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Follow-up to the Fourth World Conference on Women: implementation of strategic objectives and action in the critical areas of concern

Thematic issues before the Commission on the Status of Women

Report of the Secretary-General

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I. Introduction

1. According to its multi-year work programme in the follow-up to the Fourth World Conference on Women (Economic and Social Council resolution 1996/6 of 22 July 1996), the Commission on the Status of Women at its forty-third session will review analytical reports on two critical areas of concern of the Beijing Platform for Action: "Women and health" and "Institutional mechanisms for the advancement of women". The reports are based on the results of two expert group meetings convened in 1998 by the Division for the Advancement of Women of the Department of Economic and Social Affairs of the United Nations Secretariat. The expert group meetings focused on issues that either had not previously received the attention of the Commission or in the view of the Secretariat required further exploration in the light of the Platform for Action.

2. In the critical area of concern "Women and health", the focus of the expert group meeting was on mainstreaming gender into the health sector. The meeting also addressed reproductive health and a number of specific health concerns of women, such as mental health, environmental and occupational health, and infectious diseases. The expert group meeting adopted specific recommendations with regard to these sectoral women's health issues and problems and developed a framework for a gender-sensitive health policy, which is a useful tool for gender mainstreaming.

3. In the critical area of concern "Institutional mechanisms for the advancement of women", the meeting considered the role of national machineries in mainstreaming gender in all programmes and policies at the national level. The meeting also addressed the relationship of national machineries with civil society and the accountability of Governments for gender mainstreaming and endorsed a sample project to strengthen national machineries, to be carried out by the Division for the Advancement of Women. The meeting requested the Secretariat to summarize the "best practices" described in the experts' papers, in order to provide Governments and national machineries with practical examples.

4. The aim of the present report is to identify policy measures that may be taken to accelerate the achievement of equality between women and men, eliminate discrimination against women and empower women in the context of the Platform for Action. The reports of the expert group meetings are before the Commission as background documents in one official language of the United Nations only. It should be noted that progress achieved in implementing the Platform for Action and overcoming the remaining obstacles will be presented in the context of the high-level review of the implementation of the Beijing Platform for Action and the Nairobi Forward-looking Strategies in the year 2000. The five-year review and appraisal of the Programme of Action of the International Conference on Population and Development in 1999 will analyse key successes and constraints, as well as lessons learned, in developing effective strategies, actions, policies, programmes and resource allocation, which are also of relevance for the review and appraisal of the implementation of the Platform for Action. The present report brings strategies for accelerating the implementation of the two critical areas of concern to the attention of the Commission as a basis for formulating its agreed conclusions.

II. Women and health

5. The Platform for Action identified women and health as one of the critical areas of concern and defined five strategic objectives: to increase women's access throughout their life cycle to appropriate, affordable and quality health care, information and related services; to strengthen preventive programmes that promote women's health; to undertake gender-sensitive initiatives that address sexually transmitted diseases, HIV/AIDS and sexual and reproductive health issues; to promote research and disseminate information on women's health; and to increase resources and monitor follow-up for women's health.[1] In doing so, it also emphasized the importance of a holistic and life-cycle approach to women's health. The Platform for Action reiterated the agreements reached at the International Conference on Population and Development, held in Cairo in 1994, in particular with regard to women's reproductive health and rights, and added new ones addressing the right of women to control all aspects of their health and the relationship between women and men in sexual relations.

6. Women and health is one of the few critical areas of concern in the Platform for Action where a number of clear targets have been established for implementation by Governments in collaboration with non-governmental organizations and employers' and workers' organizations and with the support of international institutions. These include, in particular, universal access to high quality health services for women and girls; reduction of maternal mortality and infant and child mortality (para. 106 (l)); worldwide reduction of severe and moderate malnutrition among children under the age of five, giving special attention to the gender gap in nutrition, and a reduction in iron deficiency anaemia in girls and women (para. 106 (w)).[2] In all other instances, the Platform gives open recommendations without setting specific

targets, as, for example, when it recommends increasing the number of women in leadership positions in the health professions, including researchers and scientists, to achieve equality at the earliest possible date (para. 109 (c)).

A. Women's health and human rights

7. The Platform for Action stresses that women have the right to the enjoyment of the highest attainable standard of physical and mental health. Making a connection between women's personal life and health and their roles in the community, the Platform states that the enjoyment of this right is vital to their life and well-being and their ability to participate in all areas of public and private life (para.89). The International Conference on Population and Development recognized that reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents.[3] These include the Universal Declaration of Human Rights and its two initial implementing covenants, the International Covenant on Economic, Social and Cultural Rights (1966), article 12 of which refers to the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, and the International Covenant on Civil and Political Rights (1966), which includes a number of health-related human rights, such as the right to life, the right to liberty and security of the person and the right to privacy.

8. Building on the International Conference on Population and Development and its Programme of Action, the Platform for Action states that the human rights of women include their right to have control and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence (para. 96). The Beijing Declaration[4] further states that the explicit recognition and reaffirmation of the right of all women to control all aspects of their health, in particular their own fertility, is basic to their empowerment (para. 17). In addition, it is noted in the Platform for Action that the equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences (para. 96). With regard to abortion, the Platform for Action reiterates paragraph 8.25 of the Programme of Action of the International Conference on Population and Development, which states that in no case should abortion be promoted as a method of family planning. The Platform for Action also requests Governments to consider reviewing laws containing punitive measures against women who have undergone illegal abortions (para. 106 (k)).

9. Efforts have increased to consider health in the framework of human rights. When health is considered a human right, and not merely a social good, rights and responsibilities need to be defined accordingly. The linkage between women's human rights and health has been pioneered through the collaborative efforts of women's health and women's rights advocates. Inattention and neglect of women's health issues, in particular reproductive health, in the legislative and regulating frameworks of countries, have been recognized as part of a systematic discrimination against women. Issues linked to women's health and human rights go beyond reproductive health and became visible when increased attention was paid to the widespread incidence of violence against women in all its manifestations, which has a human rights and a health dimension. The link between the vulnerability of women to HIV infection and women's status in society and discrimination against women was also recognized. In addition, health and human rights groups considered gender discrimination in areas such as preventable diseases, disability, the interdependence of rights of various groups of people and discrimination in health care and the setting of health-care policy.[5]

10. Women's right to health is addressed in the Convention on the Elimination of All Forms of Discrimination against Women. Article 12 thereof concerns rights regarding access to health-care services, including family planning and appropriate services in connection with pregnancy, confinement and the post-natal period. The Convention also addresses women's health in a number of other articles.[6] The Committee on the Elimination of Discrimination against Women is preparing a draft general recommendation on health, based on the results of the Committee's examination of the periodic reports of States parties and its expertise in this area. Many other provisions of the Convention have implicit or indirect bearing on women's rights in relation to health and have been taken up in previous general recommendations of the Committee.[7]

11. The human rights dimensions of women's health are not only the concern of the Committee on the Elimination of Discrimination against Women, but of all human rights treaty bodies. As the right to health is enshrined in a number of international instruments; it is consequently monitored by the relevant treaty bodies.[8] The Human Rights Committee has made important pronouncements in this regard. The Round Table of Human Rights Treaty Bodies on Human Rights Approaches to Women's Health, held at Glen Cove, New York, United States of America, from 9 to 11 December 1996 adopted a number of recommendations for treaty bodies, the

United Nations system and non-governmental organizations, which were endorsed by the eighth meeting of persons chairing the human rights treaty bodies, held at Geneva from 15 to 19 September 1997.[9]

B. Follow-up activities to the Fourth World Conference on Women

12. Many Governments and international organizations have followed up on the recommendations related to women and health of United Nations global conferences, in particular the Fourth World Conference on Women (1995) and the International Conference on Population and Development (1994). As a first step towards implementation, many have prepared national implementation strategies or action plans, as suggested in the Platform for Action, which contain, *inter alia*, concrete action-oriented proposals for the health sector. Health is a priority issue in 90 national action plans out of the 105 received to date.[10] Although the Platform for Action established clear, time-bound targets related to women and health, only a limited number of Governments make reference to those tangible targets contained in the Platform for Action. For example, while some national action plans from all regions aim at reducing maternal mortality, not all set specific targets nor do all follow the targets set in the Platform for Action.

13. At the international level, a number of initiatives have been taken with regard to health in the integrated conference follow-up. Health was included on the agenda of the Administrative Committee on Coordination (ACC) Task Force on Basic Social Services for All.[11] The Task Force established working groups on, *inter alia*, primary health care, reproductive health care and national capacity-building in tracking child and maternal mortality care. Working groups prepared guidelines for the particular topics, which provide definitions, describe data sources, measurement problems and estimation methods and give advice on how to assist countries in tracking child and maternal mortality. They also suggested a number of key actions for the resident coordinator system to improve reproductive health.[12]

14. Since the adoption of the Programme of Action of the International Conference on Population and Development, greater emphasis has been put on the use of quantitative and qualitative indicators for measuring progress in the implementation of programmes, including reproductive health. While at the national and local levels countries may select the indicators most appropriate to their needs and capacity for data collection, data for international comparability and global monitoring have to be gathered in accordance with an accepted list. Several examples exist, such as the Minimum National Social Data Set,[13] in which 8 data sets out of 15 are directly related to health: life expectancy at birth, infant and child mortality, maternal mortality, contraceptive prevalence rate, access to safe water and sanitation and monetary value of the basket of food needed for the minimum nutritional requirements. The Working Group on Reproductive Health of the ACC Task Force on Basic Social Services for All agreed on 15 global indicators for reproductive health. The World Health Organization (WHO) also issued a list of indicators to be used at the local level. Since some of the indicators, such as maternal mortality, are difficult to collect, WHO also established process indicators, which would enable better data collection in the future.[14] WHO further developed the direct and indirect sisterhood method, in which respondents are asked simple questions about the health and pregnancies of their sisters.[15] UNFPA has selected a comprehensive and detailed set of indicators for population programmes to be used in the first place by managers of country programmes.[16]

15. It is against this background, that the Division for the Advancement of Women, jointly with WHO and UNFPA, and in association with the Commonwealth Secretariat, organized an expert group meeting on women and health — mainstreaming the gender perspective into the health sector, which was hosted by the Tunisian Ministry of Women and Family Affairs in Tunis, from 28 September to 2 October 1998. The topics and recommendations below derived from the expert group meeting.

C. Specific health concerns of women: strategies and recommendations

16. The Platform for Action put emphasis on women's sexual and reproductive health, which is at the centre of concern for women's and girls' health and affects the health of women beyond their reproductive years. However, other health problems mentioned in the Platform for Action also require attention. They include women's vulnerability to HIV/AIDS and to violence and abuse, and health problems faced by older women in view of the growing number of older women and the interrelationship of ageing and disability in women. A number of specific health concerns are addressed without great detail, mostly under access or research (para. 109 (d)). Mental health is mentioned either as a goal or a condition related to other health issues, including violence against women or abortion (paras. 99, 106 (q) and 109 (i)). Reference to cancer is made in relation to prevention and research (paras. 107 (m) and 109 (d) and (e)). Occupational

health is referred to under access and research, as are disability issues (paras. 106 (o) and (p) and 109 (d)). Tropical disease is only referred to under research (para. 109 (d)). No recommendation addresses the need to combat tuberculosis, now recognized by WHO as the number one killer of women in developing countries.

1. Sexual and reproductive health

17. In preparation for the five-year review and appraisal of the Programme of Action of the International Conference on Population and Development, a number of issues of concern have been identified. They include the integration of family planning into a comprehensive package of reproductive health services addressing the reproductive health needs of adolescents, the provision of emergency reproductive health services for refugees and displaced persons and the elimination of violence against women.

18. Maternal mortality remains at the top of the list of indicators for women's equality and development. The Programme of Action of the International Conference on Population and Development and the Platform for Action aim at reducing maternal mortality within an established time-frame: by 50 per cent of the 1990 levels by the year 2000 and a further 50 per cent by the year 2015. Political will, community efforts and international assistance are needed to achieve this goal. The Safe Motherhood Initiative of WHO remains a major initiative to ensure a woman's full enjoyment of her right to life. If every pregnancy is at risk, steps need to be taken to identify the risk for every pregnant woman and protect her reproductive health. Questions related to the collection of reliable data on maternal mortality deserve more concentrated attention to ensure greater accuracy of figures, which are in many cases only estimates. Unsafe abortions continue to be a major public health problem, causing maternal death and widespread damage to women's physical and mental health. Women with low incomes, rural woman, young women and adolescent girls are particularly vulnerable to risks related to reproductive health.

19. Governments and international organizations should:

(a) Give priority to the following areas of research:

(i) Development of female-controlled methods, including microbicides, post-coital/emergency contraception and dual methods that protect against both sexually transmitted diseases and HIV and unwanted pregnancy; and methods of male contraception;

(ii) Encouragement of social and anthropological research in order to evaluate the real needs of women, the factors influencing their behaviour and their degree of satisfaction as to the services provided;

(b) Ensure the implementation of the Beijing Platform for Action with respect to the problem of unsafe abortion.

20. Governments should:

(a) Address the reality and consequences of unsafe abortion by revising and modifying laws and policies that perpetuate damage to women's health, loss of life and violation of gender equality in health care;

(b) Integrate sexual and reproductive health services, where appropriate, including screening of genital cancers and treatment for menopause, to respond to the broad health needs of users;

(c) Develop policies and formulate legal tools to support activities aimed at eliminating the practice of female genital mutilation and other harmful practices and prevent their acceptance as a medical practice.

2. Disease control programmes for tuberculosis, malaria and other diseases, including HIV and AIDS

21. The enormous impact of gender inequality is demonstrated by the millions of women who have become infected with HIV and AIDS by their partners. The number of new infections in females is now growing faster than in males. Tuberculosis, often linked to HIV/AIDS, has become a global health problem and has been identified as a current development challenge with high economic and social costs, since the overwhelming number of victims are in the economically most active period of their lives (ages 15 to 49).[17] Communicable diseases such as tuberculosis, malaria and, to a growing extent, HIV and AIDS are diseases of poverty. Poor women are especially vulnerable because of their low nutritional status, restricted access to education and gainful employment, and heavy workloads. The stigma attached to many communicable diseases, particularly those involving disfigurement, leads to the hiding of the disease and a decrease in life opportunities, including marriage.

22. Once infected, women are more likely to treat themselves and to postpone seeking professional care because of gender-based constraints, including domestic responsibilities, caring for others and the cost of travel and treatment. Having sought treatment, they receive low priority owing to their low social status. Health services thus miss an important opportunity to provide women, the main health providers within the household, with the information required to perform the role of providing effective medical care at the right time and more effectively.

23. Little research has been conducted on how communicable diseases affect women and men differently, and what is known is not taken into account in planning services. Despite the magnitude of the tuberculosis epidemic, its gender dimension has been neglected. WHO only recently drew up an agenda for research into the biological, epidemiological, social and cultural differences in the occurrence of tuberculosis in women and men, focusing on reproductive health, diagnosis and patient education. With regard to HIV/AIDS infection, steps need to be taken to ensure better and more affordable and available independent protection for women (e.g., female condoms). Recent research in mother-to-child transmission and in drug research is promising for populations where pregnant women can choose to be tested for HIV and have access to treatment.

24. Governments and international organizations should promote research on how communicable diseases, particularly malaria, tuberculosis, and HIV and AIDS affect women and men differently and take these differences into account in planning and delivering services.

25. Governments should:

(a) Ensure that stigmatization (in leprosy, filariasis, HIV and sexually transmitted diseases) does not lead to under-detection and lack of treatment, especially for women;

(b) Avoid all forms of compulsory testing for HIV on women, including those related to prevention of mother-to-child transmission;

(c) Improve sexual and reproductive health services available to women with HIV and AIDS;

(d) Improve accessibility to high quality prenatal care for all women, including prenatal and post-natal counselling services associated with HIV testing and avoid all forms of discrimination in the health services against women living with HIV when applying prevention programmes for mother-to-child transmission.

26. Health workers and professionals should:

(a) Encourage their patients to inform their partners in the case of HIV infection so as to protect them from infection, and counsel them as to ways of doing so;

(b) Encourage families to ensure that all girls and boys are fully immunized and monitored and treated for childhood diseases.

3. Mental health

27. Although the right to the enjoyment of the highest attainable standard of physical and mental health is universally recognized, mental health and its gender dimension remain vastly neglected. A first step would be to acknowledge the existence and causes of women's psychiatric disorders and trauma, ranging from poverty to exposure to violence. Poverty, armed conflict, domestic isolation, powerlessness (resulting from illiteracy, low education, economic dependence and patriarchal oppression) are all associated with the higher prevalence of psychiatric morbidity in women, compounded by sexual and physical violence. Family and social abuse of women, as well as violence against women in all its forms, have a devastating effect on their physical and mental health. Good quality mental health services need to be integrated with other services, in particular with legal, educational and other social and law enforcement services in order to deal with mental illness resulting from, or aggravated by, violence and other forms of abuse to women. Inappropriate medication for emotional distress and psychological illness should be avoided, as it can result in silencing women and men rather than dealing with the root causes of their problems. It should not be assumed that female relatives are able to provide the full range of mental health care to those with serious mental illness within the home.

28. Governments should:

(a) Invest in educating communities about the effectiveness of mental health interventions and make available the necessary services tailored to the different needs of women and men (e.g., treatment for civil and domestic trauma and injury, psychiatric illness and substance abuse). Priority should be given to mental health care as an integral part of primary health care;

(b) Encourage systematic efforts to improve the amount and quality of mental health training for workers at all levels, from medical students to physicians, from nurses to community health workers;

(c) Encourage efforts to document the use of psychoactive substances by both women and men and the different causes and effects. This should lead to parallel efforts in developing effective approaches to prevent and treat such use.

4. Occupational and environmental health

29. With more women entering the labour market, the gender dimension of occupational health can no longer be neglected, in particular the long-term effects of a variety of health hazards in the workplace to which women and men are exposed. Women are more likely to suffer from occupational stress and musculoskeletal disorders owing to their work as unskilled or semi-skilled workers in agriculture and the informal sector. Occupational stress is likely to result from

their multiple overlapping roles (as housewives, mothers and workers), repetitive monotonous jobs, sexual harassment at the workplace and shift-work. Musculoskeletal disorders in women are caused by combined manual work, household work and poorly designed tools and work stations. Exposure to chemicals in the workplace, such as solvents in small-scale industries and pesticides in agriculture, has been known to result in adverse reproductive outcomes both in females and males. There is some evidence that a number of persistent environmental chemicals are associated with long-term health hazards in women and men. Exposure of the foetus in utero to compounds such as dichlorodiphenyltrichloroethane (DDT) and polychlorinated biphenyls (PCBs) may cause endocrine disruption, manifesting as disease at a later stage.

30. More research needs to be carried out on the environmental and other risks posed to women's health by their occupational activities in both rural and urban settings with the synergistic effects of heavy household work, malnutrition, multiple pregnancies and adverse climatic conditions as they affect millions of poor women in developing countries. There is also need for ergonomic redesigning of tools, equipment and work stations to reduce most occupational morbidity in women.

31. Government and international development agencies should:

(a) Increase their support of research, particularly in developing countries, on occupational and environmental health risks, both short- and long-term, of work performed by women and men. This should include risks in the household and from environmental chemicals and appropriate interventions, including necessary legislation, to reduce environmental and occupational health risks in both urban and rural settings;

(b) Undertake gender analysis of various sectoral policies to establish health and environment risk profiles for women and men.

32. Governments should extend environmental and occupational health policies to cover informal and agricultural sector workers, who are mostly women and who are often not covered by protection laws, labour laws or occupational health and safety regulations.

5. Mainstreaming the gender perspective in health care, medical education and research

33. Applying a fully comprehensive gender perspective would require all health statistics to be disaggregated by sex and the construction of a comprehensive women's health profile. It would also require a gender analysis of health, which would reveal the biological causes and social explanations for the health differentials between women and men and demonstrate that they are often due to unequal social relationships and not merely to the consequences of biology. However, the traditional medical teaching that has reduced women's health and ill health primarily to a matter of their biology is still retained. This view became institutionalized in scientific medicine and the new public health in the early decades of the twentieth century. Medical textbooks still consider the male as the norm or reference point and regard women as exceptions.

34. Governments, professional associations and other institutions, as appropriate, should ensure that:

(a) The education of health professionals, from those in planning and reform to service delivery, includes gender training, with the intention of formulating health policies that are equitable and based on the principle of gender equality;

(b) Health professionals are educated in human rights as part of their training in health care ethics to ensure that clients are treated with respect, dignity, privacy and confidentiality;

(c) Health personnel with the requisite skills are strongly encouraged to pursue the specialty of their choice irrespective of their gender, even though it could require support in the form of child care or a scholarship.

35. Governments, medical authorities and other health professions should ensure that

(a) Women are given information about the choices available to them, for example with respect to breastfeeding or contraceptives, the risks and benefits involved, and the freedom to decide which action to take;

(b) Women are not deprived of their right to health services on the basis of conscience clauses cited by health providers and that health services implement referral systems promptly for women requiring services that certain health professionals were unwilling to provide, such as contraception (including voluntary surgical contraception) and abortion (in all circumstances where it is allowed by law).

6. Health reform and financing

36. A gender-based analysis of health reform and financing reveals the adverse effects of poverty on the health of women, which are also reflected in the health services available to them under different systems of health-care financing. Individually financed services based on private payment for services and those based on third party insurance, whereby health coverage is paid for by individuals and employers, leave large groups of the population, especially women (as

they fall into the lower economic groups and have less resources) without coverage. Female-headed households and elderly women are characteristically impoverished and dependent on the family and the State for health-care services. State-financed health services, in which the State pays for all health care, and social insurance systems, whereby an essential health-care package is provided for the whole population with additional services provided under other schemes, can also raise gender issues by increasing the gap between rich and poor in terms of health status and access to high quality care. An equitable division of coverage by the public and private sectors is required to avoid all non-profit services being automatically assumed by the public sector.

37. Currently, decentralization of management is being proposed to bring health services nearer to communities and to strengthen their accountability over resources. This should be accompanied by the provision of adequate resource allocations to local levels in order to provide basic health services. Otherwise, health-care providers, the majority of whom are women, carry a burden of increased workload, as do women who are required to provide home care because of the limited services available.

38. Governments should:

(a) Secure funds to protect the health of the most vulnerable population groups, particularly poor women, throughout their lifespan. A social pact should be established between the State and all interested parties to guarantee a minimum package of services to cover the health care of those vulnerable groups;

(b) Ensure that health reform is based on the human right to health and not only on economic criteria.

7. Partnership for health

39. A number of actors and stake holders have an important role to play in mainstreaming gender into the health sector. While the ministry of health is usually in charge of the health sector within the Government, other ministries can also have an impact on health care. The influence of parliamentarians is crucial in the establishment of gender-sensitive health policies and in the introduction of legislation. District and local authorities are important in the delivery of health care services, in particular when services are decentralized. The WHO “healthy cities” initiative demonstrates the leading role that can be played by local governments in improving access to and quality of care. Non-governmental organizations play an effective role in promoting a gender approach to health care by acting as advocates and trainers. Professional organizations and the private sector need to become aware of their influential role and actively involved in all aspects of mainstreaming gender in the health sector.

40. Government and international development agencies should ensure active community participation and input into the design, implementation and monitoring of disease control programmes and health services.

41. The private sector, including pharmaceutical companies and private clinical services, should collaborate in ensuring quality of care and access to and provision of services, particularly for poor women.

8. A framework for designing national health policies with an integrated gender perspective

42. The Platform for Action addresses the importance of gender mainstreaming in health policies (para.105). A series of efforts have been undertaken to develop a framework for a gender-sensitive health policy in the past years. The Commonwealth Secretariat has been pioneering the introduction of gender management systems, both at the level of the national government and within the health sector in Member States. Adapted to the specific conditions and requirements of each country, gender management systems are an effective tool for mainstreaming gender within policies and programmes, if they take into account the need for the sensitization and training in gender concepts of actors at all levels of the health sector, government and public administration. There has to be political commitment at the highest levels involving the health minister and senior cabinet colleagues. External actors such as international organizations and local players such as non-governmental organizations can play vital catalytic roles in helping to secure this political commitment. The expert group meeting on women and health developed a framework for designing national health policies with an integrated gender perspective which provides a useful tool for politicians, practitioners and decision-makers to apply a gender perspective to the health sector. The framework is contained in the annex to the present document.

III. National machineries

43. Institutional mechanisms for the advancement of women is one of the 12 critical areas in the Beijing Platform for Action (chap. IV.H). Eleven critical areas of concern are of a substantive nature, while one critical area deals specifically with institutional mechanisms that should be put in place to ensure the implementation of the other eleven substantive areas.

44. The international community played a crucial role in the establishment of national machineries. Discussion of the role of national machineries preceded the World Conference of the International Women's Year, held in Mexico City in 1975. The Conference recommended that all Governments establish a machinery to promote the status of women. Since then, the international community has given increased attention to the role and structure of national machineries. The discussion has focused on the role of national machineries in promoting women-specific issues.

45. The Beijing Platform for Action adds a new focus to the role of national machineries in promoting the status of women: the mandate to support the mainstreaming of gender in all government policies and programmes. It states that:

> "a national machinery for the advancement of women is the central policy coordinating unit inside government. Its main task is to support government-wide mainstreaming of a gender-equality perspective in all policy areas" (para. 201)

and further 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" (para. 202).

46. The Platform for Action states that in order to be effective, national machineries should be located at the highest possible level of government, should involve non-governmental organizations and should have sufficient human and financial resources and the opportunity to influence development of all government policies (para. 201). While the Platform for Action provides a very broad and comprehensive mandate for gender mainstreaming, the role and responsibilities of national machineries in translating this conceptual approach into practice are less known and differ from country to country.

A. The situation of national machineries

47. A national machinery is the body recognized by the Government as the institution dealing with the promotion of gender mainstreaming and the advancement of women. National machineries are crucial for the implementation of the Beijing Platform for Action at the national level.

48. The role of national machineries at the international level is increasing. Many represent their country during international debates, such as the United Nations world conferences or the Commission on the Status of Women. Furthermore, national machineries establish networks at the regional and international levels to learn from each other's experiences. Despite the international presence of national machineries, little research has been done to assess their increasingly important role at the international and regional levels.

49. Today, the majority of countries have some form of national machinery in place. The 1998 Directory of National Machineries for the Advancement of Women,[18] lists 129 different countries. Most mechanisms for the advancement of women are part of the Government. In some countries, the national machinery might also include bodies outside the government, such as an office of the ombudsperson or equality commission to ensure compliance with gender equality legislation. It might also include autonomous research institutions supporting gender mainstreaming through data collection and analysis.

50. National machineries are very diverse, since they reflect the cultural and political context of their country. There is no agreed-upon model for national machinery. However, some elements are crucial for the functioning of national machineries across all regions: (a) location at a high level in decision-making and authority to influence government policy, (b) a clear mandate and functions, (c) strong links with civil society groups and (d) sufficient human and financial resources.

51. Countries have established different mechanisms for gender equality. In 1996, the Division for the Advancement of Women conducted a survey on national machineries among Member States. The results, based on 100 replies, show that two thirds of the national machineries are located in the Government, while one third are either non-governmental organizations or have a mixed structure. Within the Government, more than one half of the national machineries are part of a ministry, one third are located in the office of the Head of State and the remaining ones are self-standing ministries (based on 88 replies). Among the national machineries forming part of a ministry, almost half are located in the ministry of social affairs and about one-third are part of the ministry of labour (based on 88 replies).

52. In many countries, the success of the national machinery derives from its location at a high level within the Government. In Namibia, for example, the national machinery was successful in including gender issues in all sectors of the Government's national development plan. Uganda established

a system of focal points and cross-ministerial planning. Each ministry is responsible for designating a high-ranking official as a gender focal point; all were trained and encouraged to initiate policy reviews on progress made in the area of gender equality. Furthermore, a national gender policy has been formulated to provide policy makers with guidelines on how to integrate a gender perspective in their work. Also, all budgets and programmes at the national and district levels have to reflect how women and men are benefiting. In some other countries, however, it is more effective for national machineries to operate outside the Government. The national machinery in India, for example, is a consultative body on women's interests with the purpose of transforming ideas into politics.

53. The Platform for Action recommends that national machineries should have the power to influence the design and implementation of all government policies and to formulate and review legislation (paras. 204 and 205). According to the survey of the Division for the Advancement of Women, most national machineries do not have the authority to review existing legislation (based on 94 replies). However, almost four fifths have the authority to initiate legislative action (based on 96 replies) or to review legislation before adoption (based on 95 replies).

54. Some national machineries exclusively focus on their role as policy advisers and catalysts for gender mainstreaming, leaving the actual implementation of programmes to other entities. In Sweden, for example, each minister is responsible for gender mainstreaming in his or her field of responsibility. This is based on the conviction that a policy for equality cannot be developed independently from other policy areas. Most national machineries, however, focus on specific programmes for the advancement of women. According to the survey by the Division for the Advancement of Women, planning such programmes and monitoring their implementation received the highest ratings when national machineries indicated their own major activities (based on 133 replies).

55. In order to be effective, national machineries need strong links with civil society groups. There are many different ways for national machineries to create and maintain these links. In Chile, non-governmental organizations and the Government jointly designed a plan to achieve gender equality. The Government publicly committed itself to the implementation of this plan. In Ecuador, non-governmental organizations also played an important role in designing the national gender policy. A special process enables women's groups to include their concerns in the formulation of the national policy.

56. The Lebanese national machinery and a group of non-governmental organizations jointly developed a strategy to improve the status of women in Lebanon and jointly took responsibility for its implementation. In the Republic of Korea, the national machinery provides funding to women's groups in civil society and invites them to participate in its projects. Furthermore, both sides regularly hold consultative meetings. The Government of Sweden provides funding to women's non-governmental organizations and includes them in official delegations to international forums.

57. In the Philippines, non-governmental organizations play an essential role in promoting gender issues in the Government. Non-governmental women's organizations have contributed to the drafting of the national development framework and have established a forum for civil society groups on the implementation of the Beijing Platform for Action.

58. Access to modern information technology is crucial for national machineries so that they may network and be informed about developments on the international level. The survey by the Division for the Advancement of Women, however, showed that only one quarter of all national machineries have full access to the Internet (based on 84 replies).

59. In spite of their diversity, many national machineries face similar problems:

(a) Marginalized location in the political system and little influence on the overall policy-making process;

(b) Unclear mandate;

(c) Disconnection from civil society;

(d) Lack of relationship between the national machinery and line ministries in the steep vertical structure of state institutions;

(e) Lack of support from government officials and parliamentarians for the idea of gender mainstreaming and the assumption that gender is not relevant in areas such as the economy, defence or energy policy;

(f) Difficulties in combining policy advisory functions and the actual implementation of programmes and projects;

(g) Lack of know-how and training on gender issues;

(h) Shortage of financial resources.

60. It was in this context that the Division for the Advancement of Women, jointly with the Economic Commission for Latin America and the Caribbean (ECLAC), organized an expert group meeting on national machineries

for gender equality, in Santiago, Chile, from 31 August to 4 September 1998. The meeting made recommendations to strengthen the role of national machineries in order to implement the Platform for Action. Experts suggested actions to promote gender mainstreaming and to strengthen the link between national machineries and civil society, and suggested specific mechanisms to hold Governments accountable for gender mainstreaming.

B. Strategies to strengthen national machineries

1. Strengthening of national machineries as catalysts for gender mainstreaming

61. National machineries have to be embedded in the national context in order to be sustainable. They have to be sensitive to the prevailing cultural norms, while at the same time promoting gender mainstreaming and equality between women and men. The expert group meeting identified certain elements that are crucial for national machineries to act as catalysts for gender mainstreaming: structure and location, human and financial resources, mandate and functions and international cooperation and support.

(a) Structure and location

62. In many countries, the national machinery is constituted by a body outside the Government. Some experts recommended, however, that national machinery should include an officially institutionalized unit within the Government with overall responsibility for coordinating, facilitating and monitoring the mainstreaming process in all ministries and agencies. Governments should:

(a) Locate the gender coordination unit at the highest level of government, falling under the responsibility of the President, Prime Minister or Cabinet Minister. This will give the national machinery the political authority needed for its mandate of coordinating the mainstreaming process across all ministries;

(b) Ensure that senior management in each ministry or agency takes responsibility for integrating a gender perspective in all policies. For this purpose, ministers should ensure that senior managers get appropriate assistance from gender experts or gender focal points;

(c) Create separate structures for the promotion of gender equality in personnel policy to avoid confusion with the gender mainstreaming functions of the national machinery.

(b) Human and financial resources

63. In order to function effectively, national machinery bodies, whether inside or outside the Government, require adequate human and financial resources. Governments should:

(a) Finance national machineries in a sustainable manner through national budgets;

(b) Ensure the appointment of adequate levels of staff for national machineries, with appropriate seniority, relevant qualifications and gender expertise;

(c) Make budgetary provisions to ensure that the staff of national machineries has access to further training.

(c) Mandate and functions

64. A clear mandate is a prerequisite for the efficient functioning of national machineries. National machinery at the governmental level is a catalyst for gender mainstreaming, not an agency for policy implementation. It may, however, choose to be involved in particular projects. Its mandate should include:

(a) Developing policies (in collaboration with appropriate ministries);

(b) Coordinating and advocating policies;

(c) Monitoring policy for gender impact, in particular monitoring all cabinet submissions;

(d) Reviewing legislative and policy proposals from all ministries to ensure inclusion of a gender perspective;

(e) Initiating reforms to create more gender-sensitive legal systems;

(f) Coordinating gender audits of implementation of policies;

(g) Ensuring that constitutional and other framework debates include a gender perspective.

65. National machineries should undertake the following functions:

(a) Ensuring appropriate gender training for top-level government management and encouraging gender training at all levels of government;

(b) Developing methods and tools for gender mainstreaming such as gender impact assessment, guidelines for gender training, and for gender audit across all government activities;

(c) Collecting and disseminating best practice models of gender mainstreaming;

(d) Coordinating the development and regular updating of national action plans to implement the Beijing Platform for Action and reporting on their implementation to parliaments and international bodies;

(e) Cooperating with the mass media to mobilize public opinion on gender issues.

(d) International cooperation and support

66. International organizations, especially the United Nations, have played a critical role in developing an international consensus on the importance of national machineries. These organizations should:

(a) Provide further assistance to national machineries, for example by compiling best practices and preparing a handbook; and establishing electronic networks, for example by creating links between the web sites of different national machineries;

(b) Provide, jointly with national Governments, assistance for regular regional networking between national machineries, in order to facilitate the exchange of experience and the dissemination of best practices and strategies for mainstreaming.

2. Links of national machineries with civil society

67. Civil society groups have often played a crucial role in establishing national machineries. Support from civil society also strengthens the position of national machinery vis-à-vis other parts of Government.

68. National machineries need strong links with non-governmental organizations. Whenever possible, they should institutionalize their relationship with such organizations. National machineries can also be an important conduit between civil society and other parts of the Government. In order to strengthen links with non-governmental organizations, national machineries within the Government should:

(a) Consult with major non-governmental organizations on national and international policy related to women and gender;

(b) Involve non-governmental organizations representing diverse groups of women in the drafting of reports of States parties to the Committee on the Elimination of Discrimination against Women, and the establishment of national action plans on the implementation of the Beijing Platform for Action, as well as in the delegations to international meetings, such as the Commission on the Status of Women;

(c) Strengthen the voice of women's advocacy groups by providing funding to such groups or by publicly acknowledging the importance of their work;

(d) Establish formal channels of two-way communication, such as regular participation of the national machinery in conferences of non-governmental organizations, and appointment of representatives of non-governmental organizations to boards and councils of the national machinery.

69. In order to expand support in civil society for their mandates, national machineries should:

(a) Cooperate with mass media to raise public awareness regarding gender equality and the role of national machineries in its promotion;

(b) Develop and use electronic media to disseminate information on the situation of women and to network with civil society organizations, with other gender units in Government and with national machineries of other countries;

(c) Inform civil society on international agreements in the area of women and gender equality and the outcomes of the major United Nations conferences;

(d) Organize conferences that bring together researchers, policy makers and women's advocacy groups to facilitate the exchange of experiences and networking.

70. The United Nations system should assist in strengthening the links between national machineries and non-governmental organizations by:

(a) Encouraging Governments and national machineries to include the views of civil society in their reporting on gender and women's issues to international bodies such as the Committee on the Elimination of Discrimination against Women and the Commission on the Status of Women. This could be in the form of either a joint report by the Government and the non-governmental organization or as an independent report by the non-governmental organization;

(b) Providing advisory and logistical support to national machineries and women's advocacy groups for the implementation of the Beijing Platform for Action. In this regard, the offices of the United Nations resident coordinators, in particular the women in development programmes and gender units, should play a critical role. The United Nations, in collaboration with international non-governmental organizations, could also assist in disseminating information at the regional and subregional levels.

3. Mechanisms to hold Governments accountable for mainstreaming gender

71. The meeting agreed that there was a need for special mechanisms to hold Governments accountable for gender mainstreaming. The Platform for Action states that Governments should report on a regular basis, to legislative bodies on the progress of efforts, as appropriate, to mainstream gender concerns (para. 203 (e)).

72. In order for these accountability mechanisms to be effective, consideration should be given to such elements as disaggregated statistics, performance indicators, expert scrutiny, transparency and regular public reporting. Statistics should not only be disaggregated by sex, but should also be broken down with respect to variables such as urban/rural residence, age, ethnicity, race, disability, and other socio-economic variables. Performance indicators, both qualitative and quantitative, should be regularly reviewed to ensure their continuing relevance to the advancement of gender equality.

73. National machineries play a key role in the process of accountability. National machineries should:

(a) Assist ministries and agencies with including a gender perspective in their budgetary and other reports to parliament and with preparing progress reports on gender mainstreaming;

(b) Assist government agencies to formulate clear qualitative and quantitative indicators to measure their performance with regard to gender mainstreaming;

(c) Develop, in conjunction with the national statistical agency, overall indicators of government performance;

(d) Coordinate regular reports showing government-wide progress in advancing gender equality and meeting commitments under the Beijing Platform for Action.

74. A specific form of accountability for gender outcomes is that of audit and gender budgeting. Governments should:

(a) Ensure that gender audit is included in routine auditing functions;

(b) Consider the adoption of gender budgeting, which requires ministries and agencies to disaggregate all outlays in terms of benefit to women and men in their budget documents. This process creates awareness of the differential allocation of resources to women and men.

75. Parliaments should also play a role in ensuring the accountability of Governments. Parliaments should set up a standing committee to monitor progress of gender mainstreaming and to scrutinize gender-related aspects of all government reporting. It is expected that ministries will be using gender performance indicators, developed in conjunction with the national machinery, in their reporting to parliament. A standing committee should have a secretariat with technical expertise in gender analysis to scrutinize this aspect of reporting.

76. National machineries should use international agreements in order to hold Governments accountable. National machineries should:

(a) Urge their countries to report in a timely fashion to the Committee on the Elimination of Discrimination against Women, and to regularly review any reservations to the Convention on the Elimination of All Forms of Discrimination against Women with the aim of their eventual removal. Countries that have not ratified the Convention should reconsider their position;

(b) Urge their countries to ratify optional protocols to international treaties, which provide a complaint mechanism.

77. The relationship between national machineries and civil society needs to be strong in order to ensure effective functioning of national machineries. Civil society also plays an important role in monitoring and drawing attention to government accountability for gender mainstreaming. Civil society organizations should:

(a) Use the national, regional and international legal systems to challenge laws that violate the principle of gender equality;

(b) Initiate and support legal challenges based on public interest and test cases relating to the status of women;

(c) Mobilize public opinion for the implementation of international and national commitments to gender equality;

(d) Produce alternative reports to supplement periodic country reports to international treaty bodies and the Commission on the Status of Women.

78. If national machineries are to enjoy sustained support among civil society organizations, they must be held accountable for implementation of their mandates. Experts recommended that representatives of non-governmental organizations be involved, where possible, in reviews of national machineries against performance indicators, and that the institutional channels recommended earlier be utilized.

Notes

[1] See *Report of the Fourth World Conference on Women, Beijing, 4–15 September 1995* (United Nations publication, Sales No. 96.IV.13), chap. I, resolution 1, annex II, paras. 89–111.

[2] The International Conference on Population and Development (1994) specified those global targets in further detail, recommending that "countries with intermediate levels of mortality should aim to achieve by the year 2005 a maternal mortality rate below 100 per 100,000 live births and by the year 2015 a maternal mortality rate below 60 per 100,000 live births. Countries with the highest levels of mortality should aim to achieve by 2005 a maternal mortality rate below 75 per 100,000 live births. However, all countries should reduce maternal morbidity and mortality to levels where they no longer constitute a public health problem." (*Report of the International Conference on Population and Development, 5–13 September 1994*. United Nations publication, Sales No. E.95.XIII.18), para. 8.21).

[3] Ibid., para. 7.3. The same statement is contained in the Platform for Action (see *Report of the Fourth World Conference on Women* ..., annex II, para. 95).

[4] See *Report of the Fourth World Conference on Women ...*, annex I.

[5] Jonathan Mann and Sofia Gruskin "Women's Health and Human Rights: Genesis of the Health and Human Rights Movement", *Health and Human Rights*, vol. 1, No. 4, (1995), pp. 309–314.

[6] The right to decide on the number and spacing of children (art. 16, para. 1 (e)) the right to access to specific educational information and advice on family planning (art. 10 (h)), the right of rural women to access to adequate health-care facilities, including information, counselling and services in family planning (art. 14, para. 2 (b)) and the right to protection of health and to safety in working conditions (art. 11, para. 1 (f)).

[7] See in particular general recommendation 12 (1989) on violence against women; general recommendation 14 (1990) on female circumcision; and general recommendation 15 (1990) on avoidance of discrimination against women in national strategies for prevention and control of acquired immunodeficiency syndrome.

[8] The Human Rights Committee, the Committee on Economic, Social and Cultural Rights, the Committee on the Elimination of Racial Discrimination, the Committee on the Elimination of Discrimination against Women, the Committee against Torture and the Committee on the Rights of the Child. See, in particular, *Official Records of the General Assembly, Fifty-second Session, Supplement No. 40* (A/52/40), paras. 160, 167, 287 and 300.

[9] A/52/507, annex.

[10] As of 19 November 1998, a total of 104 Member States and one observer had officially submitted their national action plans and implementation strategies to the Secretariat. See also E/CN.6/1998/6.

[11] Members of the Task Force were the United Nations Population Fund (Chair), the United Nations Secretariat, the United Nations regional commissions, the Food and Agriculture Organization of the United Nations, the International Labour Organization, the International Monetary Fund, the Office of the United Nations High Commissioner for Refugees, the United Nations Centre for Human Settlements (Habitat), the United Nations Children's Fund, the United Nations Development Fund for Women, the United Nations Development Programme, the United Nations Educational, Scientific and Cultural Organization, the United Nations Environment Programme, the United Nations Industrial Development Organization, the United Nations International Drug Control Programme, the United Nations Relief and Works Agency for Palestine Refugees in the Near East, the World Bank, the World Food Programme and the World Health Organization.

[12] Basic social services for all guidelines on a common approach to national capacity-building in tracking child and maternal mortality (1997), guidelines on primary health care (1997), guidelines on reproductive health (1997).

[13] The Minimum National Data Set was endorsed by the Statistical Commission at its twenty-ninth session (see *Official Records of the Economic and Social Council, 1997, Supplement No. 4* (E/1997/24), para. 67 (a)).

[14] World Health Organization, *Monitoring reproductive health: selecting a short list of national and global indicators* (Geneva 1998); *Selecting reproductive health indicators: a guide for district managers*, Field testing version (1997); *Reproductive Health Indicators for Global Monitoring*, Report of an inter-agency technical meeting, 9-11 April 1997.

[15] World Health Organization, *The Sisterhood for Estimating Maternal Mortality: Guidance Notes for Potential Users* (1997).

[16] United Nations Population Fund, *Indicators for Population and Reproductive Health Programmes* (forthcoming).

[17] See United Nations *World Economic and Social Survey, 1997* (United Nations publications, Sales No. E.97.II.C.1).

[18] The Directory is based on replies from Governments and is regularly updated by the Division for the Advancement of Women.

Annex

A framework for designing national health policies with an integrated gender perspective

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I. Introduction

1. Over the last two decades, women's issues have moved rapidly up the policy agenda of national Governments and international organizations. During the 1980s there was a major increase in policies designed to prevent women from being marginalized from the mainstream of economic, political and social life. Though such policies did lead to significant improvements in women's lives, their overall status in society has remained very much the same. In recognition of this continuing discrimination, the focus on women alone is now shifting towards a broader concern with gender relations. In health care and in other areas of public policy, the emphasis is now on identifying and removing the gender inequalities that prevent women, and sometimes men, from realizing their potential.

2. This shift towards a gender perspective is an important step forward. However, it has not yet delivered the expected results, and two main reasons for this can be identified. First, there has been considerable confusion about the terms being used. What is meant by "gender" and why is it different from "sex"? And how is the gender approach different from one that focuses only on women? These are important issues that must be properly understood by all those involved in the implementation of gender-sensitive health policies. Second, there has been a lag in the development and dissemination of appropriate techniques for the incorporation of gender issues into the policy process. If gender equality is to be a major goal in the development of a health service, those involved must be properly informed about the most effective means by which this can be achieved.

II. Sex, gender and health: clarifying the concepts

3. Despite its increasing use there is still considerable confusion surrounding the term "gender". It is not simply a more modern word for "sex". Rather it is a term used to distinguish those features of females and males that are socially constructed from those that are biologically determined. Thus women and men are differentiated by social characteristics, on the one hand, and by biological characteristics, on the other. This means that gender issues are not just of concern to women. Men's health too is affected by gender divisions in both positive and negative ways. These differences in "femaleness" and "maleness" are reflected in the patterns of health and illness found among women and men around the world.

4. There are marked variations in the prevalence rates of particular health problems between women and men. Any attempt to explain these differences has to make sense of the impact of both biological and social influences on well-being. Existing research reveals that some diseases strike women and men at different ages. For example, cardiovascular diseases are diagnosed at a later age in women than in men; some diseases, such as anaemia, and eating and musculoskeletal disorders are more prevalent in women than in men, while other diseases or conditions affect only women, such as pregnancy-related health problems.

A. Biological influences on health and illness

5. Biomedical and social research on the differences between women and men has traditionally focused on their reproductive biology. This approach is clearly important, since the structure and functioning of their reproductive systems can lead to particular health problems for both women and men. Only men have to worry about cancer of the prostate, for example, while only women can develop cancer of the cervix. However women's capacity to conceive and give birth means that they have reproductive health care needs additional to those of men, both in sickness and in health. Women need to be able to control their fertility and to give birth safely, so that access to high quality sexual health and reproductive health care throughout their lives is crucial to their well-being.

6. The truth of this claim is evident when looking again at female and male patterns of life expectancy. Women's greater longevity is generally accepted to be biological in origin. This biological potential for longer life may be significantly reduced and the quality of life affected if women are subjected to discriminatory practices such as a failure by society to provide effective and appropriate health services. It is here, then, that the biological meets with the social and it is these social or gender differences that are potentially amenable to change.

B. Gender divisions in society

7. The complex construct of gender interacts with biological and genetic differences to create health conditions, situations and problems that are different for women and men as individuals and as population groups. This interaction and how it plays out across different age, ethnic and income groups should be understood by health providers and health policy makers.

8. All societies are divided along a female/male axis, with those on either side being seen as fundamentally different types of beings. Most obviously, those who are female are usually allocated primary responsibility for household and domestic labour, while males are more closely identified with the public world — with the activities of waged work and the rights and duties of citizenship.

9. In most societies these are not just differences but inequalities. What is defined as male is usually valued more highly than what is defined as female, and women and men are rewarded accordingly. The work women do at home, for instance, is unpaid and usually of low status compared with waged work. Thus most women have access to fewer resources than males in the same social situation.

10. Gender also shapes the development of the self. The social norms that sanction acceptable male and female behaviour in different settings influence the formation of the individual's subjective identity. Research has shown how the expectations and the cognitive, emotional and social functioning of girls and boys are gender-differentiated and how they evolve into the distinctive ways in which women and men perceive and act within given social contexts. These norms put almost all women in a subordinate position in relation to men, placing limits on their hopes and aspirations. Poverty is often an aggravating factor.

11. The importance of gender should be stressed at institutional as well as individual and household levels. A complex set of values and norms permeates organizational systems, such as health care, the legal structure, the economy and religious practices. This reinforces wider patterns of gender discrimination, shaping the opportunities, resources and options available to individual women and men.

12. The health status of both women and men is affected by their biological characteristics, but also by the influence of gender divisions on their social, cultural and economic circumstances. For women, the effects of gender divisions are predominantly negative. The impact on men is more difficult to assess, since male status involves a more complex mixture of risks and benefits.

C. The impact of gender inequalities on women's health

13. The existence of social and economic inequalities means that in many countries women have difficulty in acquiring the basic necessities for a healthy life. Of course, the degree of their deprivation will vary depending on the community in which they live but the "feminization" of poverty remains a constant theme. "Cultural devaluation" is also important, though it is difficult to measure or even to define. Because they belong to a group that is seen by society to be less worthwhile, many women find it difficult to develop positive mental health. This process begins in childhood, with girls in many cultures being less valued than boys, and continues into later life, where "caring work" is given lower status and less rewards. These gender inequalities are further reinforced by women's lack of power and the obstacles they face in trying to effect social change.

14. The prevailing tendency is to view as pathological what are normal processes in women's physical and mental health. For example, pregnancy and childbirth are normal physiological processes under most circumstances. Unlike diseases affecting males, they are not diseases or surgical events. In many societies pregnancy and childbirth have been treated as medical processes rather than as healthy processes. Gender inequalities that prevent access to high quality health services doubly disadvantage women already at risk because of their childbearing role.

15. The nature of female labour itself may affect women's health. Household work and child care can be exhausting and debilitating, especially if they are done with inadequate resources and combined, as they are for many women, with pregnancy and subsistence agriculture. They can also damage mental health when they are given little recognition and carried out in isolation. The time consumed by caring for others leads to neglect by women of their own health. For women, domestic life and labour also carry the threat of violence, since the home is the arena in which they are most likely to be abused. The emphasis on their domestic roles also means that women suffer more severe consequences than men when a family member is a substance abuser or if they abuse substances themselves. Even in the context of paid work, "female" jobs often pose particular hazards that receive little attention.

16. Gender-based violence is a risk factor for many women. Not only is it a violation of their human rights, but it has wide ranging consequences for their physical and mental health and the health system. Women are victims of assault as a result of inequalities in society, and are most at risk of abuse from their partners and close relatives.

17. The sexual subordination of girls and women has increased their vulnerability to sexually transmitted diseases, HIV and AIDS, exacerbating the burden of disease among them and greatly reducing life expectancy and quality of life. In addition, girls and women with HIV and AIDS are exposed to stigma and mistreatment in most circumstances.

18. Women are under-represented as policy makers, decision-makers and educators in many segments of the health sector. Inequality of access to training and education is one cause. This translates into reduced access to resources and a lack of attention to women's needs and priorities.

D. The impact of gender inequalities on men's health

19. Thus far it has been women and their advocates who have paid most attention to the impact of gender divisions on health. However, new questions are now being raised about the possible health hazards of being a man and these may also need to be addressed in the development of gender-sensitive policies.

20. On the face of it, "maleness" can only be health-promoting, since it is likely to give a man greater power, wealth and status than a woman in the equivalent social situation. However certain disadvantages have also been identified. In the context of paid work, for instance, the idea of the male "breadwinner" has meant that in many societies men have felt compelled to take on the most dangerous jobs. As a result, male rates of industrial accident and disease have historically been higher than female rates, and deaths from occupational causes are more common among men than among women.

21. Men in the majority of societies are also more likely than women to adopt a variety of unhealthy habits, such as using licit and illicit psychoactive substances and dangerous sports. These activities are linked in most cultures to ideas about masculinity, so that young men in particular may feel pressure to indulge in risk-taking behaviour in order to show that they are "real men". Similar concepts have been used to explain the high rates of male-on-male violence found in many parts of the world. In the area of mental health, too, some men are now arguing that gender stereotyping narrows the range of emotions they are allowed to express, making it difficult for them to admit weakness, for example, or other feelings regarded as feminine.

22. Gender inequality affects men's behaviour and may affect relationships between women and men. It has impeded men's appreciation of their responsibility for the health hazards of violence in relationships between women and men.

III. Gender bias in health practice

A. Gender bias in research

23. Most health-related research continues to be carried out within the biomedical tradition. Though social factors are beginning to be taken more seriously, by far the largest proportion of resources is still spent on projects falling within the formal domain of biomedicine. This applies not just to clinical and epidemiological research, but also to the routine collection of morbidity and mortality statistics, which continue to be framed within standard medical categories. There is a lack of qualitative research. As a result, the information collected and the findings generated are often inadequate for the implementation of gender-sensitive policies.

24. It is therefore important to develop more adequate health information systems to inform policy and programme decision-making. This should include locally collected data (both qualitative and quantitative) that is more sensitive than existing disability-adjusted life years (DALYs) to both socio-economic conditions and gender issues. The data can then be used to set priorities through a process that includes a systematic gender analysis.

25. Most medical research continues to be based on the unstated assumption that women and men are physiologically similar in all respects apart from their reproductive systems. Other biological differences are ignored as are the social differences that have such a major impact on health. The consequence of this approach is the generation of biased knowledge. In the context of routine data collection, statistics are not always disaggregated by sex and age, making it difficult to plan for the specific needs of women and men. Similarly, many clinical studies leave women out altogether or fail to treat sex and gender as important variables in the analysis.

26. As a result, both preventive and curative strategies are often applied to women, when they have only been tested on men. Particular concern has been expressed about this in relation to coronary heart disease as well as HIV and AIDS. There is also growing evidence that sex and gender differences may be important in a range of infectious and parasitic diseases, including tuberculosis and malaria. Sex-related biological differences may affect both susceptibility and immunity, while gender differences in patterns of behaviour and access to resources may influence the degree of exposure to infection and its consequences. However, without more accurate information it is difficult to translate

these observations into more effective policy-making or clinical practice.

B. Gender bias in the delivery of health care

27. Similar concerns have been raised about gender bias with regard to access to medical care and the quality of care received. There is considerable evidence to show that women experience gender-related constraints on their access to health services and that this affects the poorest women in particular. The obstacles they face include lack of culturally appropriate care, inadequate resources, lack of transport, stigma and sometimes the refusal of their husband or other family members to permit them access. Limited public expenditure on health care will affect men as well as women, but in conditions of scarcity it is often the females in the family whose needs are given the lowest priority.

28. If they do gain access to health care, there is also evidence that the quality of care women receive is inferior to that of men. Too many women report that their experiences are distressing and demeaning. The gender bias and superiority stance of medical and health professionals of both sexes too often intimidate women, giving them no voice in decisions about their own bodies and their own health.

29. When women are excluded from the decision-making process, gender bias in staff deployment, promotion, postings and the career development of health personnel obstruct the health-seeking behaviour of women.

IV. Mainstreaming gender in health research

30. Gender inequality in the wider society is also reflected in the way medical research is carried out. If this is to be changed, women's health should have a more prominent place in the research process. A formal set of policies will be needed to ensure that their interests are represented.

A. Measuring women's health

31. One of the most basic problems facing many policy makers is lack of specific information on the situation of women. The failure to separate women from men in national and regional statistics can make it difficult to plan effectively to meet the particular needs of either group. It is essential therefore that data be collected about both sex and gender differences in health status and that the results be clearly presented for easy use. The conceptual framework for this data-collection process should be appropriate to the setting in which it is being used and should also recognize the diversity of women's experiences over their lifespan. Older women and young girls, for example, may have particular health problems, making it essential that factors such as their nutritional status or their access to health care be routinely monitored. This will require the development of appropriate indicators for measuring different aspects of their health and quality of life. Other groups of women whose vulnerability may require special attention include rural women, industrial workers, sex workers, refugee or migrant women, women bringing up children alone and women coping with chronic disease or long-term disabilities. For example, research has shown that women suffering from stigmatizing or disfiguring diseases such as tuberculosis and leprosy were more isolated than men from all activities and were treated as outcasts, even within the family setting.

32. In many developing countries, the lack of data on women's health reflects, in part, the very limited nature of the vital registration system, which affects both sexes. However, this is often compounded by a failure on the part of the relevant authorities to recognize the importance of gender issues and a lack of understanding of the complex social pressures that may render women's health problems invisible. Health statistics are based on clinical records in which male data is more prominent and hence females are under-represented. In the case of maternal mortality also, a wide range of religious, cultural and social factors can contribute to serious under-reporting. Process indicators have now been identified, and these need to be used routinely by those responsible for monitoring community health.

33. Similar problems are evident in relation to the identification and measurement of rape, domestic violence and sexual abuse. This represents a huge public health problem which has not yet been adequately documented. To fill this knowledge gap, individual countries need to move forward with the development of ethical and culturally appropriate methods for the collection of relevant data in their own particular settings. This can be facilitated by cooperation with international organizations such as WHO which have already developed a range of resources for work in this area.

34. Gaps in the availability of information on women's lives are now beginning to be filled, providing new sources of accessible data. For instance, the recent elaboration by the United Nations Development Programme (UNDP) of a number of new gender-related indicators offers important tools with which individual countries can assess the levels of gender equality in their own society. Indicators for reproductive health have been established by WHO and

United Nations Population Fund (UNFPA). Also, a number of specialized programmes in WHO are now focusing on sex and gender differences in the impact of specific diseases such as malaria, leprosy, onchocerciasis and tuberculosis. However, there is still a need for national Governments and international organizations to work together to develop more specific health-related measures combining both biomedical and socio-economic data to monitor the epidemiological profile of women's and men's health, particularly with respect to emerging epidemics such as tuberculosis, HIV and tobacco and neglected areas such as occupational and mental health and substance abuse.

B. Including women in biomedical research

35. Few women are currently involved in what has been the male-dominated arena of medical research, either as researchers or as subjects. However, strategies for change are beginning to emerge. Concerns about bias in medical research have led to attempts in a number of countries to include women in study samples wherever appropriate. However, it is essential that this only be done with the relevant ethical safeguards, such as informed consent protocols. Long-term studies have also been initiated to investigate the particular problems of women as they move through the life cycle, and more of these are needed in different socio-economic and cultural settings. Attempts to involve women in the determination of research priorities have included formal dialogues between researchers and women's health advocates, particularly in reproductive health services.

C. Expanding the disciplinary boundaries in health research

36. Reforming biomedical research can only be a partial strategy for extending understanding of sex and gender inequalities in health and illness. Social science research is also needed if the full range of influences on human health is to be understood. In particular, Governments should encourage multidisciplinary research involving social, environmental and biomedical researchers as co-investigators, and use their findings to develop more comprehensive health promotion policies.

37. The most useful studies are often those that have used both quantitative and qualitative methods in which statistical data are enriched by in-depth information from people's own experiences. Good examples of this kind of work can now be found in the areas of sexual and reproductive health, tropical diseases, mental health and occupational and environmental health, where new techniques have been developed to explore the intimate concerns of women and men which would otherwise remain hidden. For example, research on onchocerciasis and lymphatic filariasis has shown that women are concerned about the impact of the disease on their physical appearance, while men are troubled by sexual performance and virility.

D. Getting the whole picture

38. It is essential that strategies to improve the health of women and men be grounded in a rigorous analysis of the whole range of reproductive and productive activities undertaken across the lifespan. In the case of women, this is especially problematic because many of their activities are invisible. Femaleness cannot be equated with motherhood, and the scope of health research needs to shift accordingly. Hence planners need to acquire much more information on the risks women face, both in the home and in the workplace.

39. Until recently, few researchers had examined the occupational and environmental risks associated with domestic work. This is beginning to change as new techniques are being developed to explore the interior of the family. A number of hazards have been revealed that are especially dangerous for the poorest women. Analysis of the relationship between patterns of energy consumption and the volume of household work, for instance, suggests that some women s responsibilities impose long-term damage on their health. A range of environmental risks have also been identified, including lung damage caused by pollution from cooking stoves, as well as a range of unregulated but toxic substances in the household.

40. Women's work outside the home also needs much more attention from both researchers and policy makers. Though health records show that male workers die more often than females from work-related causes, women's work-related disease and disability is rapidly increasing in many parts of the world. Evidence is now emerging that traditionally "female" jobs, such as nursing and clerical work, can pose both physical and psychological risks. The millions of women now taking on traditionally "male" jobs may also be facing serious risks, especially if they are forced to combine heavy physical labour with domestic work and with reproduction.

41. Occupational health researchers need to develop greater gender sensitivity in their methods of investigation, as well as a clearer understanding of the differences between women and men. Their findings need to reflect both the different jobs done by women and men and the biological and social

differences that mediate the impact of waged work on health and well-being. Only then will regulatory bodies have accurate information upon which to base health and safety policies at work that can benefit women and men equally.

42. The strategies should be adopted to make health and health services research more gender-sensitive and therefore more appropriate as a base for national and international policy-making. However, a great deal of information on gender issues is already available, and it is essential that health planners and policy makers use the most up-to-date and gender-sensitive resources as the basis for developing their services.

V. Mainstreaming gender in health service delivery

43. The mainstreaming of gender concerns is vital at every stage of the policy process, from policy formulation, planning, delivery and implementation to monitoring and evaluation. Lack of awareness, or "gender blindness", on the part of policy makers and planners frequently leads to gender bias and to the prioritization of male interests in decision-making. If this is to be avoided, those involved need to have not only a clear understanding of the relevant issues, but also the political will to reduce the inequalities between women and men.

44. In mainstreaming gender into the health sector, establishing effective partnerships with women and men's groups is critically important. While the ministry of health usually has the mandate to deliver health services, interventions from other ministries, especially finance, education, women's affairs and social welfare, environment and youth ministries, should be encouraged. Alliances between the ministries, the target population, local authorities, the private sector, international organizations and donors should be formed. The private sector, in particular employers of men and women with potential occupational health concerns, should be key partners in the provision of health care.

45. Both sexes should not be treated in exactly the same way. Despite their commonalities, women and men have their own particular needs. Hence, adherence to the principle of equality is required to ensure that these different needs are met. Nor does it mean that all women or all men should receive the same treatment. Their varying circumstances will mean that here, too, a range of strategies will be needed if equality is to be achieved between women and men.

A. Generating political will

46. In order to achieve these goals, there should be a serious commitment at the highest levels of government. Experience shows that little is likely to change unless there is the necessary political will, the responsibility for the achievement of greater gender equality, both in health and elsewhere, is clearly allocated and the goal itself is given a high priority. Ministries of health, finance, education and environment should allocate special resources for mainstreaming gender in health service delivery through, for example, the creation and support of gender focal points and by establishing the necessary budget line items.

47. Political will can be generated in different ways. One strategy should be to use examples demonstrating the cost-effectiveness of gender intervention in order to strengthen arguments based on equality and human rights considerations. The media can also be used, in particular through the publicizing of individual cases. In addition, strategic networks can be deployed to campaign for change.

48. Individuals and groups in civil society should press for public sector reforms and good governance mechanisms. These will lead to a more transparent system and to the greater availability of data that can be used to make the necessary arguments to politicians about gender priorities for action. International organizations also play a role by encouraging Governments to implement their commitments to gender equality.

B. Instituting a gender-sensitive needs assessment

49. If the goal of developing gender-sensitive policies is to be achieved, it needs to be built explicitly into the original objective of the programme in a way that can be used later for evaluation purposes. This will require a preliminary analysis of the context in which the policy will be operating and a clear understanding of the gender issues involved. It will involve a comparison of the numbers of males and females in the target population and an assessment of the gender patterns in the current use of services.

50. In order to do this, the following questions, *inter alia*, should be answered:

(a) Do gender differences in daily life expose women and men to different kinds of health risks?

(b) How are existing gender differences in the use of services to be explained?

(c) Can any differences be observed in the quality of care women and men currently receive?

(d) In what ways are health services themselves gendered? Do gender relations within health services affect the experiences of users?

(e) Who currently controls access to health-related resources and do the allocation criteria take into account the different needs of women and men?

(f) Are health sector reforms likely to have a differential impact on women and men, and what will the impact be on gender equality and access to care?

C. Including gender issues in the planning process

51. To make the planning process gender-sensitive, the following steps should be taken:

(a) Women themselves and health advocates, including non-governmental organizations, need to be more involved in the design, implementation and evaluation of all services, as well as in the definition of strategies related to women's health;

(b) An appropriate form of consultation should be devised either with representative organizations and community groups, or directly with those requiring services;

(c) Tools, methods and training material should be developed to assist in conducting gender analysis in policies and programmes and in implementing gender impact assessment.

52. Health sector reforms have failed until now to take into account gender issues that are critical if a negative impact, particularly on women, is to be avoided. User charges often negatively affect poor women, who tend to be more vulnerable than men for reasons of economic dependency or limited access to paid work.

53. Institutional changes in the national health systems to address inefficiencies and to raise levels of service coverage, without consideration of the specific health risks and needs of women and men, have often resulted in maintaining or reinforcing gender roles and relations that have an adverse impact on health.

54. Health sector reform has a direct impact on staff composition, and unless it is done in a gender-sensitive way, may run the risk of reinforcing occupational segregation between women's and men's jobs. Gender disadvantages are reflected in occupational segregation between female and male health staff, with women being posted to more marginal areas and rarely in senior positions.

55. In order to achieve a balance of the sexes throughout the process of health sector reform, attempts should not be restricted to improvements in managerial and administrative skills. There are a number of often unrecognized issues that adversely affect the contribution of women health care providers. Examples include civil service regulations, "old-boy" networks, rigid hierarchies and seniority patterns, and failure to provide incentives for gender-sensitive performance.

56. Decentralization is perceived as an alternative policy and as a way of transferring resources, functions and authority to the periphery. However, owing to the existing interregional inequalities within developing countries, less wealthy districts will be unable to raise funds to protect the most vulnerable population groups, such as orphans, widows, unsupported elderly and landless and female-headed households.

D. Developing the framework for gender planning

57. In order to mainstream gender issues in health service, it will be necessary to create a national or regional policy framework within which both the planning process itself and delivery of services can be located. Though there is no single model for such a framework, a range of options already exists in countries with varying political and legal structures.

58. The issue of setting targets for service delivery needs to be examined carefully on a case-by-case basis, particularly where there are built-in incentives for the service providers. There are many examples where human rights have been violated, gender inequalities perpetuated and priorities distorted by the application of incentive-driven programmes, especially in the field of sexual and reproductive health and mass screening.

E. Incorporating capacity-building for gender-sensitive services

59. The effective operation of services will require a strategy for educating health workers to understand the full significance of gender issues in health. Capacity-building programmes should be designed for both female and male workers. They should focus not just on women's issues but on the wider topic of gender itself, human rights and gender identities of female and male health providers. They may

include broadly based gender-awareness courses and participatory approaches at every level.

60. It is important that these programmes be culturally appropriate to the settings in which they are to be used, but a number of models already exist that can be used as the foundation for their development. Courses of this kind, taught by competent gender experts and advocates need to be provided for qualified health workers at all levels and need to be formally built into the curriculum for all those undertaking health care education and training. Medical and nursing curricula, in particular, need to be very carefully shaped so that gender issues are properly embedded in the future planning and delivery of services.

61. The attitudes of many doctors and nurses often constitute particular obstacles to women seeking to make informed decisions concerning their own health. Therefore, one of the most important goals of capacity-building should be to inculcate in all health workers a respect for the dignity and human rights of all service users, including the formal right to full information about their condition and available treatments. This should be expressed in an explicit charter of rights.

F. Accountability, monitoring and evaluation

62. Gender dimensions, which cross all aspects of health systems, should be subject to accountability as an essential part of good management practice. Access to education and information alone will rarely be enough to ensure appropriate and ethical treatment. Therefore a range of mechanisms is needed to ensure that women have access to advocacy services. The existence of formal and easily accessible opportunities for complaint and redress through an independent system is needed as well.

63. It is essential that all policies include gender issues in their strategies for monitoring and evaluation. This will enable service providers to measure the differential impact of the policy on women and men in their roles as both users and workers. The results will then provide the basis to plan any changes needed to promote greater gender equality and equity in health. The lessons learned can be more widely disseminated to help those at an earlier stage of innovation. These monitoring and evaluation strategies need to be culturally sensitive and designed to reflect and change existing patterns of gender relations. However, a range of practical tools from different countries are now available as a starting point for this work.

VI. Intersectoral collaboration for gender equality and health

64. While intersectoral coordination is important, because of gender inequality in decision-making within and between sectors and in financial allocations, it does not, in itself, solve women's health problems. Good governance to ensure women's participation in health decision-making is essential. The first principle is that health is a human right, and that includes women's human rights. The second is a gendered democracy or parity democracy that ensures women's equal political participation. Accountability and transparency are also vital.

65. The framework for intersectoral coordination should be based on the agreements made in the Beijing Platform for Action, in which 12 critical areas of concern were identified. This document, combined with the Convention on the Elimination of All Forms of Discrimination Against Women and other international human rights instruments, provides strategies and recommendations to improve the political, economic, social and cultural well-being of women. However, these need to be more systematically integrated and linked across sectors to women's health.

66. Health care is only one of the influences on health. If, therefore, gender inequalities in health are to be tackled successfully the strategy also needs to include a range of other public policies in areas as diverse as education, law and order, agriculture, industry, transport, social security and the legal system. In each of these areas, gender equality needs to be a specific goal and targeted interventions need to be introduced to tackle traditional patterns of gender disadvantage. Only then will the root causes of gender inequalities in health be challenged.

67. In the development of macroeconomic policies for example, attention needs to be paid to the informal sector, to unpaid labour and to the "care economy" so that the implications of any decisions for women's work receive appropriate attention. Similarly, legislation is required to create a level playing field through the control of gender discrimination in access to social and economic resources. Looking at more specific areas of public policy, targeted interventions that can reduce gender inequalities in health include the development of an integrated policy to meet women's practical energy needs, female literacy programmes, special subsidies to meet the transport needs of rural women, strategies to increase women's management of agrochemicals and water resources and provision of credit for women, especially in the agricultural sector.

68. It is essential that all policy makers recognize that gender inequalities cross all determinants of health, such as class, ethnicity and socio-economic status. Policies to improve the health of women and men should also take factors such as these into account.

69. Intersectoral coordination should, furthermore, be implemented across sectors and at all levels, from the local to the global level, by a variety of actors.

70. Recognizing that countries vary according to their infrastructure, capability and history of intersectoral planning, the main focus should be to ensure gender mainstreaming in all policies and programmes.

71. The following examples illustrate the challenges and some best practices of intersectoral coordination that include a gender perspective:

(a) **Gender-based violence, trafficking of women and child prostitution.** The Pan American Health Organization coordinates a prevention programme on gender violence in seven Central American and three Andean countries that involves criminal justice, law enforcement, health, employment and a broad group of actors, including women's non-governmental organizations;

(b) **Environmental health.** Sweden has adopted Agenda 21 and applied it on a national and municipal level with ombudsmen to ensure integration of gender equality into environment programmes. Examples in Asia are found in water and sanitation programmes in which women's participation combined with good intersectoral coordination were key in achieving success;

(c) **Occupational health and access of women workers to health services.** In the l970s, women's trade unions in Hong Kong improved occupational health in the free trade zones by educating women on labour laws. This included more than maternity leave and covered safety and environmental conditions. In Botswana, Cuba and the Netherlands, national policies striving for universal access to health care helped to ensure unpaid women working in the household, and those in the informal sector access to health services;

(d) **Promotion and prevention.** In Zimbabwe, the HIV and AIDS programme uses a wide intersectoral approach involving women's non-governmental organizations, the media, schools and various governmental agencies. Some anti-smoking programmes in the United States of America, including those which reach out to young women, have been successful in reducing smoking through intersectoral cooperation;

(e) **Community health.** In the Women's Total Health Care Programme in Sao Paulo, women and their organizations played a key role in setting up community-based health care systems with a strong gender component. In collaboration with the municipal government's Women's Health Office and its local health centres, women participated in designing and applying epidemiological surveys, based on their needs, establishing priorities and monitoring their application. Outcomes of this programme include free access to family planning, including emergency contraception, abortion and counselling services for women in special situations and establishment of maternal mortality prevention and survey committees;

(f) **Sexual and reproductive health.** The initiative to eradicate female genital mutilation in the Sabini community in Uganda demonstrates effective horizontal collaboration at the local level. These efforts involve health workers, non-governmental organizations, community-based organizations and traditional leaders who provide information, education and communication on the dangers of female genital mutilation. These efforts are supported by women parliamentarians, educators, the media and health activists, who provide strong advocacy at the policy level;

(g) **Tropical diseases.** The positive role of the private sector, combined with community involvement of women, is illustrated in the partnership of the African Programme for Onchocerciasis Control, in which a pharmaceutical company provides free medication (Ivermectin) for prevention to many countries in Africa and the Americas.