Women in Development

A position paper

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Background

The Forty-seventh session of the Regional Committee of the WHO Regional Office for the Western Pacific (WHO, WPRO) addressed the full involvement of women in all aspects of the work of WHO in the Western Pacific Region paying particular attention to the recruitment policies of the Organization. In line with that agenda, the Regional Committee stressed the ‘importance of increasing the representation of women in higher-graded professional posts in WHO’. To achieve this objective the Committee urged ‘Member States to identify appropriate females to participate in government delegations, special bodies and representations, and fellowship programmes, and as candidates for employment in WHO’ and ‘to increase training opportunities for women’. A request was made to the Regional Director for WHO, WPRO ‘to continue efforts to reach the 30% target for representation of women in the professional category’ and ‘to report to the Regional Committee on progress made’ (WPR/RC47/SR/8).

The Regional Director is pleased to report that at the Regional Office in 1996-1997 43% of new professional appointments were women and 45% of the 316 fellowships were awarded to women. Shortlisting for professional positions also exceeded the target (50% in 1996; 36% in 1997). WPRO is thus in a good position to meet the 2002 global target of 50% female recruitment in professional categories which was set at the Fiftieth World Health Assembly in 1997 (WHA50.16). Countries are also actively promoting the full involvement of women in all aspects of WHO in the region. The Ministry of Health and Social Welfare in Fiji, the Ministry of Health and Medical Services in the Solomon Islands, the Department of Health in Vanuatu, the Department of Public Health in the Northern Mariana Islands, the Tokelau Apia Liaison Office in Samoa and the New Zealand Ministry of Health have all made written commitments, on behalf of their governments, to meet the regional target of 30% recruitment of women at decision making levels throughout WHO, WPRO by the year 2000.
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At the Forty-seventh session of the Regional Committee, the representative from New Zealand suggested that the agenda be broadened (beyond recruitment policies) at the Forty-eighth session of the Regional Committee to focus on the ‘impact of WHO activities on women and the ability of women to participate and benefit from those activities’, in other words, to shift the focus to how WHO’s programmes can incorporate a gender perspective in all their activities (Ministry of Women’s Affairs, The Full Picture Te Tirohanga Whanui: Guidelines for gender analysis, 1996).

The Regional Director welcomes the opportunity at the Forty-eighth session of the Regional Committee to address this more expansive approach to women’s involvement in development as both receivers and providers of health care and health policy.

Although WPRO does not currently have a mandate to develop a specific policy on women in health development, the unanimous endorsement by Member States in the Western Pacific Region of both the United Nations Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the Beijing Platform for Action (BPFA), and their strategic objectives suggests a clear role for WPRO in contributing to improvements in women’s participation in health decision-making and in encouraging countries to consult with women on all matters pertaining to their health. In contrast to other WHO regions, no country in the Western Pacific Region put forward reservations to the BPFA so the tasks before the Regional Office, as mandated in the PFA, are relatively straightforward.

Since the start of the United Nations Decade for Women (1976-1985), many global and regional forums (including several sessions of the World Health Assembly) have addressed the issue of systematic inequity in health experiences, based on gender, and some consensus has been reached on the measures needed to minimize such gender inequity. The benchmark global agreement to eliminate gender inequities, contained
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More recently, the Platform for Action (PFA) of the United Nations World Conference on Women in Beijing in 1995 named institutional mechanisms for the advancement of women as one of its critical areas of concern (paragraphs 196-209).

The Beijing PFA recommended that greater participation of women in decision-making at all levels of economic and social policy development (including health policy) was essential to generate gender sensitive programmes which could address the systematic discrimination against women which significantly affect their health and well-being.

This was not the first time that this recommendation had been made in an international forum. The 1975 Mexico Declaration and Plan of Action for implementing the objectives of International Women's Year recommended that investment be made by governments, in cooperation with women's organizations, to support concrete programmes for the advancement of women (paragraphs 34 to 36). However, little had been achieved at the country level by the end of the United Nations Decade for Women in 1985, so the recommendation appeared again in the Nairobi Forward-Looking Strategies for the Advancement of Women. In particular Resolution 40/108 (1985), on the establishment of machinery within government to ensure the advancement of women, was made more directive with the addition of the qualification that 'To be effective, this machinery should be established at a high level of government and should be ensured adequate resources, commitment and authority to advise on the impact on women of all government policies' (paragraph 78).
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The restatement of these recommendations in the Beijing Platform for Action (BPFA) in 1995 points to the difficulties that countries are having in implementing the recommendations of 1975 and 1985. ‘Two decades later, governments concur that national machinery remains inadequate for promotion of the advancement of women’ (Nuss, ESCAP, 1996:20). Some of the reasons for failure of national mechanisms to advance women’s interests over the last two decades relate to the fact that such mechanisms are ‘often marginalized in national government structures’ and are frequently ‘hampered by unclear mandates, lack of adequate staff, training, data and sufficient resources, and insufficient support from national political leadership’ (BPFA paragraph 196). To overcome these barriers to implementation of policies to advance women, the Beijing PFA recommends that ‘in addressing the issue of mechanisms for promoting the advancement of women, governments and other actors should promote an active and visible policy of mainstreaming a gender perspective in all policies and programmes so that, before decisions are taken, an analysis is made of the effects on women and men, respectively’ (paragraph 202). In addition, it is recommended that steps be taken to ‘promote the increased participation of women as both active agents and beneficiaries of the development process, which would result in an improvement in the quality of life for all’ [paragraph 205 (d)]. Achieving strategic objective H.3. of the Beijing PFA to ‘generate and disseminate gender-disaggregated data and information for planning and evaluation’ is seen as a necessary first step to developing effective gender sensitive development policies.

The Human Development Report 1997 (UNDP, 1997) provides a comprehensive global review of the ‘gender gap’ in health, social, political and economic status. The Report proposes a six-point plan of action to eradicate poverty, which includes urging ‘nations to commit themselves to gender equality in order to unleash the energy and productive capabilities of women around the world’ (Wenzel, 1997). The Report argues that ‘Poverty eradication without gender equality is impossible and a contradiction in terms’ suggesting that priorities for closing the gender gap should include ‘equal access to education and health, to job opportunities and to land and credit and actions to end domestic violence’ (UNDP, 1997:110). In the 1997 edition of the Human Development Report, progress towards gender equity is assessed using two measures of the
disparities in opportunities for men and women which were first developed for the 1995 Human Development Report and which use gender-disaggregated data. They are the Gender-related Development Index (GDI) measuring achievements in life expectancy, educational attainment and income by gender, and the Gender Empowerment Measure (GEM) which measures women's access to professional, economic and political opportunities. These measures are designed to 'help nations monitor their progress in closing the gender gap'.

At the regional level, the Second Asian-Pacific Ministerial Conference on Women in Development in Jakarta in June 1994 (Jakarta Declaration for the Advancement of Women in Asia and the Pacific) reviewed and evaluated the extent to which governments in the Asia Pacific region had succeeded in advancing women's participation in development since 1985. The conclusions were similar to those of the Beijing Conference. A further review of the Asia Pacific situation was carried out in September 1996 in Seoul, at the Regional Meeting on Strengthening National Machineries for the Advancement of Women for Implementation of the Beijing Platform for Action, where the need for urgent action to strengthen 'both national machinery and women's organizations' to achieve advancement of women, in all spheres of life, was emphasized.

At the regional meeting a two-pronged approach was promoted to plan, advocate, coordinate, monitor and mobilize support for, women-centred development. The first strategy is to involve women as decision-makers, the second is to incorporate women's perspectives into all programmes and policies. The first step in both these strategies is to assess the current situation for women in each country by gender disaggregating all data and undertaking research on how women's perspectives on issues are different from men's.

At the same time, where the dimensions of women's disadvantage are clear, as in their low participation rates in senior decision-making bodies, specific measures can be applied immediately. For example the specific measures needed to bring about increased participation of women in key decision-making roles involve providing genuine equity of employment and training opportunities for men and women.
The conditions needed to maximize such equity would involve both structural and attitudinal change. At the structural level, the provision of adequate and acceptable childcare for mothers who wish to train and/or work in senior administrative roles, allowing for flexibility in working hours and affirmative action in areas where women are underrepresented may enhance participation by women.

At the attitudinal level initiatives to improve women's participation would include active promotion of the sharing of household tasks between men and women, breaking down workplace attitudes which militate against women and provision of assertiveness training for girls at an early stage of their education to enhance their self-esteem and confidence in taking on such senior responsibilities in the future. These measures obviously involve a multisectoral approach, with the health sector combining forces with education, industry and the media to promote such change.

Acknowledging that health is a product of biological, psychological, social, political, cultural and economic factors, and that improvements in health rely on a multisectoral approach, WPRO, in collaboration with governments and nongovernmental organizations, is committed to enhancing women's role in economic and social development and governance such that policies which are appropriate and acceptable to women are promoted.
WPRO’s commitment: From rhetoric to action

The challenge for organizations (government, nongovernmental and grassroots), charged with developing policies and programmes to improve health in the countries and areas of the Western Pacific region, is to take the concerns raised in Beijing, and other global and regional forums, seriously and to initiate concrete steps to eliminate discrimination against women in all fields of existence such that all barriers to women potentially attaining a 'state of complete physical, mental and social well-being' are removed.

WHO’s role is to support the initiatives being taken by countries and areas in the Region to implement the recommendations of the Beijing PFA and to identify barriers to implementation of those recommendations. The Beijing PFA (endorsed by all countries in the Region), and New horizons in health (WPRO’s blueprint for health advancement into the twenty first century) together provide the guiding framework and the strategy for enhancing women’s health and well-being in the Region. WHO, WPRO, also plans to evaluate the impact of its activities on women and the ability of women to participate in, and benefit from, those activities.

WPRO, for its part, is committed to applying the principles enunciated in the Beijing PFA to its programmes. In partnership with governments, nongovernmental organizations, women’s groups and other grassroots organizations in the member countries, WPRO aims to fulfil its mandate of providing scientific and technical expertise, and all other resources at its disposal, to improve the health, well-being and quality of life of all people of the Western Pacific Region.
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Ultimately, women within countries are in the best position to decide on their priority health concerns and develop appropriate strategies to deal with such problems. WPRO does not make unilateral decisions, its role is to support country-initiated strategies and to bring together information from all Member States such that countries can learn from each others' experiences. WPRO, as the clearing house for national data, is in a position to identify priority issues and set goals for the region as a whole, and, in consultation with Member States, suggest regional strategies to deal with problems such as the continuing high maternal mortality ratios in many parts of the Western Pacific.
WPRO’s specific responses

The WHO Regional Office for the Western Pacific has taken the messages from Beijing seriously and is starting to build a gender-sensitive approach into all of its programmes, starting with a commitment to gender disaggregate all data collected from countries such that the extent of women’s disadvantage in health status, provision of services etc. can be ascertained. This is based on the development by WPRO, in 1994, of a new framework for addressing health inequalities into the twenty first century, *New horizons in health*. The framework adopts a lifespan approach to health needs which acknowledges that peoples’ health experiences and needs vary by age, gender, socioeconomic class, ethnicity, race and geographical location. In line with the *New horizons in health* document new indicators were developed to monitor progress towards the achievement of the goals of *New horizons in health*, including the use of quality of life measures (such as the WHOQOL) which are sensitive to gender differences.

Research on how gender impacts on health experiences is being supported in all programmes of WHO, WPRO and steps are being taken to empower women in the decision-making processes around health. Thus WHO, WPRO is promoting ‘an active and visible policy of mainstreaming a gender perspective in all policies and programmes, so that, before decisions are taken, an analysis is made of the effects for women and men, respectively’ (paragraph 104 PFA).

The Human Resources Development programme is providing a series of fellowships and other training programmes, within an affirmative action framework, to upgrade the skills of women in national development activities. This action is in response to discussions at the Forty-seventh session of the WHO Regional Committee for the Western Pacific in Seoul in 1996 and paragraph 109 (c) of the Beijing Draft Platform for Action which recommends action to ‘increase the number of women in leadership positions in the health professions, including researchers and scientists, to achieve equality at the earliest possible date’. To remove some of the barriers to achieving employment equity with men, WPRO is also
advocating on behalf of women for countries to provide support for childcare while women are undergoing training programmes. As outlined at the Forty-seventh session of the WHO Regional Committee for the Western Pacific in Seoul in 1996 (WPR/RC47.R11), WPRO aims to meet the WHO headquarters’ target of 30% female representation in professional category staff and continues to urge member states to identify women participants to represent governments in official delegations and women candidates to fill employment vacancies in WPRO.

A four-country study on adolescent girls and risk is planned for late 1997, to address the problems outlined in paragraphs 93 and 95 (BPFA) in relation to high-risk sexual behaviour in adolescence and teenage pregnancy, paragraph 98 on particular risks for adolescents of contracting HIV/AIDS and STDs, and paragraph 100 on the risks of tobacco use in adolescents, and the recommendation that actions be taken to promote healthy behaviour in adolescents [paragraphs 106(l), 107(g), 108(k)].

Young women will be consulted on their perceptions of risk and suggestions about possible solutions to risky practices and risky environments. The young women will then be invited, with material, logistical and financial support from WHO and its collaborating centres, to develop their own networks (e-mail, telephone, fax and/or mail) with women of same age group in other countries to continue dialogue around minimizing risk. This is in line with the suggested action to be undertaken by ‘Governments, the United Nations and its specialized agencies, international financial institutions, bilateral donors and the private sector, as appropriate’ (paragraph 111) to ‘provide appropriate material, financial and logistical assistance to youth nongovernmental organizations in order to strengthen them to address youth concerns in the area of health, including sexual and reproductive health’ [paragraph 111(b)].
The Maternal and Child Health (MCH) programme staff and a team of consultants prepared a Women’s Health series of monographs, which were presented and distributed at the Beijing Conference, addressing key concerns for women’s health in the region. This series covered reproductive health, women’s experiences of ageing, abortion, women and education, women and lifestyle changes, violence against women and specific needs of women in several countries in the region.

The MCH programme is preparing a monograph on Women, Health and Development for distribution to countries in the region, which address key issues identified in the PFA. The monograph, in line with paragraph 89 (PFA), examines the context of women’s health, identifying the social, cultural, economic and political antecedents to reproductive health and well-being. In the light of differential experiences of countries in the region of the demographic transitions, the monograph identifies some of the barriers to improvements in maternal mortality and morbidity in response to the need to:

*Strengthen and reorient health services, particularly primary health care, in order to ensure universal access to quality health services for women and girls; reduce ill health and maternal morbidity and achieve worldwide the agreed-upon goal of reducing maternal mortality by at least 50 per cent of the 1990 levels by the year 2000 and a further one half by the year 2015 [PFA paragraph 106 (l)].*

The monograph also deals with ways of combining traditional and indigenous knowledge with scientific medicine practices in reproductive health to enhance women’s positive experiences of childbirth and other reproductive transitions. It addresses Strategic objective C.4. of the PFA to ‘promote research and disseminate information on women’s health’ by ‘promot(ing) gender-sensitive and women-centred health research, treatment and technology and link(ing) traditional and indigenous..."
knowledge with modern medicine, making information available to women to enable them to make informed and responsible decisions' [paragraph 109 (b)]. It also acts to empower indigenous women by ‘acknowledg(ing) and encourag(ing) beneficial traditional health care, especially that practised by indigenous women, with a view to preserving and incorporating the value of traditional health care in the provision of health services, and support research directed towards achieving this aim’ [paragraph 109 (j)].

The Maternal and Child Health programme is also supporting the formulation of a safe motherhood policy in Viet Nam and Lao People's Democratic Republic, and the family spacing policy in Cambodia, in collaboration with women's groups in those countries, in an attempt to address the major source of inequity for women in the region, namely maternal mortality and morbidity.

The Nutrition programme is concentrating on the special needs of women, in particular anaemia (which affects 40% of the female population in the Western Pacific Region) and other micronutrient deficiencies. Other nutritional problems which disproportionately affect women are iodine deficiency (producing goitre) in China and Vitamin A deficiency which has serious consequences for pregnant women and their offspring. Both malnutrition and under nutrition are major problems for many women in the Western Pacific Region, both of which relate to women's role in the food chain. Women's nutritional status is dependent on who makes the money in the family, who decides on spending and what status women have in the community.

In response to a reduction in breast-feeding in many countries in the region, the Nutrition programme encourages countries to 'promote public information on the benefits of breast-feeding; examine ways and means of implementing fully the WHO/UNICEF International Code of Marketing of Breast-milk Substitutes, and enable mothers to breast-feed
their infants by providing legal, economic, practical and emotional support' [Para 106(r)]. Differential practices in relation to breast-feeding between male and female infants is also a major problem which women's groups in the countries are addressing in collaboration with WPRO.

The Environmental Health programme is also exploring ways to increase understanding of women’s health. Sims (1994) *Anthology on Women, Health and Environment* points to specific issues for women associated with both external environmental pollution of water, air, workplaces, and agriculture and indoor air pollution. In particular the use of 'smoky' coal for cooking in Xuan Wei, China, has been associated with a high incidence of lung cancer amongst women and the combination of passive smoking and smoke from unvented coal stoves in Beijing produces high prevalence rates of respiratory symptoms in women. The solution to such problems may relate to increasing women’s participation at the community level. For example, community level participation by women deciding to make mosquito nets in Malaysia had a dramatic effect on levels of malaria.

In other parts of the region similar gendered experiences produce differential health outcomes for women. Para 102 (PFA) suggests we need to be cognizant of both similarities and differences in men’s and women’s experiences of environmental pollution and degradation:

> 'Women, like men, particularly in rural areas and poor urban areas, are increasingly exposed to environmental health hazards owing to environmental catastrophes and degradation. Women have a different susceptibility to various environmental hazards, contaminants and substances and they suffer different consequences from exposure to them.'
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The Environmental Health programme supports countries in their efforts to 'formulate special policies, design programmes and enact the legislation necessary to alleviate and eliminate environmental and occupational health hazards associated with work in the home, in the workplace and elsewhere with attention to pregnant and lactating women' [paragraph 106(p)]. It also supports the recommendations of the Rio Conference on environment and Development and encourages countries to 'reduce environmental hazards that pose a growing threat to health, especially in poor regions and communities; apply a precautionary approach, as agreed to in the Rio Declaration on Environment and Development, adopted by the United Nations Conference on Environment and Development, 18/ and include reporting on women's health risks related to the environment in monitoring the implementation of Agenda 21; 19/ [107 (n)].

The Healthy Cities and Healthy Islands projects, which span several of WPRO's programmes, address the specific needs and issues associated with health promotion and healthy environments for women and for men.

The Sexually Transmitted Diseases and AIDS programme, has been active in supporting the idea that AIDS is not just a homosexual and intravenous-drug-users problem. The gender-disaggregated epidemiological data suggests that women are closely approaching men's incidence rates. Similarly rates of other sexually transmitted diseases for women has increased substantially in the last five years. The STD and AIDS programme is employing consultants to assist staff in developing a concentrated prevention programme for both men and women cognizant of the fact that:

HIV/AIDS and other sexually transmitted diseases, the transmission of which is sometimes a consequence of sexual violence, are having a devastating effect on women's health, particularly the health of adolescent girls and young women. They often do not have the power to insist on safe and responsible sex practices and have little access to information and services for prevention and treatment. Women, who represent half of all adults newly infected with HIV/AIDS and other sexually transmitted diseases, have emphasized that social vulnerability
and the unequal power relationships between women and men are obstacles to safe sex, in their efforts to control the spread of sexually transmitted diseases. The consequences of HIV/AIDS reach beyond women's health to their role as mothers and caregivers and their contribution to the economic support of their families. The social, developmental and health consequences of HIV/AIDS and other sexually transmitted diseases need to be seen from a gender perspective (paragraph 98).

Major research initiatives in Lao People's Democratic Republic, Cambodia and Viet Nam, which are seen as the highest risk parts of the Region, are being supported by the WPRO programme on sexually transmitted diseases (STDs) and AIDS. Research is also being undertaken on young women's risk-taking in relation to sexuality and women's needs as carers of those with AIDS.

The Sexually Transmitted Diseases and AIDS programme is working with countries to encourage them to recognize the specific needs of adolescents and providing technical and training expertise to assist the implementation of 'specific appropriate programmes, such as education and information on sexual and reproductive health issues and on sexually transmitted diseases, including HIV/AIDS, taking into account the rights of the child and the responsibilities, rights and duties of parents' [107(g)].

The programme is also supporting Strategic objective C.3. to 'undertake gender-sensitive initiatives that address sexually transmitted diseases, HIV/AIDS, and sexual and reproductive health issues' (PFA, 1995) including taking steps to 'ensure the involvement of women, especially those infected with HIV/AIDS or other sexually transmitted diseases or affected by the HIV/AIDS pandemic, in all decision-making relating to the development, implementation, monitoring and evaluation of
policies and programmes on HIV/AIDS and other sexually transmitted diseases' [paragraph 108(a)].

The programmes on Ageing and Health and Mental Health are also adopting a gendered response to applying the *New horizons in health* multisectoral framework in line with paragraph 101 (PFA) on older women and paragraph 106(q) on mental health. The monograph on *Women's Experiences of Aging in the Western Pacific Region: A Diversity of Challenges and Opportunities* (WHO, WPRO 1995) provides a framework and a set of recommendations (including specific recommendations to improve women's quality of life as they age) which the programme is implementing. The comprehensive guidelines that are being developed, in conjunction with one of the collaborating centres, for countries to use in developing national policies and programmes for care of older people, address the differential experiences of ageing of men and women.

Despite these extensive current and planned initiatives WHO, WPRO still has some way to go in fulfilling the commitments made in Beijing by the United Nations system. Similarly, countries still have work to do in collaboration with women from all walks of life to ensure a democratic and participatory process in developing programmes and policies which benefit women.

**Some country initiatives**

*Strategies, at the country level, to encourage increasing awareness of gender issues in health, increased use of gender analysis and gender disaggregated data and gender impact assessment*

Most countries in the Region have adopted the BPFA as the blueprint for development strategies for the advancement of women at the governmental level and are in the process of developing country national action plans on women's health. Nongovernmental organizations (particularly women's groups) within countries and across countries are also initiating projects to implement the Beijing PFA or to monitor implementation of the PFA recommendations. In many cases the nongovernmental organizations and governments are working together to develop programmes to advance women.
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Western Pacific Region

The Eighth National Congress of Vietnamese Women organized by the Vietnamese Women's Union in Hanoi in May 1997, brought together 1200 women from the many local branches of the Vietnamese Women's Union, industry, rural areas, the professions, government representatives, women from the fifty six ethnic minority groups and foreign delegates to explore strategies for implementation of the resolution of the Eighth Congress of the Communist Party of Viet Nam on a Development Strategy for the Advancement of Women in Viet Nam to the year 2000 (which was the Vietnamese governments commitment to the Fourth World Conference on Women in Beijing). Delegate speakers from Australia, Cambodia, China, Republic of Korea, Lao People's Democratic Republic, Malaysia, Mongolia and Singapore pointed to the overlaps between Viet Nam's commitments to the advancement of women and those of their own countries while emphasizing the differences in strategies to implement such commitments dependent on local experiences and conditions.

The Australian delegate, Ms Di Kilsby (from International Women's Development Agency), praised Viet Nam for its 'very real involvement of the government, government departments and (NGO) agencies, and the army... in making plans and commitments for improving the lives of women'. She further marvelled at the level of grassroots support for such initiatives in Viet Nam. An integrated approach between these stakeholders, under the leadership of the Viet Nam Women's Union, has generated a micro credit project which is 'an innovative model of credit for the poorest women, ensuring not only more income but also better health and nutrition for the women themselves and their families'. Ms Kilsby noted that 'through the experience of taking out loans and managing their own businesses, women gain confidence in themselves and respect from others to enable them to take further steps towards fuller involvement in decision-making'. Delegates from Cambodia, China, Republic of Korea and Lao People's Democratic Republic suggested that the micro credit scheme for women could provide a model for all countries in the Region. Similarly, Viet Nam's high level of female literacy accounts for the overall positive health status for women, despite very low per capita income.
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Lao People's Democratic Republic, on the other hand, is 'one of the ten least developed countries in the world and an estimated 50% of the ethnically diverse population of approximately 4.574 million live below the poverty line' and in addition it has low rates of literacy and primary and secondary education, especially for women and girls (UNICEF-Lao People's Democratic Republic Country Programme of Cooperation 1998-2002, 1997). In some rural provinces, primary school completion rates are as low as 23%. It is thus hardly surprising that the 'child survival indicators in Lao PDR are amongst the lowest in South-East Asia (and the world) with the Infant Mortality Rate (IMR) and Under 5 Mortality Rate (U5MR) at 113 and 142 respectively' and a 'high maternal mortality ratio (MMR) estimated at 653 per 100 000 live births'.

In line with Lao People's Democratic Republic's accession to both 'the Convention on the Rights of the Child and to the Convention to End All Forms of Discrimination Against Women (CEDAW)' the Lao Women's Union is addressing these major problems and setting priorities for a gendered approach to policy and services for women in its preparation for the Fourth Congress of Lao Women. In particular literacy rates for women, infrastructure developments to cater for the social, economic, health and educational needs of women in remote areas, economic growth and creating the conditions for political and social stability will be emphasized (Madame Khempet Pholsena, Vice-President Lao Women's Union, May 1997).

Creative measures are being developed to overcome the barriers to achievements of these ends which have been partly brought on by the unintended consequences of the reform economic programme, The New Economic Mechanism. The recently established 'National Development Plan emphasizes rural development and a commitment to maximize human resource development' however, 'the government faces a very severe shortage of trained and skilled human resources and this has a major impact on the government's ability to deliver the quality services that it is committed to providing'. This creates a dilemma whereby the 'socioeconomic changes provide greater opportunities to the populace at large' but 'adversely affect the governance and service delivery capacities, pose greater risks and increase the need for better protection from exploitation and other threats to family and community security especially
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amongst those who are more vulnerable during times of rapid change—minorities, the poor, women and girls and young people in general’ (UNICEF-Lao People’s Democratic Republic Country Programme of Cooperation 1998-2002, 1997). Lao People’s Democratic Republic’s entry into ASEAN in 1997 may exacerbate this trend or it may open up opportunities to minimize inequities such as providing more accessible teacher training.

In partnership with the Lao Women’s Union, UNICEF has been involved in many women and development activities to improve conditions for women and guide ‘women’s participation in national development’ especially in the area of improved ‘access to resources that are vital to personal and family well-being’ particularly in the new market economy. Areas such as knowledge and skills, credit, access to emergency food resources and essential medicines have been targeted. ‘In the last three years with significant funding assistance from the Netherlands, New Zealand and Japan UNICEF National Committees, women in approximately 390 village communities have established successful revolving fund microcredit facilities. Over 40 rice banks have been created in especially vulnerable communities, training in revolving fund credit programme management was also provided in the 390 village communities’ (UNICEF-Lao People’s Democratic Republic Country Programme of Cooperation 1998-2002, 1997).

Developed Countries with high income economies

The Health Ministries of Australia and New Zealand have reviewed their women’s health programmes in the light of the recommendations of the Beijing PFA. Australia has reviewed its National Women’s Health Policy and recommended mainstreaming of gender issues in all Australia’s health programmes. New Zealand has produced a set of guidelines for gender analysis (New Zealand Ministry of Women’s Affairs, 1996) which it is applying to its own programmes and activities but which will be made available to other countries in the region should they wish to adapt the guidelines to review their countries health organizations.

The Government of the Republic of Korea, in response to its commitments in Beijing, has formulated Ten Policy Priorities for the Advancement of Women. In December 1995 the Women’s Development
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Act was legislated ‘consolidating the legal basis for adequate institutional and financial support to promote the status of women and protect women’s rights’. To support the Act ‘The National Women’s Development Fund was created... with the goal of raising ... US$110 million by the year 2001.’ Most of the fund ‘will be utilized to support the activities of civil society for promoting the status of women’ and to ‘elevate international cooperation in women’s development initiatives’ (Yun-Duk Kim, Minister of Political Affairs, May 1997).

Newly-Industrializing Economies

An excellent regional model is provided by the Asian-Pacific Resource and Research Centre for Women (ARROW) in Malaysia which has applied the principles and guidelines of the Full Picture (New Zealand Ministry of Women’s Affairs, 1996) to the Asia Pacific region.

ARROW has prepared a highly accessible health resource kit entitled Women-Centred and Gender-Sensitive Experiences: Changing our perspectives, policies and programmes on Women’s health in Asia and the Pacific for use by countries in the Region. Potential users of the kit will be policy makers, health programme managers, family planning and women’s organizations, those involved in planning, evaluation and programme implementation for women’s health, and trainers and educators of health care providers, libraries, community and women designated health centres, women’s information centres (including women’s hotline services and women’s information switchboards) and high school and university teachers dealing with general health issues. It adopts a lifespan approach that is inclusive of all women from the womb to the tomb. Inclusiveness is also offered in the trans-cultural mix of contributing authors. It also establishes the need to recognize the social, political and economic contexts within which change can occur, to account for cultural relativity and difference and thus avoid the trap of establishing universal guidelines for all countries to follow.
The kit emphasises women as active agents shaping their own destiny and suggests practical strategies and provides tools for empowering women. For example, in the section on ‘Perspectives for Change’, the kit provides a checklist to guide would-be-interviewers undertaking qualitative research to assist in planning the research, carrying it out and analysing the findings. It also provides user-friendly interpretations of documents such as the BPFA. Case studies from countries like the Philippines and Viet Nam contextualize the experiences of women emphasizing the need to be cognisant of both national and intranational variations between women in their health experiences, beliefs and knowledge and of differing political, economic, religious and social realities. In the section on ‘Programmes for Change’ the culturally rich examples of implementation of policies in concrete programmes are a celebration of the diversity of womankind by age, race, location, and a variety of other dimensions.

ARROW is establishing baseline data on accessibility of services for women in its role as co-ordinator of a regional research project, funded by the UK Department for International Development (DFID), formerly Overseas Development Administration (ODA), on Women’s Access to Gender-Sensitive Health Programmes. The objectives of the study are based on specific recommendations in the Beijing Platform for Action (PFA) (section on ‘Women and Health’). In particular, the project plans to assess the extent to which major governmental and nongovernmental health services in ten countries appear to be affordable, accessible, gender-sensitive, of high quality, and women-centred; and to determine the extent to which these organizations have health services that are designed and implemented in cooperation with women and women’s groups. The project also intends to refine, develop, and disseminate effective women’s health programme research and evaluation tools which are gender-sensitive and women-centred; and encourage organizations in Asia and the Pacific to review their health programmes for women within the Beijing PFA using appropriate frameworks, criteria, and tools.
ARROW is also planning a project on ‘Strengthening of South-East Asian Government Organizations and Nongovernment Organizations Capacity to Implement and Monitor the Health Section of the Beijing Platform for Action.’ The purpose of the project is to initiate the establishment of South-East Asian regional and national processes and mechanisms to monitor and support the swift and effective implementation of the health section of the Beijing Platform for Action (BPFA). One of the primary objectives is to develop comprehensive and gender-sensitive databases of indicators and analysis at country and regional levels of women’s health needs and position in South-East Asia, within the framework of priorities of the BPFA, as a foundation for monitoring progress in implementing the BPFA immediately and long-term. A main component of the project will be the development of eight country papers on women and health and a South-East Asian regional overview. The framework for the country paper will include indicators of women’s health status and socioeconomic position; relevant laws and policies affecting health; ratification and reservations on CEDAW, ICPD, and the BPFA; and actual National Plans and activities to implement the health section of the BPFA.

Pacific island countries and areas

The Ministry of Health and Social Welfare in Fiji responded rapidly to the Forty-seventh session of the Regional Committee, nominating a woman to represent Fiji at the WHO Sub-Committee meeting in Manila in June 1997 and committing the Ministry to ‘continue to do all it can to support the participation, training and fellowship programmes and the representation of women in government delegations and special bodies’ (Dr Goneyali, March 1997). The Ministry of Health and Medical Services in the Solomon Islands ‘has increased the awards of training fellowships to 45% for girls/women in the 1996-1997 period’. Commitment has also been made to ‘utilise specific training fellowships under New Zealand support for 1997 to be for women only’ and, within the Ministry, to give ‘at least 50% of training and employment opportunities to women’ (Mr Ramoifuila, Ministry of Health and Medical Services, Solomon Islands, March 1997).
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The Department of Health in Vanuatu has identified 11 key women with expertise in particular areas as potential candidates to represent Vanuatu in government delegations and special bodies as well as for employment with WHO (Mr Kalorib, Acting Director of Health, February 1997). The Department of Public Health in the Northern Mariana Islands is working with the CNMI Office of Women's Affairs to establish baseline data on women's level of participation in governance in the private and public sectors in the Mariana Islands and in promoting the further involvement of women in such activities (Dr Abraham, Department of Public Health Northern Mariana Islands, April 1997). The Tokelau Apia Liaison Office in Samoa has been promoting women's participation in special bodies and government delegations, as well as in internally funded and externally sponsored traineeships, for some time. In 1997 four out of five externally sponsored traineeships were awarded to women.

Remaining gaps in meeting the commitments of the BPFA

Despite the many global, regional and country initiatives referred to above, there are still alarming statistics at all levels. At the global level, Janet Lee of the Singapore Council of Women's Organizations, in May 1997 at the Eighth National Congress of Vietnamese Women, noted that:

- women constitute nearly 70% of the world's 1.3 billion poor;
- of the world's 1 billion illiterate adults, two thirds are women;
- in 1993, 130 million children had no access to primary school; 81 million of them were girls;
- one fourth of families worldwide are headed by women;
- women earn one tenth of the world's income, own less than one tenth of the world's property and hold 1% of chief executive positions worldwide; and
- most women over 40 years old still earn 50-80% of men's wages (based on UNDP 1995-1996 statistics).
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To these disturbing statistics the 1997 World Development Report adds:

- in developing countries illiterate women outnumber illiterate men by 60%;
- women overall earn only three-fourths of men's earnings;
- women bear a disproportionately large share of chores and child-rearing responsibilities in the household;
- women have less access to land, credit and employment opportunities;
- in industrialized countries the unemployment rate among women is higher than among men; and
- globally, women still hold only 13% of parliamentary seats and 6% of cabinet posts.

Although these statistics refer to the global situation and some statistics are four years old, preliminary baseline data from the countries of the Western Pacific Region (WHO, WPRO 1997) paint a similar picture for the WPR. Health and socioeconomic statistics in some countries of the region point to a need for urgent action (especially Lao People's Democratic Republic, Cambodia and Papua New Guinea). Others suggest significant improvements in women's health and social status (for example Mongolia).

However, it is not only the developing countries that have problems in gender (and race) equity. As the Human Development Report 1997 notes 'some developing countries outperform much richer industrialized countries in gender equality in political, economic and professional activities' (UNDP, 1997:41). For example, although China ranks 108th out of 175 countries globally on the human development index (HDI) and 90th on the gender-related development index (GDI), it ranks a high 28th on the gender empowerment measure (GEM). In contrast, Japan ranks a high 7th out of 175 countries on HDI yet only 12th on GDI and a low 34th on GEM.
In some countries, good national statistics disguise huge disparities in the health status of certain groups. In Australia the aboriginal population has four times the infant and maternal mortality ratios of the non-aboriginal population and a far lower life expectancy for both men and women of aboriginal descent (ABS, 1997).

The latest country information profile for Lao People's Democratic Republic shows a very low life expectancy for both men and women (51 years), a total fertility rate of 6.8, an alarming infant mortality rate of 125 per 1,000 live births and a maternal mortality ratio of 656 per 100,000 live births. Only 51% of the Lao population are served with safe water and only 23% have adequate sanitary facilities (WHO, WPRO, 1997). Adult literacy rates for women in Lao People's Democratic Republic are 36% compared to 65% for men.

Similar figures represent the situation in Cambodia with a life expectancy of 52 years for men and 55 years for women. Although the total fertility rate has declined from 4.5 in 1990 to 3.7 in 1995, the infant mortality rate has remained almost unchanged (117 per 1,000 live births in 1990 to 115 per 1,000 live births in 1995) as has the maternal mortality ratio (500 per 100,000 live births in 1990 to 473 in 1995). The male adult literacy rate is 48% while that for females is a very low 22%.

Papua New Guinea also has a low life expectancy for both men and women (56 years for men and 58 years for women), a fertility rate of 4.7, a high infant mortality rate of 82 per 1,000 and the highest maternal mortality ratio in the world of 930 per 100,000 live births. Although overall national statistics show 31% of the population being served with safe water, disaggregation of that data reveals that in rural areas only 18% have safe water. Similarly the provision of adequate sanitary facilities covers 25% of the total population but only 12% of rural dwellers. Adult literacy rates are 50% for men but only 40% for women.
Mongolia on the other hand has shown dramatic improvements in health status for women over the last five years. It has better life expectancies (60 years for males and 65 for females) and a dramatically falling fertility rate (3.7 in 1992 to 2.7 in 1995) compared to the countries referred to above. The infant mortality rate has declined from over 57 per 1,000 live births in 1993 to 44.6 in 1995 and the maternal mortality ratio, although still high, fell from 238 per 100,000 live births to 185 in the same period. There is little disparity in adult literacy rates by gender (98.2 for males, 95.7 for females).

There are several areas that WPRO still needs to critically examine in terms of meeting the recommendations of the BPFA. The most pressing problem is establishing baseline gender disaggregated data in some countries such that appropriate policies can be put in place to narrow the gender gap. In establishing the Gender-related development index (GDI) and the Gender empowerment measure (GEM) in 1997, UNDP reported on only 19 of the 36 countries and areas of the Western Pacific Region and from this sample was able to obtain relevant gender disaggregated data from only 15 countries and areas for the GDI and only 10 for the GEM. Little is still known about gender inequities in most of the Pacific island countries.
Conclusions and recommendations

In line with the PFA of the Beijing United Nations World Conference on Women, WPRO proposes to:

- continue the emphasis on women’s health that it highlighted in the lead up to the Beijing Conference, and in the process,
- consult with women from all levels of the health system, from senior government officials to grassroots women’s organizations to individual users of health services, in decision-making around women’s health;
- acknowledge the social, cultural, economic, religious, political, racial, environmental, occupational, educational, psychological and physical contexts that impact on women’s health;
- adopt an intersectoral approach both to understanding issues in women’s health and to implementing measures to improve women’s health;
- acknowledge the heterogeneity amongst women;
- incorporate the principles of gender sensitivity into its application of the lifespan approach to health programmes (New horizons in health) and acknowledge that women’s health needs vary across situations and across the lifespan;
- gender disaggregate all data (quantitative and qualitative) collected and collated by WPRO and develop gender sensitive and gender specific indicators of health where appropriate;
- in partnership with governments, nongovernmental organizations, women’s groups and other grassroots organizations, extend its support for specific country initiatives as outlined in the recommended actions in response to strategic objectives of the Beijing PFA;
- pay particular attention to the health of the girl child and adolescent girls including advocating to ensure that girls have an equal chance of being born and thriving through childhood;
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- do all in its power to prevent sex-role stereotyping, including encouraging males to participate, and share responsibilities, in the domestic sphere and in reproductive health decisions and encouraging countries to legislate against gender discrimination in the workplace;

- incorporate a gender perspective into policy development and service delivery in its programmes;

- train WPRO staff in gender issues per gender analysis to facilitate changes to the culture of the organization such that gender considerations become part of the mainstream thinking of staff in the organization; and

- put in place monitoring and evaluation systems and undertake periodic reviews to follow the progress in implementing the recommendations listed above.

Proposed actions

As a first step in this direction the four areas on which WPRO will concentrate in developing a gender sensitive approach to all its activities are:

1. gender disaggregating all data;
2. actively and visibly mainstreaming a gender perspective in all programmes;
3. promoting increased participation of women as both providers and users of policy and services (including consultation); and
4. monitoring progress towards the achievement of the above.

To monitor and evaluate outcomes, indicators for achievement must be developed and targets (including time frames) specified.
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Targets: dates and indicators

1. In line with resolution WHA50.16, established at the Fiftieth World Health Assembly in 1997, WPRO is committed to meet the global target of 50% female recruitment for professional categories, temporary advisers, consultants and members of scientific and technical advisory groups by the year 2002. To monitor progress towards this goal, the Regional Office’s focal point on women, will review on a yearly basis the gender composition of WHO, WPRO’s senior staff and the results will appear as a regular item in the Regional Director’s report to the Regional Committee from 1998 to 2002.

2. WPRO will promote collection of gender disaggregated data by countries and aims to have 100% of data which can be disaggregated in that form by the year 2000.