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When welfare is not female: healthcare socialisation and gender inequalities in Italian medicine

*Luisa Nardi**

Author information
* Department of Law Studies, University of Salento, Lecce (Italy).

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Luisa Nardi

Abstract: This paper analyses gender inequalities in the Italian healthcare system by focusing on the gap between formal policy frameworks and everyday care practices. Moving beyond explanations centred on the lack of regulations, it argues that inequalities are reproduced through processes of healthcare socialisation that shape the recognition of symptoms, access to services, and the credibility of patients' experiences. Drawing on a theoretically informed policy analysis and the conceptually driven case study of the Bollino Rosa (Pink Badge) initiative, the paper identifies key mechanisms through which gender-sensitive policies are selectively translated into practice. These include organisational constraints, professional routines, and implicit gender norms. The analysis shows that, despite the institutionalisation of gender medicine in Italy, the implementation of equity-oriented approaches remains uneven and contingent. The Bollino Rosa programme is understood as a governance device that mediates between policy and practice, highlighting both the potential and the limits of relational welfare initiatives. The paper then contributes to sociological debates on welfare and gender by showing how healthcare systems reproduce inequalities through everyday practices and calls for a relational rethinking of healthcare governance.

Keywords: Healthcare Welfare, Inequalities, Gender Medicine, Health Socialisation, Care Practices

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Women and Health: A Twisting Path

The critical issues facing the healthcare system cannot be attributed solely to budgetary constraints or limited resources. Alongside economic and organisational factors, there continue to be gender inequalities. These inequalities are rooted in cultural representations and stereotypes that influence women's access to, and quality of, care, as well as their care pathways. These inequalities are often normalised within healthcare practices and tend to remain invisible in both the public debate and current scientific literature, thus contributing to their reproduction over time (Doyal, 1995).

As Cersosimo (2023) points out, Western medicine has historically developed according to an androcentric view, taking the male body as the reference model for clinical research, diagnosis, and treatment of diseases. Female specificities have long been attributed almost exclusively to the reproductive sphere, while pathologies not directly related to it have been addressed through protocols based on male parameters. This approach has resulted in the systematic underrepresentation of women in clinical studies and less appropriate care, with significant effects on health outcomes.

An important contribution to challenging this model is Bernadine Healy's (1991) essay on the *Yentl syndrome*, which revealed how women, particularly those with cardiovascular disease, have long been misdiagnosed and undertreated compared to men. Healy's metaphor highlights how women have had to "take on" masculine characteristics to be recognised as legitimate patients, revealing the structural nature of gender inequalities in healthcare.

These critical issues have gradually established gender medicine as a cross-cutting perspective, integrating sex and gender into the analysis of diseases, clinical pathways and prevention strategies (Signani, 2015). This approach aligns with feminist thought, which has criticised the social construction of medical knowledge and its historical association with male models of power. The distinction between sex and gender has highlighted the interaction between biological and social factors in producing health inequalities, making dichotomous and reductive interpretations inadequate (Doyal, 1995; Rieker & Bird, 2005).

Despite the increased presence of women in healthcare professions and medical training over recent decades, there continue to be gender asymmetries in the organisation of healthcare systems and care practices (Rieker & Bird, 2005; Cersosimo, 2023). Therefore, recognising gender medicine as a field of research and intervention is a pivotal scientific development, while also providing a valuable opportunity to critically question the relationship between medical knowledge, welfare and social inequalities (Bertin, 2012a; Bertin, Ellison & Moro, 2021). This paper argues that gender inequalities in healthcare are not primarily the result of missing policies, but of the ways in which policies are translated into everyday practices through processes of healthcare socialisation. By focusing on the Italian case, it shows how the gap between formal equality frameworks and lived experiences is shaped by organisational routines, professional cultures, and implicit gender norms.

This raises a key sociological question: how are gender inequalities reproduced within healthcare systems that formally recognise gender equality?

From a methodological perspective, the study is based on a theoretically informed policy analysis and a conceptually driven case study. The aim is not an empirical generalisation but analytical generalisation, using the *Bollino Rosa* initiative as a heuristic case to explore broader dynamics of healthcare socialisation and gender inequality.

Weaknesses in the Italian healthcare model: areas in need of improvement

Despite the proliferation of guidelines and regulatory measures, the Italian healthcare system continues to face significant challenges, particularly regarding the practical implementation of policies and access to services. In several cases, the adoption of measures aimed at tightening procedures and access criteria has been ineffective as they do not adequately consider the actual organisational contexts and behaviours of those involved. An approach that interprets these problems predominantly in technical terms tends to marginalise the perspectives of patients and healthcare professionals, viewing them as disturbance variables. This often results in interventions that are disconnected from the complexity of everyday practices, producing limited effects and sometimes contributing to the reproduction of the critical issues they are intended to address (Saiani & Di Giulio, 2017).

In this context, gender is a decisive factor in understanding how health inequalities arise and become established over time. Several studies have highlighted how gender influences perceptions of health, demand for care, and experience of services. Biological differences interact with social, cultural, and institutional factors, making interpretations that rigidly separate ‘sex’ and ‘gender’ inadequate (Cersosimo, 2023; Saiani & Di Giulio, 2017). Although gender equality is formally protected by the Italian Constitution, it encounters persistent obstacles in the transition from norms to practices. Well-structured public policies can reduce inequalities and facilitate access, whereas restrictive approaches or organisational shortcomings tend to amplify them.

One emblematic area that brings together institutional, cultural and power dimensions is the voluntary termination of pregnancy (VTP). Although it is legally recognised under Law 194/1978, effective access to abortion can be hindered by organisational and professional conditions, particularly the widespread practice of conscientious objection and the uneven distribution of services across the country. The discrepancy between formal and substantive rights hinges not only on regulations, but also on institutional structures, professional culture, and access networks. Data reported in ministerial reports show high rates of conscientious objection in several regions, which could significantly impact the availability of services (Ministero della Salute, 2022). In many contexts, the consequence is that women need to rely on informal knowledge and external support to navigate between facilities and access options, which could accentuate inequalities for those with fewer social and informational resources.

A second critical area regards the forms of violence and devaluation that can occur in healthcare practices, particularly in relation to sexual and reproductive health. Gender-based violence is recognised as a public health problem with direct effects on physical and psychological well-being, along with broader social consequences (WHO, 2009). In the healthcare setting, these dynamics can take on specific forms, including so-called obstetric violence. From this perspective, the crucial aspect is not only the episodic nature of harmful behaviour, but also its possible normalisation within organisational cultures and asymmetrical relationships between professional knowledge and patient subjectivity. The World Health Organization emphasises the need to ensure respectful and non-discriminatory care during pregnancy and childbirth, drawing attention to the prevalence of non-consensual practices, forms of verbal abuse, lack of information and inadequate structural conditions, which constitute violations of women's rights (WHO, 2014). In this context, patients' narratives and testimonies can be considered useful indicators of organisational climate and situations of vulnerability. However, they must be accompanied by empirical evidence and institutional or research sources in the scientific field, which allow the quantitative data to be contextualised and verified (Lanzetti, Lombi & Marzulli, 2008; Saiani & Di Giulio, 2017).

A third area, closely linked to processes of health socialisation and the credibility attributed to female pain, concerns delayed or incorrect diagnosis of conditions that significantly impact the quality of life, such as endometriosis. The issue is not only clinical: social representations of pain (e.g. normalising it as 'part of the female condition'), communication in the doctor–patient relationship and interpretative biases that can lead to symptoms being minimised also play a role (Rieker & Bird, 2005). This results in longer, more fragmented and more uncertain treatment pathways, with significant individual and social costs. From a sociological perspective, this example makes it possible to observe how widespread beliefs, stereotypes, and institutional practices can converge to produce inequalities in terms of access, recognition, and appropriateness.

The analysis of these critical areas allows to identify key mechanisms through which gender inequalities are reproduced within the healthcare system. First, the selective implementation of gender-sensitive policies, which are unevenly translated across organisational contexts. Second, the influence of professional routines and organisational constraints, which shape how policies are enacted in everyday practice. Third, the persistence of implicit gender norms that affect the recognition of symptoms, the credibility of patients, and the interpretation of care needs.

These mechanisms show that the gap between policy and practice is not incidental; rather, it is structurally embedded in the processes of healthcare socialisation.

Overall, these areas highlight how the fragility of the healthcare model is not solely due to a lack of resources or organisational issues. It also reflects the mechanisms through which healthcare systems recognise (or fail to recognise) needs, rights, and subjectivity, as well as the interplay between gender and power in practice. For this reason, an analysis of policies and institutional mechanisms must consider processes of healthcare socialisation, relational asymmetries, and differentiated access conditions, paving the way for discussion on gender medicine in Italy and initiatives attempting to translate a gender-oriented approach into recognisable practices and services.

Gender medicine in Italy: between institutional recognition and implementation limitations

Over the last two decades, gender medicine has gradually become a more visible topic in Italian scientific and institutional debates, positioning itself at the intersection of health policies, biomedical research, and sociological reflections on inequalities. This recognition is a response to the growing awareness that the healthcare system, which has historically been based on an androcentric model, is not gender neutral and has different effects on the prevention, diagnosis and treatment of health conditions for men and women (Doyal, 1995; Stanistreet, Bambra & Scott-Samuel, 2005).

From this perspective, gender medicine is not a specialised field, but rather a cross-cutting dimension of healthcare. It is aimed at the systematic integration of the biological and socio-cultural differences between men and women into clinical, organisational, and decision-making processes. The World Health Organization has repeatedly highlighted how sex and gender interact to determine health outcomes, necessitating an approach that transcends the dichotomy between biological factors and social determinants (WHO, 2016).

A significant first step was taken in Italy in 2007 with the establishment of the Women's Health Commission at the Ministry of Health. This marked the beginning of the institutional legitimisation of the gender perspective in healthcare (Signani, 2015). This initiative promoted greater attention to the production of sex-disaggregated data and encouraged a public debate on health inequalities, paving the way for subsequent regulatory developments.

Another significant milestone was Law 3/2018, which tasked the Ministry of Health, in collaboration with the National Institute of Health, with developing a national strategy for the implementation and dissemination of gender-based medicine within the National Health Service. Article 3 of the law explicitly recognises the need to consider gender differences in clinical and care pathways, introducing coordination and monitoring tools at the national and regional levels.

The 2019 enactment of the *National Plan for the application and dissemination of gender medicine* further reinforced this approach by outlining objectives and lines of action aimed at ensuring greater uniformity in service provision throughout the country. The Plan stresses the importance of patient-centred and personalised care, highlighting that clinical appropriateness must necessarily consider gender differences throughout the life cycle.

A gender perspective is also strategically important in the *National Prevention Plan 2020–2025*, which explicitly calls on health services to produce, use, and communicate risk factor and lifestyle data disaggregated by sex and gender. Health profiles are a fundamental tool in this context, allowing for any systematic differences to be identified and targeted interventions to be guided.

However, as highlighted in current literature, translating these guidelines into operational practices presents several challenges (Vicarelli, 2023). Despite the increased availability of evidence on gender differences in healthcare, specific recommendations and shared methodologies for evaluating the effectiveness of gender-sensitive prevention policies are often lacking (Morgan *et al.*, 2022). There is a discrepancy between the formal recognition of the problem and the ability of healthcare systems to measure and reduce inequalities in practice.

The establishment of the Observatory for Gender Medicine, as set out in Law 3/2018, addresses the need to monitor the implementation of policies and support the ex-post analysis of regional programmes. However, the monitoring function is often limited by fragmented data and the difficulty of integrating quantitative indicators with qualitative dimensions related to service experience (Saiani & Di Giulio, 2017). From a sociological perspective, these limitations highlight how the institutional recognition of gender medicine does not automatically translate into changes in everyday healthcare practices. Rather, it is mediated by processes of healthcare socialisation, through which policies are interpreted, adapted, and sometimes reconfigured within organisational settings. This helps to explain why, despite the formal advancement of gender-sensitive frameworks, inequalities persist in practice.

Progress and critical issues: a sociological perspective

From a sociological point of view, the development of gender medicine in Italy seems to be characterised by an ongoing tension between innovation and institutional inertia. On the one hand, the introduction of regulatory and programmatic frameworks signals a significant cultural shift in recognising gender as a fundamental health determinant. However, the persistence of rigid organisational models, a lack of specific training, and difficulties in assessing the impact of policies risk reducing gender medicine to a stated principle rather than an established practice.

Gender medicine can be seen as a way of redefining the relationship between medical knowledge, institutions, and patient experience. This requires a re-evaluation of healthcare socialisation practices, encompassing not only clinical skills, but also modes of communication, recognition, and participation. Numerous studies show that integrating the gender perspective into healthcare systems does not automatically produce equity but rather requires organisational learning processes and the active involvement of institutional and professional stakeholders (Rieker & Bird, 2005; WHO, 2016).

It is in this space, defined by the discrepancy between norms and practices, that initiatives that can translate a gender-oriented approach into tangible and accessible services emerge. An analysis of initiatives promoted by civil society and institutional networks, such as the *Bollino Rosa* programme, demonstrates how gender medicine can become operational, affecting access to, and experience of, the healthcare system, as well as relations with it. The following section discusses these experiences. In this perspective, such initiatives can be interpreted not only as practical responses to existing gaps, but also as analytical sites through which it is possible to observe how gender-sensitive policies are translated into organizational and relational practices.

The Bollino Rosa initiatives: healthcare socialisation and gender welfare practices

Considering the structural challenges associated with the implementation of gender medicine within the Italian healthcare system, the *Bollino Rosa* initiatives, promoted by the ONDA Foundation (National Observatory on Women's Health and Gender), are an interesting example of how a gender-oriented approach can be translated into tangible practices concerning access, information, and care. These initiatives occupy an intermediate space between public policies, healthcare organisations and civil society, helping to operationalise the concept of gender-sensitive healthcare (Bertin, 2012b). Rather than considering *Bollino Rosa* merely as a best practice, this paper interprets it as a governance device through which it is possible to observe how gender-sensitive policies are translated into organizational and relational practices. In this sense, the case functions as an analytical lens to examine the dynamics of healthcare socialization and the conditions under which gender-oriented approaches become operational.

Founded in 2005, the ONDA Foundation was established with the aim of promoting a culture of gender-specific health at institutional, healthcare and scientific levels. Since 2007, the awarding of the *Bollino Rosa* (Pink Badge) to Italian hospitals offering services dedicated to women's health has given rise to a national network of healthcare facilities assessed according to criteria geared towards the prevention, diagnosis and treatment of the main female diseases, as well as the quality of reception and care pathways (Signani, 2015).

From a sociological perspective, the *Bollino Rosa* can be interpreted as a symbolic and practical device that influences patient orientation processes within the healthcare system. The recognition given to hospitals not only certifies the presence of specific clinical services but also establishes a framework that facilitates an informed choice of place of care. This reduces the information asymmetry that often characterises the experience of users, particularly in contexts marked by territorial and organisational inequalities (Cesareo & Giarelli, 2007).

Publishing hospital evaluation results and rankings on the ONDA Foundation website makes information more transparent and comparable, strengthening women's active role in healthcare pathways. The *Bollino Rosa* initiative acts as a mediator between citizens and healthcare institutions, promoting informational empowerment to influence access behaviours and expectations of services.

A key aspect of the *Bollino Rosa* initiatives is the dimension of healthcare socialisation, which is defined as the process through which individuals and groups develop their understanding of health and their relationship with the healthcare system. These initiatives are particularly important for young women, who are often at the stage of consciously accessing healthcare services for the first time and constructing their own ideas about prevention and care. The open days, open weeks and campaigns organised by participating hospitals offer structured opportunities for the public to engage with services, where prevention and information take on an educational role.

These initiatives, dedicated to diseases that have a significant impact on women's health, such as cardiovascular disease, osteoporosis, rheumatic diseases and mental health, help to challenge the long-standing perception that women's health is almost exclusively related to reproduction. Free access to examinations, consultations and information sessions reduces economic and symbolic barriers, thus promoting familiarity with the healthcare system and encouraging early preventive behaviours.

The *Bollino Rosa* initiative also pays particular attention to the quality of care and the care relationship. These are recognised by sociological literature as fundamental determinants of the healthcare experience (Doyal, 1995). Participating hospitals are assessed on criteria relating to the organisation of spaces, the availability of support services, and the management of particularly vulnerable situations. Examples include dedicated pathways for women who are victims of violence.

In this context, the multidisciplinary approach of *Bollino Rosa* hospitals appears to be consistent with the concept of gender medicine, overcoming specialist fragmentation and valuing the integration of clinical, psychological, and social skills (Rieker & Bird, 2005). The emphasis placed on personalising diagnostic and therapeutic pathways reflects the need to recognise the evolving needs of women throughout their lives, in line with WHO guidelines and the principles of the *National Plan for Gender Medicine.*

The analysis of the *Bollino Rosa* initiatives also highlights the importance of networks in creating a more inclusive healthcare system. The collaboration of foundations, hospitals, scientific societies, pharmacies and local services shows how the promotion of gender-sensitive healthcare can benefit from network governance that can mobilise various resources and adapt to local contexts. Such networks also facilitate intergenerational meetings and exchanges, where prevention practices, health terminology and care models are shared, adapted and debated by women of different ages.

However, this configuration raises critical questions. While networks offer an opportunity to innovate practices and services, there is a risk that they will compensate for deficiencies in the public system by transferring responsibilities that should be uniformly guaranteed by the state to project initiatives and civil society. Without systematic integration into regular health policies, there is a risk that positive experiences will remain limited or dependent on the availability of resources and the sensitivity of individual institutional contexts.

Despite these limitations, the *Bollino Rosa* initiatives significantly contribute to the promotion of gender medicine in Italy by raising awareness of practices geared towards equity and personalised care. They show how the gender perspective can be translated into tangible actions affecting healthcare socialisation processes, the relationship between citizens and services, and the quality of care.

From a sociological perspective, these experiences are valuable not only for the services they provide, but also for their ability to generate shared meanings around women's health and to counter stereotypes and simplistic models. The *Bollino Rosa* can be understood as a laboratory of practices that, to some extent, anticipates the rethinking of healthcare governance in relational and gender terms, which is becoming increasingly necessary today (Doyal, 1995). In this sense, the *Bollino Rosa* case illustrates how healthcare socialisation processes mediate between policy frameworks and everyday practices, making visible the mechanisms through which gender inequalities can be both reproduced and partially transformed.

Conclusions: When Welfare is Not Female

The analysis presented in this paper has shown how gender inequalities in health protection do not simply arise from a lack of regulatory instruments or policy guidelines; rather, they emerge from the persistent gap between stated principles and actual practices in healthcare. In this context, the title of this paper (*"When welfare is not female"*) does not refer to an absence of policies targeting women's health. On the contrary, it highlights the structural challenges of the healthcare system in recognising and systematically incorporating the unique needs, experiences, and care pathways of women (Cersosimo, 2023; Doyal, 1995). More specifically, this paper has shown that gender inequalities are reproduced through healthcare socialization processes that mediate between formal policy frameworks and everyday practices. These processes operate through organizational routines, professional cultures, and implicit norms that shape access to care, the recognition of needs, and the credibility of patients.

In the Italian context, the progressive institutionalisation of gender medicine has been a significant step forward, introducing a conceptual and regulatory framework oriented towards equity and the personalisation of care. However, as the analysis shows, this recognition risks remaining largely formal unless accompanied by changes in organisational practices, professional cultures, and healthcare socialisation processes (Signani, 2015; Vicarelli, 2023). The fragilities highlighted in critical areas, such as access to sexual and reproductive health services, the management of female pain and forms of violence in healthcare settings, demonstrate how gender inequalities are perpetuated in implicit and normalised ways.

From this perspective, gender inequalities in health cannot be understood exclusively through biomedical categories or quantitative indicators (Lanzetti, Lombi & Marzulli, 2008). They require an interpretation that integrates relational, symbolic, and institutional dimensions (Rieker & Bird, 2005; Cesareo & Giarelli, 2007). Health socialisation processes play a crucial role in shaping representations of health and pain, as well as the legitimacy of healthcare demands. This influences the ways in which women access services and interact with the healthcare system. Mechanisms of exclusion and devaluation are embedded in these processes, contributing to making healthcare less equitable and inclusive.

Analysis of the *Bollino Rosa* initiatives has shown how practices can emerge within this framework that translate the gender approach into concrete experiences of access, information and reception. These initiatives demonstrate the potential of a healthcare governance model that is relationship-oriented, transparent and participatory. In this model, women's health is recognised as a cross-cutting dimension of collective well-being, not confined to a specialist field. However, they also highlight the limitations of a model that relies on specific networks and projects to compensate for deficiencies in the public system, raising questions about the sustainability and uniformity of interventions across different regions.

Thus, a gender-based rethink of healthcare welfare cannot be limited to introducing new regulatory measures or multiplying isolated examples of good practice. It requires greater investment in training healthcare professionals, producing and using gender-sensitive data, and promoting healthcare education programmes that recognise the complexity of women's needs throughout their lives (Cersosimo & Merico, 2020). Only through an integrated approach combining governance, practices, and socialisation can we imagine more equitable, inclusive, and consistent models of care that reflect contemporary social transformations.

In conclusion, to question *when* and *why* welfare is not female is to question the neutrality of healthcare systems, recognising that gender equality is not an automatic outcome of policies but rather the result of organisational, cultural, and relational choices (Doyal, 1995; Bertin, 2012b). Gender medicine therefore presents a challenge to the healthcare system as well as an opportunity to rethink welfare as a space for recognition, care, and social justice.

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