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Gender, Equity, and Quality in Health Care: Enhancing Health System Performance through Policy and Indicators Development in Greece

Konstantina Sklavou[1], Christos Triantafyllou[2]*, João Breda[2]

1. Department of Social Work, University of West Attica, Athens, Greece.
2. WHO Office on Quality of Care and Patient Safety, Athens, Greece.

Abstract

Background: The HEALTH-IQ project addresses critical gaps in quality, equity, and gender responsiveness in Greece's healthcare system. Persistent challenges—including fragmented services, inadequate quality standards, and inequitable access—limit progress toward universal health coverage. This national initiative, aligned with Sustainable Development Goals and WHO standards, seeks to establish a standardized framework for quality assessment that incorporates evidence-based strategies, gender-sensitive indicators, and rights-based policies.

Methods: A comprehensive situational analysis, guided by the WHO Gender, Equity, and Human Rights (GER) framework, explored gender disparities in healthcare access, utilization, and outcomes. The study combined desk reviews of scientific literature, policy documents, statistical reports, and grey literature with mapping exercises to identify systemic barriers. Data were examined with a focus on vulnerable and marginalized groups, including migrants, low-income populations, LGBTQ+ individuals, people with disabilities, older adults, and rural residents, considering intersecting determinants such as socioeconomic status, geography, and discrimination.

Results: Seven priority indicators were developed to measure gender equity and service quality: gender gaps in healthcare access, life expectancy, gender-based violence and related services, mental health access, work-life balance impacts on women's health, public expenditure on gender-sensitive services, and accessibility for women from vulnerable groups. Additional indicators were proposed for future research, including cancer screening rates, maternal mortality, healthcare workforce gender distribution, gender pay gaps, chronic disease prevalence, and pandemic impacts. Findings revealed significant data limitations, particularly in gender-disaggregated and intersectional statistics, hindering effective monitoring and intervention.

Conclusions: Integrating gender and rights perspectives into healthcare measurement and governance is essential to achieving equitable, high-quality services in Greece. This requires embedding gender-sensitive indicators in health information systems, training providers to address implicit bias, and designing inclusive policies responsive to the needs of diverse populations. Community engagement and culturally competent care are critical for empowering underserved groups and improving service uptake. By institutionalizing these approaches, the HEALTH-IQ project offers a replicable model for rights-based health reform, positioning Greece as a leader in equitable health system quality and ensuring that universal health coverage is both inclusive and sustainable.

Keywords

Gender, Equity, Rights, Health care, Policies, Quality care, Health indicators.

Corresponding author: Christos Triantafyllou, WHO Office on Quality of Care and Patient Safety, 10675 Athens, Greece, triantafyllouc@who.int

Introduction

The pandemic, war, and other emergencies have exposed critical vulnerabilities in national health systems across Europe and beyond, emphasizing the urgent need for resilience and service readiness amid what has been termed a health permacrisis. These pressures have highlighted systemic challenges such as fragmentation, lack of coordination, care discontinuity, resource shortages—especially in human capital—underuse of services, and diminished patient safety. In Greece, in particular, significant deficiencies have been identified in the implementation of reliable quality standards, performance measurement, and procedures related to patient care and service delivery (clinical protocols and guidelines, leadership, experiential training of health workers, organizational and administrative issues, appropriate legal framework regarding quality of care etc.)[1]. The lack of effective tools for assessing and improving care quality, coupled with limited availability of quality-related services, continues to obstruct meaningful health system reform and equitable access to care. In response, the World Health Organization (WHO) established the WHO European Centre of Excellence for Quality in Care and Patient Safety in Athens in 2021, aiming to support health care quality improvements and patient safety in line with the European Programme of Work 2020–2025: United Action for Better Health in Europe. As part of its National Development Programme (NDP) 2021–2025, the Hellenic Republic has prioritized the restructuring of its health system, recognizing that success in this effort depends on the ability to measure and evaluate the qualitative performance of health care and services delivered by health service providers across the country. In this context, the project "Development and implementation of a framework for quality measurement and assessment of health care and of services provided by health service-providing bodies" (HEALTH-IQ Project) launched. This initiative aims to enhance the quality of care across all levels and types of health services in Greece—from prevention and primary care to hospital and long-term care—by introducing a standardized framework for quality assessment. Additionally, the project aspires to position Greece as a leader in health care quality within the EU and the WHO European Region, leveraging and promoting a new toolbox of quality standards designed to support health system improvements.

Background

Defining Quality of Care in Health Systems

Quality of care is one of the most frequently quoted principles of health policy, and it is currently high up on the agenda of policymakers at national, European and international levels [2].

At the international level, quality is receiving increasing attention in the context of the Sustainable Development Goals (SDGs), as the SDGs include the imperative to "achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all". This is reflected in two WHO reports published in 2018, a handbook for national quality policies and strategies [20] and a guide aiming to facilitate the global understanding of quality as part of universal health coverage aspirations [3].

Quality health care can be defined in many ways but there is growing acknowledgement that quality health services should be: effective (providing evidence-based healthcare services to those who need them), safe (avoiding harm to people for whom the care is intended) and people centered (providing care that responds to individual preferences, needs and values) [4]. According to WHO, Quality of care, defined as the degree to which health services improve the likelihood of desired health outcomes for individuals and populations, is grounded in evidence-based professional knowledge and is essential for achieving universal health coverage. As countries strive toward the goal of Health for All, prioritizing quality in health services becomes imperative. High-quality health care is increasingly recognized as care that is effective—delivering evidence-based services to those in need; safe—minimizing harm to patients; and people-centred—attuned to individual preferences, needs, and values [5]. To fully realize these benefits, health services must also be timely—reducing delays and wait times; equitable—ensuring consistent quality regardless of gender, ethnicity, location, or socio-economic status; integrated—offering a continuum of services across the life course; and efficient—making optimal use of resources while avoiding waste. It is based on evidence-based professional knowledge and is critical for achieving universal health coverage [6]. As countries commit to achieving Health for All, it is imperative to carefully consider the quality of care and health services. In fact, the dimensions of quality of care have been the focus of considerable debate over the past forty years [7]. The next section focuses on this international discussion around the dimensions of quality of care.

Access and Utilization of Health Services by Gender

Access to the healthcare sector can be mediated by a significant number of socioeconomic factors, giving rise to inequalities among different social groups. Women and men in the EU can expect to be in good health until 65 and 64 years of age, respectively. However, as women tend to live longer, they spend a greater proportion of their lives in poor health – an average of 19 years, compared with 14 years for men.

Gender constitutes one of the above-mentioned socioeconomic factors, with women generally considered to be in less advantaged position than men regarding this particular issue. According to Geitona, Dimitrios and Kyriopoulos' analysis, it appears that the utilization of primary healthcare in Greece depends on self-rated health status, age, income, gender, and region [8]. In this context we can see the dimension of access and utilization of health services via health literacy. Health literacy is a serious problem. Effective interventions can be implemented to mitigate the negative impact on women's health [9]. WHO defines health literacy as 'the cognitive and social skills which determine the motivation and ability of in-

dividuals to gain access to, understand and use information in ways which promote and maintain good health' and explains that "health literacy implies the achievement of a level of knowledge, personal skills and confidence to take action to improve personal and community health by changing personal lifestyles and living conditions" [10]. Low health literacy negatively affects a woman's health knowledge, preventive behavior, ability to navigate the health care system, and ability to take care of their selves [11].

Quality of care for vulnerable and marginalized groups

Quality of care for vulnerable and marginalized groups is a critical issue in healthcare systems worldwide. These groups often experience inequities in access to and quality of healthcare due to social, economic, and systemic barriers [9, 12, 13, 14, 15].

Table 1. Quality of care and marginalized groups

Groups	Characteristics	Health system
Racial and ethnic minorities	Immigrants/refugees, ROMA, and other minority groups	Often face systemic discrimination in healthcare settings. May face legal, financial, and cultural challenges when accessing healthcare.
Low-income populations	Poverty as a significant determinant of health outcomes	Limited access to preventive care, nutritious food, and health education. May face legal, financial, and social challenges when accessing healthcare.
LGBTQ+ individuals	Stigma, discrimination	Lack of providers with specific expertise in LGBTQ+ health. May face legal, financial, and cultural challenges when accessing healthcare.
People with disabilities	Physical, intellectual, or sensory disabilities	Face physical barriers to healthcare facilities, as well as biases in care. May face legal, financial, and cultural challenges when accessing healthcare.
Older adults	Complex healthcare needs that are often unmet	Inadequate resources or ageist attitudes. May face legal, financial, and cultural challenges when accessing healthcare.
Homeless populations	Often struggle to access consistent care	Their living conditions may worsen health outcomes. May face legal, financial, and cultural challenges when accessing healthcare.

Improving the quality of care for these populations involves addressing inequities in healthcare services and ensuring that care is equitable, culturally sensitive, and accessible to all. Vulnerable and marginalized groups may face multiple barriers to receiving quality care, including [16]:

- **Socioeconomic Factors**: Poverty, lack of insurance, and limited access to resources can limit individuals' ability to receive adequate healthcare.
- **Geographic Barriers**: People living in rural or underserved areas may struggle to access medical facilities, specialists, or preventive care services.
- **Discrimination and Bias**: Implicit or explicit biases against marginalized groups (such as racial or ethnic minorities, LGBTQ+ individuals, or people with disabilities) can negatively affect the quality of care they receive.
- **Cultural and Language Differences**: Cultural misunderstandings and language barriers can hinder communication between patients and providers, leading to inadequate care or misdiagnoses.
- **Legal and Policy Restrictions**: In some cases, laws or regulations may limit access to services, particularly for immigrants, refugees, or individuals with stigmatized conditions such as HIV/AIDS.

Especially, LGBTIQ asylum-seekers face multiple health risks. Yet, little is known about their healthcare needs. LGBTQI + refugees and asylum seekers experience enormous distress during their lifespan. Ill-effects of socio-cultural stigma, systemic violence, and forced migration due to sexual orientation, gender identity or expressions, and sex characteristics (*SOGIESC*) are not their only challenge. The cumbersome asylum process in host countries negatively affects their mental health and well-being [17].

Women from vulnerable groups face unique and compounded challenges in accessing quality healthcare and other essential services. These women often experience discrimination, inequality, and multiple barriers related to their gender and the intersecting factors of race, socioeconomic status, disability, sexuality, and immigration status. Ensuring quality care for women from vulnerable groups requires understanding the specific needs and addressing systemic barriers that limit their access to necessary services [18].

Table 2. Women and vulnerable characteristics

Groups	Vulnerable Category - characteristics
Women from racial and ethnic minorities Migrant, refugee, and undocumented women	These women face legal, cultural, and language barriers, along with fear of deportation or discrimination in healthcare settings. Often experience systemic racism in healthcare.
Low-income women	Poverty is a major determinant of health, limiting access to healthcare, reproductive services, and preventive care.
Women with disabilities	Physical, intellectual, or sensory disabilities can limit access to health services, particularly in facilities not designed for inclusivity.
LGBTQ+ women	Women from LGBTQ+ communities, especially transgender women, face stigma, discrimination, and a lack of providers knowledgeable about their specific health needs.
Elderly women	Older women, particularly those who are low-income or live alone, often struggle with social isolation, chronic health issues, and inadequate geriatric care.
Women in rural areas	These women may have limited access to healthcare facilities and specialists, particularly in maternal and reproductive health.
Survivors of domestic violence or trafficking	These women often face additional health needs related to trauma, mental health, and sexual and reproductive health, yet may fear seeking help due to stigma or safety concerns.

Methods

Situation Analysis

A detailed situational analysis will be conducted to investigate gender disparities within Greece's health system [19] [20] [21] [22] [23]. This includes the creation of situational, relational, social world/arena, and positional maps. Data sources include ethnographic memos, transcribed interviews, and document reviews, focusing on how gender norms affect healthcare access and outcomes [24] [25] [26] [27] [28] [29] [30]. The Situation Analysis used the Gender, equity and human rights analysis framework as an analytical framework. The Gender, Equity, and Human Rights (GER) Analysis Framework is a tool developed by WHO to systematically assess how gender, equity, and human rights considerations affect health outcomes and access to health services. It helps in identifying and addressing disparities and inequalities within health systems by integrating these key principles into policy development, programming, and decision-making.

Data Collection and Desk Review

A desk review is conducted, involving in-depth analysis of the available literature on the topic, including review of existing research and data on gender, equity and rights in health care [20]. The review will include available data of the global literature of GER and quality care worldwide and in Greece. These sources could include, but not limited to, published scientific articles, databases of international or national relative organizations, grey literature, reports from key civil society organizations representing underserved sub-populations and websites, national health plan, population health surveys, national health information system data (including trend data), performance reports (e.g. annual health statistics report), facility assessments, administrative data, research/evaluation studies, datasets/ documents from ministries, data sets/ documents from civil society – reviews, analyses, evaluations, case studies, etc. The following databases and sources could be used in order to carry out the desk research: *WHO, OECD, National School of Public Health, Archives of Hellenic Medicine, Health Science Journal, Journal of Psychiatric and Mental Health Nursing, Rostrum of Asclepius, Health Policy, The International Journal of Health Planning and Management, General Secretariat for Demographic and Family Policy and Gender equality, Observatory of Gender Equality of the General Secretariat for Demography and Family Policy and Gender Equality and the National Statistical Authority (ELSTAT)*. Data collection included an in-depth desk review to collect all available literature on the topic and any statistical data existing, disaggregated by gender to assess differences in health outcomes, access to healthcare services and risk factors [31].

The literature review was driven the needs assessment in the field under research and help us to identify gaps and areas needing further research, as well as to report on the current situation. The review will also identify any data limitations and bias in terms of adherence to the Sex and Gender Equity in Research (SAGER) Guidelines, and the Human Rights-Based Approach to Data framework (described below). Literature published the last 20 years will be searched (2004-2024), to include information, if existing, about before and after financial crisis in Greece, as well.

Desk review included but not limited to, the following key terms: ["health" OR "health services" OR "health care"] AND ["access" OR "equity" OR "quality" OR "satisfaction" OR "barrier" OR "obstacle"]. Inclusion criteria were a) published from 2004 to 2024, b) concerning Greece, c) published in Greek or English language.

Limitations

Despite its contributions, this research faces several limitations that should be acknowledged. Firstly, the availability and quality of gender-disaggregated health data in Greece are limited, making it difficult to measure some indicators accurately or consistently over time. Secondly, many existing datasets do not account for intersectional factors such as ethnicity, migration status, disability, or socioeconomic background, which are crucial for understanding the full scope of gender-related health disparities [32]. Additionally, cultural stigma around issues such as mental health and gender-based violence may lead to significant underreporting, further complicating data reliability [33]. Lastly, the lack of standardized national indicators aligned with international gender health frameworks poses challenges for comparability and policy alignment.

Results

Improving gender equity and rights in healthcare requires a multifaceted approach that begins with integrating gender-sensitive policies at all levels of healthcare delivery. This involves training healthcare professionals to recognize and address gender biases that affect patient treatment and access [34]. Healthcare systems should prioritize the recruitment and retention of a diverse workforce that reflects the communities they serve, ensuring that women's perspectives and needs are adequately represented in decision-making processes [35]. Furthermore, collecting disaggregated data on health outcomes and access by gender is crucial for identifying gaps and tailoring interventions effectively. By implementing these measures, healthcare organizations can create an inclusive environment where all individuals, regardless of gender, feel valued and supported in their health journeys.

In addition to systemic changes, community engagement plays a vital role in promoting gender equity and rights in healthcare. Initiatives aimed at raising awareness about health rights and services available to marginalized groups can empower individuals to seek the care they need [36]. Community health programs that specifically target gender-based health issues, such as reproductive health and domestic violence, can help break down stigma and encourage open discussions about these topics. Collaborating with local organizations and advocacy groups can further enhance the reach and effectiveness of these initiatives. By fostering a culture of inclusivity and support within communities, healthcare systems can significantly improve health outcomes and ensure that everyone has equal access to necessary services [10].

Ensuring quality of care that incorporates gender, equity, and well-being is fundamental to achieving universal health coverage and fostering inclusive development. These principles acknowledge that health systems must serve diverse populations equitably, considering the unique needs, barriers, and rights of individuals across different genders, socioeconomic statuses, and social contexts [4].

Gender-responsive care addresses the distinct health needs of men, women, and gender-diverse individuals while challenging harmful gender norms that can hinder access to services. Equity-focused interventions prioritize the most vulnerable populations, reducing disparities in access, outcomes, and experiences. At the same time, integrating well-being ensures a holistic approach, where physical, mental, and social health are considered integral to quality care [5]. However, achieving these goals requires actionable strategies and robust measurement frameworks. By identifying gaps, monitoring progress, and fostering accountability, policymakers and practitioners can transform health systems to be inclusive and rights-based [37].

In the frame of this program, we encompassed at seven indicators pertinent to gender, equity and well-being, with an emphasis on the quality of services among other aspects and policies on gender.

Table 3. Indicators, description and measurement

No.	Indicator	Desription	Potential Measurement Variables
1	Gender Gap in Access to Health Services [38 – 41]	Measures differences between men and women in access to health services, including reproductive and maternal care, especially in rural and remote areas.	Income, educational level, and rural or remote living conditions, to represent the barriers more commonly experienced by men and women.
2	Life Expectancy by Gender [42 – 46]	A comparison of life expectancy at birth for men and women, reflecting overall well-being and health disparities between genders.	Life expectancy as per the Hellenic Statistical Authority (ELSTAT) relies on the period life expectancy formula, which offers a snapshot of mortality conditions for a specific year.
3	Gender-Based Violence and Health Services [47 – 50]	The prevalence of gender-based violence, such as domestic violence and sexual abuse, and the availability and quality of health services for survivors.	Gender-based violence, such as domestic violence and sexual abuse, and the availability and quality of health services for survivors.
4	Mental Health Service Access by Gender [51 – 55]	Rates of access to mental health services among men and women, addressing gender-specific mental health needs and social stigma.	Variables for prevalence of mental health conditions by gender from surveys, health records, or national statistics.
5	Work-Life Balance Challenges and Women's Health [56 – 60]	The access of women in health services involves assessing the work life balance regarding work demands, personal responsibilities, and support systems.	Qualitative measurement of the relationship between work-life balance challenges and women's health involves assessing the subjective experiences of women regarding work demands, personal responsibilities, and support systems.
6	Public Health Expenditure on Gender-Sensitive Services [61 – 67]	The proportion of public health funding allocated to services addressing women's health issues (e.g., maternal health, reproductive health, gender-based violence support), indicating government commitment to gender equity in healthcare.	Funding for Women's Health and Total Public Health Fundings
7	Accessibility to health services for women from vulnerable population groups [4, 68 - 69]	It reflects how effectively healthcare systems address barriers like socioeconomic status, geographical location, and discrimination.	Quantitative methods provides insight into specific barriers and areas for improvement in healthcare equity.

For each indicator, we analyzed the following sections: Rationale, Calculation Formula, Numerator, Numerator Definition, Denominator, Target Population, Periodicity, Data Collection Steps, Notes and References and Sources for Further Reading.

As we move forward, addressing gender disparities remains crucial for fostering equitable health outcomes and enhancing the overall effectiveness of healthcare systems. Future research should focus on understanding the multifaceted factors contributing to gender inequalities in health access, workforce representation, and compensation. By leveraging data-driven insights, policymakers can implement targeted interventions that promote gender equity, improve health services for all, and ensure that both men and women have equal opportunities to thrive in the healthcare sector. Collaborative efforts among governments, organizations, and communities will be essential to create inclusive policies that not only address current disparities but also pave the way for a more equitable future in health and beyond. On this basis, we described six more indicators on gender and women's health for future research and policies [38-69].

Table 4. Indicators, description and measurement for future research

No.	Indicator	Desription	Potential Measurement Variables
1	Cervical and Breast Cancer Screening Rates	It refers to the percentages of eligible populations that participate in recommended screening tests for cervical and breast cancer.	Screening rates are measured by the proportion of eligible women who have undergone the screenings within a specified timeframe, usually reported annually.
2	Maternal mortality - reproductive health	It refers to the death of a woman during pregnancy, childbirth, or within 42 days of termination of pregnancy, from any cause related to or aggravated by the pregnancy or its management. It is a critical indicator of reproductive health and overall health system effectiveness.	Death of a woman during pregnancy, childbirth, or within 42 days of termination of pregnancy, from any cause related to or aggravated by the pregnancy or its management.
3	Healthcare Workforce Gender Distribution	It refers to the representation of different genders within the healthcare workforce, including doctors, nurses, allied health professionals, and support staff. This indicator helps assess gender equity in healthcare professions.	Data collected from national health registries, professional associations, and workforce surveys.
4	Gender Pay Gap in the Health Sector	It refers to the difference in earnings between male and female healthcare workers, often expressed as a percentage of men's earnings. This gap highlights disparities in compensation that can arise from various factors, including discrimination, occupational segregation, and differences in job roles or experience levels.	Comparing the average salaries of male and female healthcare workers within similar roles, often using median earnings to account for extreme values.
5	Prevalence of Chronic Diseases by Gender	It allows health professionals to explore biological, behavioral, and societal factors that drive gender differences in conditions like cardiovascular disease, autoimmune disorders, cancer, and mental health issues.	Rates of conditions like cardiovascular disease, diabetes, cancer (e.g., breast, prostate), autoimmune diseases, and mental health disorders broken down by gender.
6	Pandemic and Gender	It analyzes the impact of pandemics by gender involves systematically examining how men and women experience and respond to health crises differently, accounting for biological, economic, and social dimensions.	Periodic data collection on infection and mortality rates by gender can reveal trends, such as higher mortality in men, which may be linked to immune and behavioral differences.

Discussion

The development and implementation of gender-specific health indicators are crucial for addressing systemic inequalities and improving the overall quality of care. By integrating evidence-based practices and inclusive policies, HEALTH-IQ aims to enhance health system responsiveness to gender-specific needs. Additionally, the project's methodology fosters a comprehensive understanding of social determinants and structural barriers in healthcare.

To the best of our knowledge, this is the first comprehensive attempt to compile and systematize gender-sensitive health indicators specifically for the Greek context. While gender disparities in health have been acknowledged in various international reports, Greece lacks an integrated framework or dataset that captures these differences in a structured and measurable way. Existing national health statistics often fail to disaggregate data by gender or to consider intersecting factors such as geographic isolation, socioeconomic vulnerability, or gender-based violence. This work aims to fill that gap by proposing a set of indicators tailored to the Greek healthcare system, with the goal of informing evidence-based policy and promoting gender equity in health services.

The effectiveness of Greece's healthcare policies and their responsiveness to gender-specific health needs have varied significantly over time, shaped by economic crises, austerity measures, and healthcare reforms. For example, the 2008 financial crisis had profound effects on women's health outcomes, leading to reduced access to services and increased financial strain, especially among lower-income women [21]. In recent years, political efforts to improve healthcare access have aimed to address these disparities, but gaps remain, particularly in services tailored to women's mental health, reproductive health, and chronic disease management [15]. Together, quantitative and qualitative methods provide a comprehensive understanding of women's health indicators in Greece [22]. Quantitative data helps track national health trends over time, while qualitative methods reveal the lived experiences behind these numbers, highlighting systemic barriers, cultural influences, and the impact of political and economic conditions on women's health. This dual approach underscores the importance of considering both numerical data and human experience to fully address and improve women's health outcomes in Greece [42].

Women's health indicators in Greece provide critical insights into the interplay between health outcomes and the broader socio-political context. These indicators reflect both quantitative data—such as statistics on gender life expectancy —and qualitative dimensions, like personal access barriers and satisfaction with care. So methods for measuring these indicators encompass both quantitative data—gathered from national health surveys and hospital records—and qualitative research, such as interviews and focus groups, which highlight individual experiences and structural barriers [42 - 46]. Together, these methods offer a comprehensive view of women's health in Greece, illuminating how factors like political stability, economic conditions, and social policies directly impact women's health outcomes and access to care [38 – 41].

The analysis of women's health indicators in Greece reveals nuanced trends that reflect the nation's socio-economic and political landscape. Quantitative data from sources such as the Hellenic Statistical Authority and the WHO highlight concrete metrics like life expectancy, fertility rates, incidence of non-communicable diseases, and maternal and infant health. [24 – 30] These statistics underscore notable disparities, for instance, rural women in Greece face a higher prevalence of certain chronic conditions due to limited access to healthcare facilities, while urban women might have better access but still encounter long wait times and other system inefficiencies.

Qualitative research, such as interviews and case studies, provides essential context for interpreting these indicators. For example, qualitative studies have revealed that cultural factors and social expectations around caregiving heavily influence Greek women's mental health, as many women carry the dual burden of professional and domestic responsibilities [47 – 50]. Focus groups have highlighted that while public health services exist for maternal and reproductive health, satisfaction levels are often low, with many women citing feelings of neglect or lack of personalized care [51 – 55]. These insights are particularly relevant in areas where gender-based violence and mental health are concerned, where stigma and insufficient training among healthcare providers often hinder effective intervention.

Economic instability and political shifts over the past decade have led to resource cuts in Greece's healthcare system, disproportionately affecting women's health services. For example, austerity measures following the economic crisis reduced funding for preventive care programs and reproductive health services, leading to a temporary increase in rates of untreated health conditions among women [64]. Political commitments to restore and expand public health services are underway, but progress has been uneven, and many women, especially those from vulnerable groups, continue to face gaps in access and quality.

Although recent policy initiatives aim to restore healthcare resources and improve access, gaps remain, particularly in gender-sensitive services, mental health support, and culturally competent care. Moving forward, Greece's healthcare policies would benefit from a more targeted approach that acknowledges both the quantitative metrics and the qualitative realities of women's health. By doing so, Greece can work toward a more equitable, resilient healthcare system that addresses the unique needs of women and supports improved health outcomes for all. In conclusion, women's health indicators in Greece offer a critical lens through which to examine the broader impacts of socio-political and economic factors on public health.

Integrating gender and rights into Quality of Care measurement frameworks is essential for ensuring equitable healthcare in Greece, where gender disparities and social determinants impact access to and quality of services. In Greece, as in many countries, healthcare policies often fail to fully account for the distinct experiences and needs of different genders, particularly in areas such as reproductive health, mental health, and gender-based violence support. This oversight can lead to disparities in care, particularly for women and gender minorities, who may face unique healthcare barriers or stigmatization in clinical and community health settings.

Incorporating a gender and rights perspective into Greece's Quality of Care frameworks can strengthen its commitment to human rights and enhance the responsiveness of the healthcare system. By integrating gender-sensitive and rights-based indicators, healthcare providers and policymakers can better understand the impact of social and cultural norms, economic inequalities, and systemic discrimination on health outcomes. This approach not only improves patient care but also aligns with Greece's obligations under European Union directives on gender equality and human rights, reinforcing the nation's dedication to upholding inclusive and non-discriminatory healthcare standards.

A gender and rights-sensitive Quality of Care framework in Greece would entail measuring and addressing specific challenges that disproportionately affect women and gender minorities, such as access to reproductive healthcare, equitable treatment for chronic conditions, and support for mental health. It would also focus on training healthcare providers to deliver respectful and non-biased care, reinforcing the im-

portance of dignity, autonomy, and choice for all patients. This inclusive framework will ensure that healthcare policies are evidence-based and rooted in the real-life experiences of Greece's diverse population. Ultimately, integrating gender and rights into Quality of Care measurement is not only a step towards greater healthcare equity but also an investment in the nation's social and economic well-being, fostering a healthier and more inclusive society.

Integrating Gender and Rights (GRE) into Health Management Information Systems (HMIS) represents a critical advancement for creating equitable, inclusive, and rights-based healthcare frameworks. This integration enables healthcare systems to capture data that reflects the nuanced needs and experiences of various populations across gender lines and within diverse socio-cultural contexts. By embedding GRE indicators into HMIS, health data collection and analysis become more comprehensive, capturing disparities in access, utilization, quality, and outcomes of care across gender and marginalized groups. Such information is essential for identifying areas of inequity, guiding policy adjustments, and ensuring that healthcare delivery aligns with human rights principles.

An HMIS that incorporates GRE data helps reveal patterns of discrimination or unmet needs, such as gaps in maternal and reproductive health, gender-based violence response, mental health support, and other services that disproportionately affect women and gender minorities. Furthermore, GRE integration allows health systems to monitor the impacts of policies and programs on these groups over time, supporting data-driven approaches to eliminate healthcare inequities. For example, GRE-informed HMIS could track patient satisfaction, autonomy in health decisions, and access to respectful care across various demographics, ensuring that gender and rights issues are systematically addressed in healthcare delivery. Integrating GRE into HMIS requires training personnel to understand and apply gender-sensitive and rights-based metrics, modifying existing data infrastructure to capture and analyze relevant indicators, and establishing guidelines to protect privacy and ensure ethical data usage. When effectively implemented, a GRE-integrated HMIS empowers decision-makers with actionable insights, promoting a healthcare system that upholds dignity, addresses gendered health disparities, and strengthens adherence to national and international commitments to health equity and human rights.

Continuing, we explore key suggestions for integrating gender, equity, and well-being into health systems and public services in Greece while we have outlined innovative measurement tools and indicators to ensure sustainable improvements. Together, these efforts contribute to a fairer, healthier system where care is accessible, respectful, and tailored to the needs of every individual.

Conclusion

The HEALTH-IQ initiative represents a transformative approach to health system reform in Greece. By embedding gender equity, quality, and rights-based principles into policy and practice, the project aligns with international best practices and contributes to achieving SDG targets. The resulting data and indicators will support targeted interventions and policy development, ensuring that no one is left behind in accessing high-quality health care.

List of abbreviations

WHO World Health Organization
NDP National Development Programme
SDG Sustainable Development Goals
SOGIESC Sexual Orientation, Gender Identity or Expressions, and Sex Characteristics
GER Gender, Equity, and Human Rights
ELSTAT National Statistical Authority
SAGER Sex and Gender Equity in Research
HMIS Health Management Information Systems

Declarations

Ethics approval and consent to participate
Not applicable
Consent for publication
Not applicable
Availability of data and materials
The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.
Competing interests
The authors declare that they have no competing interests

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Authors' contributions

KS performed the situational analysis, desk review, and literature review, and drafted the manuscript. CT contributed to the desk and literature review, and reviewed and edited the manuscript. JB supervised the study and reviewed and edited the manuscript. All authors read and approved the final version.

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