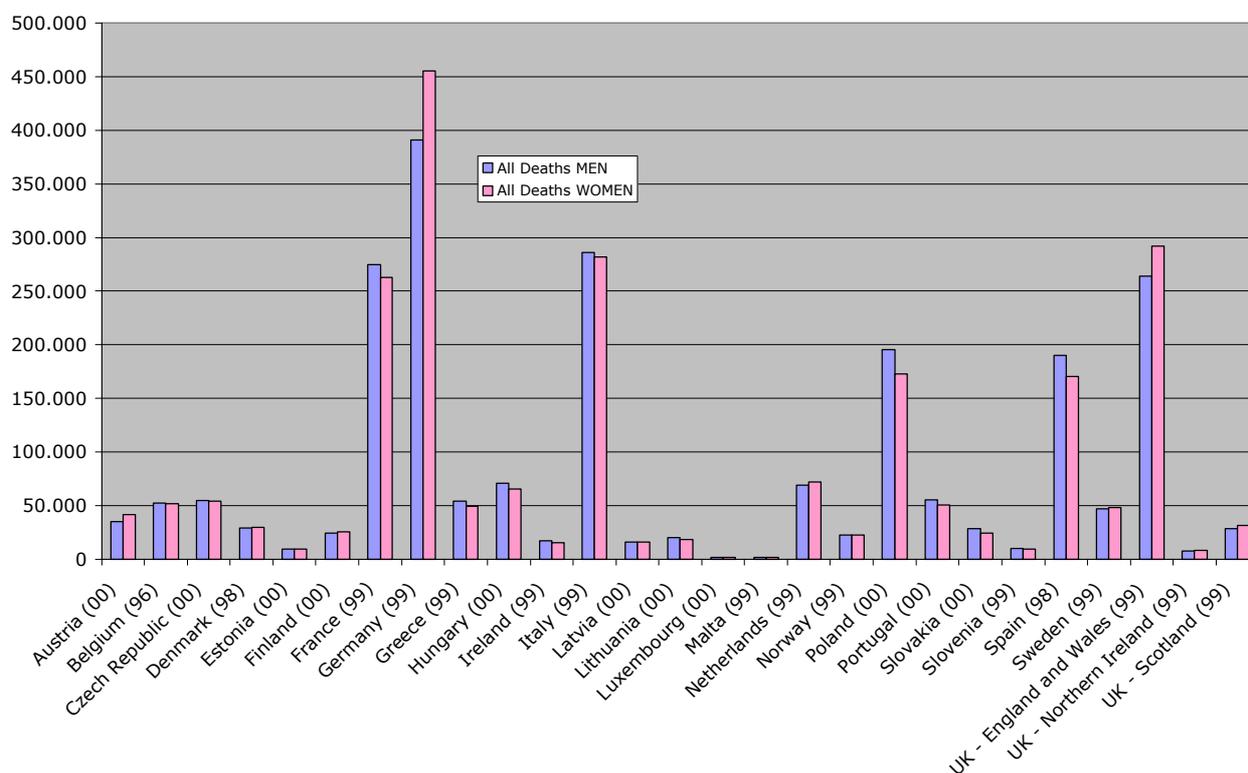
ICD codes (9th Revision, 10th Revision): CHD (410-414, I20-I25); stroke (430-438, I60-I69); other CVD such as rheumatic fever and rheumatic heart disease, diseases of the circulatory system, ischemic heart diseases, arterial hypertension. (390-459, I00-I99 minus CHD and stroke);

NB: No national mortality data is available for Cyprus

Source: World Health Organization (2004)

www.who.int published in *European Cardiovascular Disease Statistics, 2005 edition*

The gender comparison of the specified above data of all deaths causes.



The incidence of coronary heart disease in women increases dramatically in middle age, which has led to the speculation that menopause marks the end of a protective effect of ovarian hormones on cardiovascular disease. CHD results in many premature deaths and since clinical care in CVDs is costly and prolonged it is also a major economic burden in Europe.

Cardiovascular disease is an important cause of premature mortality in the ten new Member States and rates are higher than the EU-15 average. In particular, cerebrovascular mortality is disproportionately higher, with even the best countries having rates higher than any other EU-15 country except Greece. Factors that have been identified as contributors to coronary heart disease for women include cholesterol, smoking, high blood pressure, obesity, physical inactivity,

hormonal changes and diabetes mellitus. The numbers dying in Europe from CVD due to smoking rose by 13% between 1990 and 2000. To these classical risk factors we can add other ones if we incorporate the gender perspective to analyse the risk factors, as: socio-economic condition, link with the health services, subjective construction of the illness, insertion to the labour market or interconnection among the different areas: work, personal interests and family life.

The EU project EUROCISS 1 - Cardiovascular Indicators surveillance set in Europe (Phase 1) conducted between 2000 and 2003, has produced several major results, including an extensive inventory of available data from 12 Member States (MS) and a list of indicators for monitoring cardio- and cerebrovascular diseases (CVD). The most important CVDs analysed by EUROCISS were acute myocardial infarction and ischemic heart diseases, heart failure and cerebrovascular accidents.

For acute myocardial infarction recommended indicators include mortality, hospital discharge rates, incidence/attack rates and case fatality. Of these indicators, mortality and hospital discharge diagnoses are available for all countries. Information about incidence/attack rate and case fatality are available in some countries through population-based registries, usually at regional level. These registries have adopted simplified procedures and methods derived from the WHO MONICA Project – Multinational Monitoring of trends and determinants in cardiovascular disease – based on record linkage of mortality and hospital discharge diagnoses, and employ some validation procedures. Prevalence of ischemic heart diseases is assessed by surveys, but information on important clinical measures is often lacking. Recently, sensitive serologic biomarkers have become available for the identification of very small myocardial infarctions that would not have been detected earlier. The application of new, more sensitive biomarkers criteria will potentially cause a rise in the myocardial infarction incidence and a fall in the case fatality rate.

The EUROCISS 2 - Cardiovascular Indicators surveillance set in Europe (Phase 2) was launched in 2003 to elaborate a European inventory of sources of information, available indicators, including the description of differences in methods of data collection as recommended by EUROCISS 1 and the ECHI projects. Outcomes will include a European inventory of sources of information,

available indicators, a list of recommended indicators for specific CVDs. A European manual of operations for the implementation of population-based registries for myocardial infarction and stroke and a European manual of CVD surveys will be also part of the outcomes. A minimum set of questions and exams for the HIS/HES – health interview survey and health examination survey – to assess prevalence of CVD in the general population will be included.

ECHI II – European Community Health Indicators – has a current list of indicators for cardiovascular diseases monitoring. Within the area "Mortality all causes circulatory system" one can find ICD10: I00-I99 for crude death rates and standardized death rates 0-64 and 65+, by region.

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

Data

The Statistical Office of the European Communities (Eurostat) is the statistical arm of the European Commission, producing data for the European Union and promoting harmonisation of statistical methods across the member states.

The Survey on Income and Living Conditions (SILC) is an annual survey conducted by each national statistical institute to obtain information on the income and living conditions of different types of households. The survey also collects information on poverty and social exclusion. A representative random sample of households throughout each country is approached to provide the required information.

The first SILC data for all Member States (collected in 2005) is expected to be published in the beginning of 2007.

The already existing European Commission's work on producing comparable information on health and health-related behaviour of the population, on diseases and health systems aims at producing health indicators. The work has resulted in the production of the first set of European Community Health Indicators (ECHI 1 and 2). The ECHI project was carried out in the framework of the Health Monitoring Programme (HMP) and the Community Public Health Programme 2003-2008. The result is a list of 'indicators' for the public health field arranged according to a conceptual view on health and health determinants. The objective of the Community is to continue the work on specific indicators in order to complete the European Community Health Indicators list.

Sources:

The report is a compilation of data and material provided by:

Eurostat:

<http://epp.eurostat.cec.eu.int>

European Commission – Public Health:

<http://europa.eu.int/comm/health>

Statistik Austria:

<http://www.statistik.at>

WHO: European Health for all database:

<http://data.euro.who.int>

EU Indicators on the implementation of the PFA

- In December 1999, the Finnish Presidency proposed 9 indicators on Women in Power and Decision-making, introducing a new methodology in the evaluation process.
- In 2000, the French Presidency presented a report and a series of indicators relating to the reconciliation of family life and working life.
- In 2001, the Belgian Presidency proposed indicators relating to the unequal pay between women and men (gender pay gap). Furthermore, the Council invited in 2001 the forthcoming Spanish and Danish Presidencies to consider the theme ‘violence against women’.
- The Spanish Presidency prepared a study, which analysed the replies of a questionnaire, sent out to Member States on measures and data in the field of violence against women. On the basis of the study and a ministerial conference on violence against women, a report and a “Good practice guide” was presented to the Council in June 2002. At the spring European Council meeting in March in Barcelona 2002, the European Council stressed the importance of the declaration from the Social Council on violence against women. Consequently, when choosing its proposed indicators, the Danish Presidency proposed indicators that should facilitate achieving the common goal of eliminating violence against women and supporting victims of violence, in particular domestic violence. The definition of violence against women in the Beijing Platform for Action covers different forms of violence. The study and the indicators prepared during the Spanish and Danish Presidency mainly consider domestic violence. The Danish Presidency proposed that when revisiting the theme, the Council could consider taking up a broader definition, hence dealing with other perspectives and target groups.

- In 2003, the Greek Presidency prepared a comprehensive study, which analysed the replies of a questionnaire, sent out to Member States on measures and data in the field of economic decision-making. Based on the preparatory work of the Greek Presidency, the Italian Presidency subsequently formulated nine indicators on women and men in economic decision-making.

- In 2004, the Irish Presidency took the initiative to add to this information and carried out a comprehensive study, which analysed the replies of a questionnaire, sent out to Member States on measures and data on sexual harassment in the workplace. Based on this study, the Dutch Presidency formulated a limited amount of indicators that can facilitate the common goal of eliminating this particular form of violence against women.

Thus, on the background of the gender mainstreaming follow-up of the Beijing process, the European Union has by the end of 2004, adopted indicators in three critical areas of concern of the action platform , i.e.

- Critical area of concern F: Women and the Economy, 5 indicators

- Critical area of concern G: Women in Power and Decision-making, 3 indicators

- Critical area of concern D: Violence against Women and more precisely domestic violence, 1 indicator, and for sexual harassment in the workplace, 3 indicators were adopted by the December Council.

In particular, these agreed indicators are by majority based on comparable quantitative data. Furthermore the European Union has adopted indicators in two other critical areas of concern of the PFA concerning Women and Poverty on the one hand and Women and Education on the other. The corresponding indicators have been included in the employment process.

Thus, at the end of 2004, five of the twelve critical areas of concern defined by the UN can be monitored by indicators, whereas in the other critical areas of concern of the PFA, the European Union still has to agree upon relevant indicators for measuring the impact of these areas on women. The areas of concern that are actually covered by EU indicators are under activity fields for which there exists a EU-wide competence.
