WORLD HEALTH ORGANIZATION

ORGANISATION MONDIALE DE LA SANTE

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WOMEN, HEALTH AND DEVELOPMENT

Many countries of the Region have recently enjoyed considerable economic progress, which has been reflected in improvements to the overall health status of their populations. However, these improvements have not benefited all segments of society equally. Considerable disparities still exist between and within countries and, particularly, between genders. Many communities continue to suffer from poverty and malnutrition and to be excluded from the benefits of economic prosperity. In such communities women are often the most disadvantaged group. Gender discrimination and resulting inequities start from conception and continue across the lifespan. Despite the fact that in most countries of the region women outlive men, they have higher levels of morbidity and score worse than men on most quality of life measures.

Women's health is affected by the disparities generated by a wide range of socioeconomic, political and cultural factors. These include rural–urban migration; physical violence; sexual abuse; malnutrition; lack of control over fertility; increasing prevalence of sexually transmitted diseases, including HIV and AIDS; exposure to dangerous chemicals and pesticides at work; and the hardships suffered by women heads of household. This document presents a brief summary of the progress made in addressing these women's health issues, including the involvement of women in the work of WHO.

The Regional Committee is asked to take note of this report and to make recommendations on future actions to eliminate gender inequities in the Region.

1. INTRODUCTION

The need to promote women's health, to enhance their status within the family and the community, and to increase their role and participation in the overall development process has been recognized for several decades. It was reaffirmed during two major international conferences: the International Conference on Population and Development in Cairo in 1994 and the Fourth World Conference on Women in Beijing in 1995. However, 12 years after the end of the United Nations Decade for Women (1976-1985), gender inequities persist. These limit women's participation in the development process and affect, in a variety of ways, their health status at all stages of their lives.

2. FACTORS AFFECTING WOMEN AT DIFFERENT STAGES OF THEIR LIVES

2.1 From birth to adolescence

A preference for male offspring in some countries of the Region has led to selective male:female delivery ratios of up to 120:100. Girls are often taken to health services later than their brothers and many are undernourished compared to their brothers. Consequently, in some countries, under-five mortality is higher for females than males. Gender discrimination is also reflected in shorter educational periods and lower literacy rates for girls. These inhibit the assertive capacity of women in all aspects of life, affect their ability to institute changes and hamper their access to health-related information. Sex-role stereotyping starts at a very early age and contributes to girls and women being accorded lower status in many areas of life.

2.2 Reproductive age period

Many countries in the Region have recently enjoyed considerable overall economic progress; however, increased resources have not been equitably distributed among all segments of the society. The recent introduction of market economies in some countries; the establishment of new private sectors which charge for health care; and the implementation of structural adjustments, as required by some international agencies, have had detrimental consequences for some women (especially if they are heads of household). Many women now have to pay for health services which were previously free and women are often the first to lose their jobs in times of economic hardship.

Women often experience difficult working conditions, including exposure to pesticides in the agricultural sector or to toxic substances in factories. Furthermore, poor transport facilities, long working hours and the absence of child care facilities may affect both women's reproductive functions and their occupational roles. Women, and particularly single parents, often carry a double burden: at home and in the workplace.

In some countries high fertility and rural-urban migration have led to rapid population growth in urban areas. This rapid urbanization is often accompanied by a rapid deterioration in environmental and living conditions. In rural areas, women continue to constitute the majority of the workforce. Their poverty is often exacerbated by the urban migration of their partners in search of wages.

During their reproductive years, women's health problems are made worse by restrictions on their reproductive choices; by inadequate reproductive health care services; by social, economic, cultural or geographical barriers which often prevent access to health services; and by the application of some harmful traditional practices. Younger women, in particular, have an increasing risk of contracting sexually transmitted diseases (STDs), including HIV and AIDS. Women are more vulnerable than men to such diseases partly for biological reasons, but mainly because of their weak negotiating position in matters of marriage and sexual relations. Unprotected sexual activity, particularly among adolescents, often leads to unwanted pregnancies and unsafe abortion practices, which again increase women's health risks.

2.3 Menopausal and post-menopausal periods

Women generally have a longer life expectancy than men and often marry older men. Many women, therefore, spend their later years in isolation, marginalized and suffering from chronic diseases, osteoporosis, infections or permanent disabilities. Many of the health problems of elderly women are due to inappropriate delivery practices and other pathological consequences of the reproductive process, or to violence, abuse and neglect. In many countries women lose social status after their reproductive phase has ended, although in some societies their status is enhanced on reaching menopause.

3. ISSUES OF CONCERN

Before major changes can be introduced to improve women's health and social status, accurate and current data for a number of indicators relating to women must be produced. Gender-disaggregated[1], gender-specific[2] and gender-sensitive[3] data need to be routinely collected and analysed to inform the planning, design, implementation and evaluation of gender-sensitive programmes at agency and country levels.

Furthermore, programmes, particularly those on reproductive health, should be designed with direct and active women's participation and involvement.

While the health sector has a major role to play to ensure appropriate quality of care and sufficient geographical coverage of services, many other sectors should also be involved. The aim must be to minimize sectoral barriers and to improve access to, and utilization of, health care services.

Increased women's education, expanded use of fertility regulation methods, responsible parenthood with male involvement and more gender equity in all spheres of life are all necessary if women's health is to improve and their participation in the development process to increase.

4. WOMEN, HEALTH AND DEVELOPMENT IN WHO ACTIVITIES

4.1 Global level

This section briefly mentions some of the major activities undertaken by WHO in the field of women, health and development.

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[1] Gender-disaggregated data: indicator applicable to the entire population (e.g. literacy rate), but divided according to gender (e.g. female literacy rate and male literacy rate).

[2] Gender-specific data: indicator applicable to one gender only (e.g. breast, cervical, uterine cancer for females; prostate cancer for males).

[3] Gender-sensitive data: indicator capable of revealing gender differences (e.g. different treatment/remuneration for men and women under the same working conditions; delays in taking girls to medical services as compared to boys).

In order to facilitate the incorporation of women's concerns and perspectives into the work of WHO at the global level and to increase its advocacy role among Member States, a separate programme, Women, Health and Development, was established in 1981. This programme was charged with preparing a list of gender-sensitive and gender-specific indicators to help in the collection of information and analysis of factors affecting women's health and their role in society. Such a list was included in the WHO Eighth General Programme of Work 1990-1995.

The list of indicators for the global monitoring and evaluation of the health-for-all strategy included additional indicators to reflect some aspects of women's health, e.g. maternal mortality ratio and contraceptive prevalence rate.

The Women, Health and Development Programme has been able to play a considerable advocacy role at several World Health Assemblies. Consequently, many WHA resolutions have aimed to increase the participation of women in various expert committees and among WHO staff.

Most recently, WHA50.16, among other things, calls for targets to be set at 50% by 2002 for new appointments of women to professional categories (see Annex 1). The eventual goal is for women to occupy 50% of professional positions within WHO. Other recent actions have included the appointment of a Coordinator on Employment and the Participation of Women; the approval of an antisexual harassment policy within the Organization, adopted in the Region in March 1997; and initiatives in several countries, including the Philippines, to start research on determinants and health consequences of domestic violence against women.

The activities of the Women, Health and Development Programme were complemented and supported by the Global Commission on Women's Health, established by the World Health Assembly in 1993.

The Commission has helped to focus global attention on specific areas affecting women and played a leading role at the Fourth World Conference on Women.

4.2 Activities in the Region

All WHO programmes in the Western Pacific Region are responding to the recommendations of the Beijing Platform for Action. Women's issues are coordinated in the Regional Office by a long-term member of staff appointed as a focal point on women. Actions in a few key areas are described below.

Fourth World Conference on Women. In the lead-up to the Fourth World Conference on Women in Beijing, the Regional Office produced five monographs and three country profiles on subjects related to women. These were widely distributed during the conference.

In accordance with the recommendations of the International Conference on Population and Development and the platform for action of the Fourth World Conference on Women, the Regional Office promotes women's health across the lifespan as advocated in the regional document *New horizons in health.*

Women in their social context. To improve the quality of health care and to support women to make more informed choices, guidelines have been produced to enable health workers to provide better care and education and information on such topics as contraceptive options; counselling techniques; normal delivery and early identification of risks; collection, analysis and use of indicators; and maternal and children's nutrition. The social, educational, cultural and traditional determinants of women's health have been highlighted in the regional document *Women's health in a social context in the Western Pacific Region.* This document illustrates WHO's current and future challenges and suggests possible forms of cooperation with Member States.

Data collection. As part of a general drive to disaggregate more data according to gender, the Regional Office has been compiling gender-disaggregated data on lifestyle-related illnesses. One of the documents prepared for the Fourth World Conference for Women, *Lifestyle changes and their impact on the health of women in the Western Pacific Region,* details many of the social and economic factors which are increasingly affecting women's health.

Data on tobacco use reveal that significant percentages of women (over 40% in one case) in some countries smoke more than 15 cigarettes a day. On a more positive note, figures for female smokers in Hong Kong and Singapore have shown decreases over time, although from low levels. To achieve the goals set out in the *Action Plan on Tobacco or Health for 1995-1999,* it will be necessary to continue compiling such data in order to ensure that efforts to discourage people from smoking are directed at the most appropriate areas.

With regard to STDs including HIV/AIDS, although in the Region as a whole there are far more reported cases of HIV infection and AIDS among males than among females (Annex 2), the percentage of women suffering from HIV infection and AIDS is increasing. In certain countries data indicate that 20%-50% of HIV-infected cases are women. Since the campaign to reduce STDs and

HIV/AIDS depends on advising the most at-risk groups on appropriate preventive measures, gender-disaggregated data are particularly relevant here.

The nutrition programme collects and collates data to show differences in the nutritional status of boys and girls, and of men and women. In some areas anaemia affects more than 50% of women of reproductive age. Pregnant women have a much higher risk than men of having iodine deficiencies. Females are often more undernourished than males, particularly as small children, and more likely to suffer obesity as adults.

Employment of women. The human resources for health programme has requested Member States to improve training opportunities for women and to increase the participation of women in advisory bodies and delegations.

In accordance with Regional Committee resolution WPR/RC47.R11 and World Health Assembly resolution WHA50.16, the Regional Office is exerting all possible efforts to recruit suitably qualified women whenever the occasion arises, in order to achieve the targets established by the above resolutions. In 1996, three of the four long-term professional staff recruited were women. In the period January-April 1997, two of the three long-term professional staff recruited were women. With regard to fellowships, in the period 1 July 1996 to 30 June 1997, 141 out of 316 fellowships (45%) were awarded to women.

Reproductive health programme. Women's health remains central to the reproductive health programme. The main aims of the programme are the reduction of maternal morbidity and mortality through appropriate obstetric practices and increased access to a wider choice of fertility-regulation methods.

The programme is in the process of developing a series of reproductive health indicators. It is also suggesting specific analysis procedures at various levels of the health service system in order to improve the appreciation of gender issues, to reveal barriers to wider utilization of medical services and to increase use of contraceptives.

Adolescent health programme. The adolescent health programme pays particular attention to the provision of sexual education and to encouraging responsible, healthy behaviour in young men and women, often highlighting the physical and social consequences of an unwanted pregnancy in adolescence.

Expanded programme on immunization. The expanded programme on immunization and the reproductive health programme jointly promote tetanus toxoid immunization during pregnancy, which protects infants as well as mothers from contracting the disease, particularly during the dangerous delivery period.

Control of noncommunicable diseases programme. The programme on control of noncommunicable diseases has developed gender-specific components, such as cervical cancer screening. With regard to breast cancer, an extensive trial is being carried out in the Philippines to determine the effectiveness of an annual physical examination accompanied by self-examination. The International Agency for Research on Cancer is providing technical and financial support.

Ageing and health programme. The programme on ageing and health is promoting strategies to improve the quality of life in later years. Such a programme particularly benefits women, as the average advantage in terms of life expectancy at birth for women in the Region was estimated at about 5.5 years in 1994.

3. CONCLUSIONS

WHO has made considerable progress at both global and regional levels towards meeting the recommendations of the Beijing Platform for Action, although there is still scope for further progress. It is hoped that these efforts will be matched by Member States with regard to the collection and gender disaggregation of appropriate and reliable indicators, the incorporation of gender perspectives into analysis of a broad range of issues and in a determination to take all measures required to achieve more gender equity in the Region.

ANNEX 1

世界衛生大會 決議 قرار جمعية الصحة العالمية

RESOLUTION OF THE WORLD HEALTH ASSEMBLY

RÉSOLUTION DE L'ASSEMBLÉE MONDIALE DE LA SANTÉ

РЕЗОЛЮЦИЯ ВСЕМИРНОЙ АССАМБЛЕИ ЗДРАВООХРАНЕНИЯ

RESOLUCION DE LA ASAMBLEA MUNDIAL DE LA SALUD

FIFTIETH WORLD HEALTH ASSEMBLY **WHA50.16**

Agenda item 29.1 12 May 1997

Employment and participation of women in the work of WHO

The Fiftieth World Health Assembly,

Noting resolutions WHA48.28 and WHA49.9;

Noting the situation at September 1996 regarding the proportion of women on the staff in established WHO offices and their distribution by grade;

Noting that the Strategic plan of action (1995-2000),[1] which was endorsed by the United Nations General Assembly in its resolution 49/167 of 23 December 1994, established the overall goal of parity for women by the year 2000, with a target of 25% in policy-level positions (D1 and above) by 1997;

Recognizing that women can also participate in WHO as temporary advisers, consultants and on scientific and technical advisory groups;

Recognizing the additional value that a balance of male and female staff can bring to the work of the Organization,

1. CALLS FOR the target for representation of women in the professional categories to be increased to 50% in WHO;

2. CALLS FOR targets to be set at 50% by 2002 for new appointments of women to professional categories, representation of women as temporary advisers, consultants and on scientific and technical advisory groups;

3. STRONGLY URGES Member States to support the strategies and efforts of the WHO Secretariat to increase the percentage of women in professional posts, by identifying more women candidates and regularly submitting their candidatures, and by encouraging women to apply for posts;

[1] See United Nations General Assembly document A/49/587, part IV: "Strategic plan of action for the improvement of the status of women in the Secretariat (1995-2000)".

Annex 1

4. REQUESTS the Director-General and Regional Directors:

(1) to ensure full and urgent implementation of the action outlined in the Director-General's report;

(2) to raise the minimum thresholds for the recruitment of women;

(3) to set minimum thresholds for participation of women as temporary advisers, consultants and on scientific and technical advisory groups;

(4) to report annually to the Executive Board on progress in increasing the representation of women in the professional categories, and as temporary advisers, consultants and on scientific and technical advisory groups.

Eighth plenary meeting, 12 May 1997
A50/VR/8

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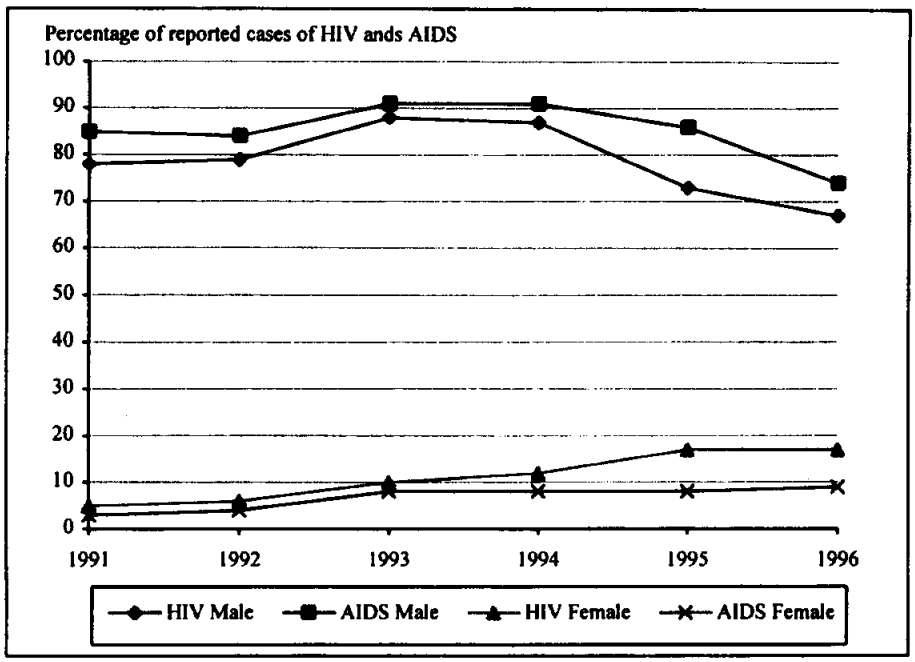
ANNEX 2

PERCENTAGE OF TOTAL REPORTED CASES OF HIV INFECTION AND AIDS IN MEN AND WOMEN WESTERN PACIFIC REGION, 1991-1996



Note: Annual figures for cases of HIV infection and AIDS, respectively, do not sum up to 100% because some cases were not identified by sex.