Women and Health

1. Global commitments

The Beijing *Platform for Action* reiterates the agreements reached at the 1994 International Conference on Population and Development (ICPD)[1], in particular with regard to women's reproductive health and rights, and added new commitments addressing the right of women to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Taking a holistic and life-cycle approach to women's health, the Beijing *Platform for Action* proposed actions toward five strategic objectives.

- Increase women's access throughout the life cycle to appropriate, affordable and quality health care, information and related services.
- Strengthen preventive programmes that promote women's health.
- Undertake gender-sensitive initiatives that address sexually transmitted diseases, HIV/AIDS and sexual and reproductive health issues.
- Promote research and disseminating information on women's health.
- Increase resources and monitor follow-up for women's health.

The outcome of the twenty-third special session of the General Assembly entitled "Women 2000: gender equality, development and peace for the twenty-first century" called for, inter alia, policies and measures to address, on a prioritized basis, the gender aspects of emerging and continued health challenges, such as malaria, tuberculosis, HIV/AIDS and other diseases having a disproportionate impact on women's health, including those resulting in the highest mortality and morbidity rates.[2] It also called for the allocation of the necessary budgetary resources to ensure the highest attainable standard of physical and mental health, so that all women have full and equal access to comprehensive, high-quality and affordable health care, information, education and services throughout their life cycle[3] as well as full attention to the promotion of mutually respectful and equitable gender relations and particularly to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality.[4]

Article 12 of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) commits States parties to take "all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning" and to "ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation."[5]

In 1999, the Committee on the Elimination of Discrimination against Women issued General Recommendation 24, further elaborating on Article 12 of the Convention. Highlighting the importance of past general recommendations on female genital mutilation/cutting, HIV/AIDS, disabled women, violence against women and equality in family relations, the Committee provided additional guidance to States parties on the interpretation and reporting required on article 12. They noted special attention should be given to the health needs and rights of women belonging to vulnerable and disadvantaged groups, such as migrant women,

refugee and internally displaced women, the girl-child and older women, women in prostitution, indigenous women and women with physical or mental disabilities. The Committee raised various issues, using a broad definition of health, including the importance of nutritional well-being by means of a food supply that is safe, nutritious and adapted to local conditions.[6]

In 1999, during its forty-third session, the Commission on the Status of Women further enhanced commitments of the *Platform for Action* on women and health in its agreed conclusions by drawing attention to women's health issues such as infectious diseases, mental health and occupational diseases.

The Millennium Development Goals (MDGs) adopted in 2000 address women's health in two of the eight goals. MDG5 focuses on improving maternal health by reducing by three quarters, between 1990 and 2015, the maternal mortality ratio. MDG6 focuses on combating HIV/AIDS, malaria and other diseases.

In 2003, the African Union adopted a landmark treaty known as the *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa*. As of March 2007, 20 States had ratified the agreement.[7] The Protocol provides broad protection for women's human rights and affirms reproductive choice and autonomy as a key human right. It is the first time that a legally binding international human rights instrument has explicitly articulated a woman's right to abortion when pregnancy results from sexual assault, rape or incest; or when continuation of the pregnancy endangers the life or health of the pregnant woman.

In 2004, the World Health Assembly adopted its first strategy on reproductive health, intended to help countries stem the serious repercussions of reproductive and sexual ill-health. The strategy targets five priority aspects of reproductive and sexual health: improving antenatal, delivery, postpartum and newborn care; providing high-quality services for family planning, including infertility services; eliminating unsafe abortion; combating sexually transmitted infections, including HIV, reproductive tract infections, cervical cancer and other gynaecological illness and disease; and promoting sexual health.

During the 2005 World Summit, Heads of State and Government committed themselves to "[a]chieving universal access to reproductive health by 2015, as set out at the International Conference on Population and Development, integrating this goal in strategies to attain the internationally agreed development goals, including those contained in the Millennium Declaration, aimed at reducing maternal mortality, improving maternal health, reducing child mortality, promoting gender equality, combating HIV/AIDS and eradicating poverty."[8] They also resolved to promote gender equality and eliminate pervasive gender discrimination by, inter alia, ensuring equal access to reproductive health.[9]

In 2005 at its fiftieth session, the Commission on the Status of Women issued agreed conclusions on "[e]nhanced participation of women in development: an enabling environment for achieving gender equality and the advancement of women, taking into account, inter alia, the fields of education, health and work." The Commission underlined the importance of incorporating a gender, human rights and socio-economic perspective in all policies relevant to education, health and work and of creating an enabling environment for achieving gender equality and the advancement of women. It called upon Governments to incorporate gender perspectives and human rights in health-sector policies and programmes, pay attention to women's specific needs and priorities, ensure women's right to the highest attainable standards of physical and mental health and their access to affordable and adequate health-care services,

including sexual, reproductive and maternal health care and life-saving obstetric care, in accordance with the Programme of Action of the International Conference on Population and Development, and recognize that the lack of economic empowerment and independence increased women's vulnerability to a range of negative consequences, involving the risk of contracting HIV/AIDS, malaria, tuberculosis and other poverty-related diseases.[10]

2. Progress at the national level

Since 1995, there have been important improvements in the health status of women at the global level, including an increase in life expectancy by more than a decade.[11] This section highlights progress in national health policies and structures, in reproductive health, and in other health issues.

National policies, structures and resources for women's health

There has been considerable progress at the national policy level and a growing awareness of the importance of gender dimensions in health policies, including general health policies and those specific to sexual and reproductive health. Almost one half of countries reporting during the ten-year review and appraisal of implementation of the Beijing *Platform for Action* highlighted progress related to revising, strengthening and amending health-related action plans, policies and agreements to include gender perspectives.[12]

Progress at the level of national health policy

In **Uganda**, the Ministry of Gender, Labour and Social Development collaborated with the Ministry of Health to ensure that gender mainstreaming was included amongst the guiding principles for the National Health Policy. On this basis, the Ministry of Health and development partners agreed at the second Joint Review Mission to incorporate a commitment to the integration of gender issues in policies, planning, service delivery and evaluation in the Health Sector Strategic Plan and in the Memorandum of Understanding between the Government of Uganda and development partners.

India's National Health Policy 2002 focuses throughout on the health of the poor, and dedicates a section to the health of women and related socioeconomic and cultural issues. The document acknowledges the importance of women's health as a major determinant of the health of entire communities. The policy endorses the need to expand the primary health care infrastructure to increase women's access to care. The policy also recognizes a need to review staffing in the public health service, so that it may become more responsive to specific needs of women.

Sources: Uganda: S. Theobald *et al*. (2005). *Engendering the Bureaucracy?*[13]
India: WHO (2005). *Gender in Tuberculosis Research*.[14]

Some countries have established specific government structures to provide policy direction regarding women's health and/or direct health services to women. For example, Canada established the Bureau for Women's Health and Gender Analysis to promote equitable health outcomes for women and men, boys and girls. It provides policy advice and leads initiatives to advance women's health and to increase understanding of how sex and gender affect health over the lifespan. It also aims to build departmental capacity by coordinating the implementation of gender-based analysis and reports on the development of gender-sensitive legislation, policies and programmes at the ministry of health.[15] In Sao Paulo, Brazil, the city government created the Women's Health Care Office (a division of the Municipal Health

Secretariat). A significant accomplishment of the Office was the implementation of a Women's Total Health Programme which brought a gender perspective to local health services and promoted women's participation in decision-making. The programme was later duplicated by other cities in Brazil.[16]

Some countries have allocated specific funds and resources for women's health, including China, Ecuador, El Salvador, Mexico, Oman, Paraguay and the United Kingdom. For example, Mexico introduced gender-sensitive budgeting to guarantee equitable and non-discriminatory access to health services and the Philippines set aside 30 per cent of its health sector investment to improve women's health. The allocation of resources to specific groups of women has also been noted, including indigenous women, minority women and women with disabilities.[17]

Reproductive health

Although much remains to be done, there have also been significant improvements in the area of reproductive health. Ongoing advocacy efforts continue to push for greater attention to the range of issues encompassed by sexual and reproductive health and rights (see box).

The scope of sexual and reproductive health and rights

"Reproductive rights are central to human rights, especially the human rights of women. They derive from the recognition of the basic right of all individuals and couples to make decisions about reproduction free of discrimination, coercion or violence. They include the right to the highest standard of health and the right to determine the number, timing and spacing of children. They comprise the right to safe childbearing, and the right of all individuals to protect themselves from HIV and other sexually transmitted infections."

Source: UNFPA (2005) *State Of The World's Population Report.*[18]

Expanding coverage and access to sexual and reproductive health for women has been a priority in many countries. For example, Colombia's comprehensive approach addresses safe maternity; family planning for men and women; adolescent pregnancies; sexually transmitted diseases, including HIV/AIDS; cancer screening; and domestic violence. Liberia focused on decentralizing reproductive health services to improve service in rural areas.[19]

Access to contraception has expanded in some countries and regions, including for example, Bangladesh, Burkina Faso, Egypt and Uzbekistan.[20] In Tajikistan, a National Programme on Reproductive Health and Reproductive Rights was approved and is being implemented.[21] Successes in access to family planning in the north African and Middle East region, including in Algeria, Iran, Morocco and Tunisia, are the result of health promotion programmes that raise awareness and strongly subsidize contraceptives.[22]

Reduced abortion rates, as a result of access to contraceptives, has been reported in countries with economies in transition. For example, in the Russian Federation abortion rates decreased by a third, and abortion-related deaths fell from 24.2 per cent of maternal deaths in 1999 to 18.5 per cent in 2002. In Slovakia, abortions fell by almost 60 per cent over the last decade.[23] China, India and the Republic of Korea have banned sex-selective abortions and penalized unqualified and illegal practitioners.[24]

Some countries reported on initiatives to reduce the number of teen pregnancies, provide life skills to prevent unwanted pregnancies and assist pregnant girls. Media campaigns, information sessions, conferences, training of health care providers, publications and programmes to keep pregnant girls in school were provided as examples.[25]

Countries successful in reducing maternal mortality include Bangladesh, Bolivia, China, Cuba, Egypt, Honduras, Indonesia, Jamaica, Malaysia, Sri Lanka, Thailand and Tunisia, among others.[26] Between 1990 and 2004, three regions showed dramatic increases in the proportion of deliveries attended by skilled health care professionals: South-east Asia (38-68 per cent); Northern Africa (40-71 per cent) and East Asia (51-79 per cent).[27]

Other health issues

Although there is a tendency to focus on women's reproductive health, countries have also reported on progress in other areas. For example increased attention to the early detection of breast and cervical cancer; recognition of violence against women as a health problem; efforts made to address women's mental health issues; attention to gender-specific factors in addiction, primarily relating to tobacco use; efforts made related to nutrition and eating disorders; and initiatives to reduce the incidence of tuberculosis and malaria among women.[28]

3. Gaps and challenges

Despite progress, the ten-year review of the Beijing *Platform for Action* identified many obstacles and challenges including insufficient statistical data, lack of expertise and resources for research on women and health, the trend to limit women's health policies to reproductive roles (neglecting other priority issues), insufficient funding, and socio-cultural attitudes.[29] This section explores a few areas where more progress is required.

Sexual and reproductive health

Despite some progress, considerable challenges continue to exist in the area of sexual and reproductive health. Reproductive health problems are the leading cause of women's ill health and death worldwide.[30] Death and disability due to sexual and reproductive health accounted for 18 per cent of the total disease burden globally and 32 per cent of the disease burden among women of reproductive age in 2001.[31]

More than half a million women in the developing world die during pregnancy and childbirth due to preventable causes, with over 90 per cent of those in Africa and Asia.[32] Unsafe abortions continue to imperil women's reproductive health in developing countries. According to WHO estimates, 19 million unsafe abortions were carried out in 2000, with Asia, Africa and Latin America accounting for the highest numbers.[33]

Many developing countries face contraceptive shortages as a result of rising demand for contraception.[34] Around 200 million women who wish to space or limit their childbearing lack access to contraception.[35] In some countries, contraceptive services are only available to married women.[36] Other barriers to women's use of contraception include legal barriers, socio-cultural attitudes and lack of information.[37]

Adolescent girls are particularly vulnerable to early pregnancy, sexual abuse, child marriage and other harmful practices such as genital mutilation/cutting. Every year, some 14 million adolescent girls give birth. Adolescent girls between the ages of 15 and 19 are two to five

times more likely to die owing to pregnancy-related complications than women in their twenties, and their babies are less likely to survive as well.[38]

Gender issues in disease and other health issues

Malnutrition, often caused by gender discrimination in food distribution, remains a challenge in many countries.[39] Anaemia and iodine deficiencies are serious problems in some countries. In industrialized countries, girls and young women suffer more than men from eating disorders such as anorexia, bulimia and obesity.[40] In some countries, given increased female life expectancy and changes of life style, certain non-communicable diseases, such as cancer, cardiovascular diseases and osteoporosis, have become more common, in particular among older women. In addition, work-related fatigue, repetitive strain injury, infections and mental health problems are more common among women than among men.[41]

Gender dimensions of diseases, including tuberculosis (TB), malaria, and mental health need to be addressed. For example, the epidemiology and course of tuberculosis differs for men and women. Women progress from infection to active TB faster than men do, but the reported incidence of pulmonary TB among women is nearly always lower than for men. It remains unclear whether and to what extent these differences are a true reflection of disease incidence, as recent research from India suggests, or an indication of health system failures to detect and report female cases, as gender-based barrier models of limited access to health care and diagnosis suggest. Women are more likely than men to adhere to treatment and to complete a full course. Consequently, women who reach treatment are also more likely than men to be treated successfully.[42]

Factors affecting access to health care

During the ten-year review and appraisal of implementation of the Beijing Declaration and *Platform for Action*, many countries reported that urban women had much better access to health services than women in rural areas, including indigenous women.[43] A lack of human and financial resources limits primary health care in rural and remote areas. Indigenous women in many parts of Latin America, for example, often have difficulties in accessing health care, as health coverage is generally low in rural areas, where they are concentrated. In addition, most indigenous communities are remote and lack access to transportation to reach urban or peri-urban medical centres. Indigenous women are often triply disadvantaged due to their ethnicity, their sex and their predominantly rural residency patterns, resulting in a lack of attention to their needs in existing health programmes. [44] Indigenous women are also often reluctant to access health services because they are more comfortable with their communities' traditional medical knowledge and midwives, and they are not understood or are poorly treated by modern health providers. Furthermore, cultural beliefs about modesty and sexuality prevent health providers (especially males) from examining them.[45]

In rural areas, low levels of literacy can be a major obstacle preventing women from identifying health problems. A 10-year study in rural Egypt published in 1999 found that perceptions women held about their own health were the single most important factor governing their utilisation of health services. The majority of women with reproductive tract infection, genital prolapse and anaemia did not seek health care services as they considered these conditions to be normal.[46]

Patriarchal attitudes and deep-rooted stereotypes regarding the roles and responsibilities of women and men in the family can limit women's control over their sexual and reproductive health. Women's lack of decision-making power can limit their access to health care and negatively affect maternal health outcomes. In many societies, men control household expenditures and decision-making in the family and families may be reluctant to use scarce resources for women's health or nutritional needs. Although men may be the principal decision-makers on seeking health services, there maybe little communication with their wives about their health during pregnancy and the postpartum period.[47] In many countries, significant percentages of women reported that their husbands alone make the decisions regarding their health, for example, Burkina Faso (74.9 per cent), Zambia (46.5 per cent), Armenia (20.2 per cent), Nepal (51 per cent) and Haiti (21.3 per cent).[48]

Insufficient funding and lack of human and financial resources constrain both health services for women and gender-sensitive health policies. Economic crises have contributed to the lack of medical coverage for women and men. National health budgets have been affected leading to deteriorating public health systems and in some areas the cost of medical care and contraceptives has increased.[49]

Health statistics[50]

Limited health data disaggregated by sex remains an impediment to effective policy-making, resource allocation, monitoring and evaluation. In the period 1995-2003, even basic statistical data such as the number of deaths disaggregated by sex were not being reported for many countries. The ability of governments to report health-related statistics by sex and age is closely tied to the existence of comprehensive national statistical systems. Underreporting and misclassification of maternal deaths are greatest in countries where maternal mortality is suspected to be high and where civil registration and vital statistics systems are weak.

The maternal mortality ratio is just one of the indicators of women's reproductive health. There is a pressing need to monitor morbidity and disability due to pregnancy and childbirth—there is currently no systematic reporting of such data internationally. In addition, some aspects highlighted in the *Platform for Action*, such as unsafe abortions, remain practically unmonitored.

When estimates on morbidity of women and men from causes other than HIV/AIDS are available, they are seldom available by sex. Even sex-disaggregated data on the prevalence of diseases that have been highlighted by the Millennium Development Goals, such as malaria and tuberculosis, are often not available.

Reliable data on morbidity, health-care practices and access to and use of health-care services are necessary to monitor and assess progress in the health status of women and men. In the case of maternal health, process indicators (i.e., measures of services the health system is actually providing), such as attendance by skilled health personnel at delivery and utilisation of emergency obstetric care facilities can be used for healthcare planning purposes.

4. Strategies to accelerate implementation

A range of strategies and actions have been recommended to address the gaps and challenges in women's health. This section explores just a few of the identified options. For example, CEDAW General Recommendation 24 (1999) set out a series of recommended actions for States parties.[51]

- Place a gender perspective at the centre of all policies and programmes affecting women's health and involve women in the planning, implementation and monitoring of such policies and programmes and in the provision of health services to women.
- Ensure the removal of all barriers to women's access to health services, education and information, including in the area of sexual and reproductive health, and, in particular, allocate resources for programmes directed at adolescents for the prevention and treatment of sexually transmitted diseases, including HIV/AIDS.
- Prioritize the prevention of unwanted pregnancy through family planning and sex education and reduce maternal mortality rates through safe motherhood services and prenatal assistance. When possible, legislation criminalizing abortion could be amended to remove punitive provisions imposed on women who undergo abortion.
- Monitor the provision of health services to women by public, non-governmental and private organisations, to ensure equal access and quality of care.
- Require all health services to be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice.
- Ensure that the training curricula for health workers includes comprehensive, mandatory, gender-sensitive courses on women's health and human rights, in particular gender-based violence.

Linking women's health to control over resources and decision-making

To address women's lack of decision-making power in the household and in the community, which can limit their access to health care and negatively affect maternal health outcomes, a number of strategies can be taken, including:

- Parallel initiatives to increase women's access to and control of resources (credit and savings groups and emergency loan funds through women's cooperative agricultural production or market activities)
- Initiatives to re-negotiate the balance of power between women and health care providers through staff training or increasing women's control over who is present during labour and delivery.
- Involving male partners, extended family and community members.

In particular, one initiative in Bolivia, took the following steps:

- Women's groups were formed to identify problems and solutions;
- Women received literacy training, practice in speaking and information on rights;
- Women raised money from family gardens for emergency loan funds; and
- Women carried out a letter writing campaign to Ministry of Health official for better services.

Improvements included a decline in maternal mortality rates (from 141 per 10,000 births at baseline to 99 post-intervention), natal mortality ratios also improved.

Source: Interagency Gender Working Group & WHO (2005), *A Summary of the 'So What' Report.*[52]

Improving reproductive health

A number of strategies have been developed to address issues related to women's reproductive health. One of the key strategies at the national level is to ensure that the breadth of issues covered is consistent with the elements agreed to at the International Conference on Population and Development (Cairo, 1994), which encompass a state of complete physical, mental, social well-being, including:

- access to appropriate, safe, effective, affordable, acceptable methods of family planning based on informed choice and dignity;
- services for safe pregnancy and childbirth;
- prevention, diagnosis and treatment of reproductive tract infections and sexually transmitted infections, including HIV/AIDS;
- a satisfying, safe sexual life; and
- elimination of violence against women and girls, including female genital mutilation/cutting, domestic violence and trafficking.[53]

In 2006, as part of the Millennium Project[54] a research report on sexual and reproductive health and the MDGs was released. In addition to documenting the links between sexual and reproductive health and all of the MDGs, the report set out a list of priority tasks.[55]

- *Task 1: Integrating sexual and reproductive analyses and investments into national poverty reduction strategies*. National development planning must be based on MDG needs assessments that include population and sexual and reproductive health concerns.
- *Task 2: Integrating sexual and reproductive services into strengthened health systems.* Attention to a person-centred continuum of care over a lifecycle and to service interventions is proposed as a guiding framework.
- *Task 3: Systematically collecting data*. Beyond health management information needs, other information is required to provide a more accurate picture of women's economic contributions to society, including their management roles and their unpaid labour in the family and in the informal sector. This includes data on population dynamics and youth needs; urbanisation and migration; deteriorating rural and agricultural conditions; poverty pockets; gender roles and relationships and belief systems; and sex-disaggregated data
- *Task 4: Acting on the Reproductive Health Quick Impact Initiative.* This is a key intervention identified by the Millennium Project to accelerate progress toward achieving the MDGs as a whole. There are two components: (1) improving access to reproductive health information and services, including family planning, and (2) closing the fundamental gap for commodities, supplies and logistics.
- *Task 5: Meeting the needs of special populations.* These include adolescents, people caught up in humanitarian crises, and men.

The report points out that the requirements for effective action include political commitment, effective coordination, community participation and cultural sensitivity as well as resources for programmes.

Reproductive health and the achievement of MDG3

The United Nation's Millennium Project has identified guarantees of sexual and reproductive health and rights for women and girls as one of the seven strategic priorities for achieving MDG3. Task Force 3 points out: At a minimum national public health systems must provide quality family planning, emergency obstetric services, safe abortions (where legal), post-abortion care, interventions to reduce malnutrition and anaemia, and programmes to prevent and treat sexually transmitted infections, including HIV/AIDS. Outside the health system, sex/sexuality education programmes are needed to lay the foundation for improved sexual and reproductive health outcomes. Ultimately, these interventions must be supported by an enabling policy and political environment that guarantees women's and girls' sexual and reproductive rights.

UN Millennium Project (2005). *Taking Action: Achieving Gender Equality and Empowering Women* [56]

Increasing the role of men and boys in reproductive health

Increasing the role of men and boys in reproductive health programmes is an important area for future work. Good practice examples that can be expanded include:[57]

- educating fathers about safer childbirth and discouraging unsafe home deliveries (Uganda);
- training physicians to involve men in maternity care, which has resulted in more husbands accompanying their wives to antenatal clinics (India);
- encouraging men to share domestic chores and parenting responsibilities, which made women more likely to receive prenatal care, to reduce their workloads before giving birth and to deliver under more sanitary conditions (China).

Involving men in reproductive health care

"Male Call, a project implemented by Population Services Pilipinas Inc. with support from the Turner Foundation and UNFPA, successfully combined educational strategies with the provision of reproductive health services in Taytay, a rural area in the Philippines. Because the approval and cooperation of their partners was needed to ensure women's access to health services in the area, men were a key target for messages delivered through print media, cultural performances, community events and seminars and workshops. Service components of the project included rural outreach, a referral system that offered discounted rates and a clinic that emphasized the links between overall family health and male reproductive health and sexual concerns. Successes included more family planning acceptors, more prenatal check-ups and pap smears and more treatment of reproductive tract infections. In addition, seminars and workshops gave men the opportunity to discuss sexual behaviours and talk more openly about reproductive and sexual issues with their partners. Evaluations showed that the project improved men's relationships with their wives."

UNFPA (2006). *Population Issues: Promoting Gender Equality: Involving Men: UNFPA in Action – Case Study*.[58]

Improving reproductive health care in emergencies

Women's reproductive health care needs continue during emergencies, including in situations of conflict and natural disasters. The Minimum Initial Services Package (MISP) was developed in response to these needs.[59] The MISP is a set of priority activities to be

implemented during the early stages of an emergency. It has grown out of ten years of work of the Inter-Agency Working Group on Reproductive Health in Refugee Situations and is a standard in the 2004 revision of the Sphere Humanitarian Charter and Minimum Standards in Disaster Response.[60] MISP activities are designed to: prevent and manage the consequences of sexual violence; reduce HIV transmission; prevent excess maternal and neonatal mortality and morbidity; and plan for comprehensive reproductive health services in the early days and weeks of an emergency.

Developing campaigns on other health issues, such as tobacco use

Recent research has sought to understand the gender perspectives of tobacco use around the world. For example, women and men often have different reasons or motivation for starting, continuing or ceasing to smoke. Research suggests that "men and boys perceive greater pressure than women and girls to accept the gendered stereotype that men should be rugged, robust and strong," while women are often more concerned about weight gain.[61] Thus, if health awareness campaigns relating to tobacco and other themes are to be effective, they need to take gender differences into account.

Swedish efforts to specifically address women's abuse of tobacco

Sweden has incorporated a gender-sensitive approach in some of its policies on tobacco control. Activities include:

- training of key professionals, such as health workers, school nurses, staff at youth clinics, and teachers, with regard to specific issues relevant to girls and women;
- publishing self-help manuals for different target groups such as pregnant women, parents, young girls and older women;
- distribution of booklets on how to give up smoking without putting on weight;
- distribution of supplements to magazines for young women;
- identification of role models for young women, including fashion models, television stars and pop stars;
- use of the media with projects like "smoke-free Miss Sweden".

United Nations Economic Commission for Europe (2006). *Gender Issues: Policy Areas: Health*[62]

Ensuring a gender perspective in efforts to roll back malaria[63]

Both social and biological factors contribute to the different impact malaria has on women and men – as sufferers and principal caregivers. A gender approach contributes to both understanding and combating malaria. Gender norms and values that influence the division of labour, leisure activities, and sleeping arrangements, may lead to different patterns of exposure to mosquitoes for males and females. There are also gender dimensions to accessing treatment and care for malaria, as well as preventative measures such as treated mosquito nets. An understanding of the gender-related dynamics of treatment seeking behaviour as well as of decision making, resource allocation and financial authority within households is key to ensuring effective malaria control programmes.

Specific strategies have been identified by the Global Gender and Malaria Network of the Roll Back Malaria Partnership.[64]

- Highlight the specific vulnerability of women to malaria in order to improve quality of service delivery and promote access and coverage of all interventions.
- Empower women & men with information about malaria and appropriate skills so that their voices are amplified when policy, research and implementation of malaria control is undertaken.
- Empower communities with information on malaria that includes a gender perspective, thereby strengthening their ownership of malaria control and building their competency as agents and advocates of change.
- Sensitize decision makers at all levels in order to mainstream gender into malaria policies and create an enabling environment so that they can respond appropriately to community concerns.
- Ensure that data, for example, on malaria prevalence, access to treatment, is disaggregated by sex and age, and that qualitative research is conducted to address gender related barriers to prevention and treatment.

Improving the health of women and girls with disabilities[65]

Women and girls with disabilities face additional challenge when accessing health care: physical obstacles to clinics, the lack of appropriate services, the lack of understanding and training on the part of health care professionals, general vulnerability, stereotypes regarding women with disabilities, poverty and lack of education. Suggested strategies include:

- raise public awareness (for examples through street plays and discussions) on the issue, highlighting that women and girls with disabilities have the same rights to health care as non-disabled people;
- ensure that health care facilities are accessible for women and girls with disabilities and meet their needs;[66]
- offer free health services for women with disabilities.
- provide public or private transportation to the health centre.
- work with NGOs who involve women and girls with disabilities and advocate on their behalf;
- create employment opportunities for women with disabilities; and
- ensure that women know about existing health services.

5. Resources

Websites

- The Eldis Gender and Health online guide is a good starting place to explore these issues. www.eldis.org/go/topics/resource-guides/health/gender-and-health (accessed 24 June 2007).
- The World Health Organisation's (WHO) website on *Gender, Women and Health* includes many full-text documents on a range of women's health issues. www.who.int/gender/en/ (accessed 24 June 2007).
- The Panamerican Health Organisation's (PAHO) website on *Gender and Health* provides general and specific resources in English and Spanish. www.paho.org/english/DD/PUB/TopicHome.asp?TP=Gender%20and%20Health&KW=reviewedPublicationsGH&Lang=E&Title=Gender%20and%20Health (accessed 24 June 2007).

- The Royal Tropical Institute (KIT) maintains a *Gender and Health* webpage with links to various resources and websites. www.kit.nl/smartsite.shtml?ch=fab&id=4599&Part=Intro (accessed 24 June 2007).

Reports and tools

- Baume, E *et al*. (2001) *Gender and Health Equity Guide*. Gender and Health Equity Network. Institute for Development Studies at the University of Sussex. This guide provides lists of annotated resources on gender analysis in the health sector, international and national initiatives, and various tools. www.ids.ac.uk/ghen/resources/papers/Geneq.pdf (accessed 24 June 2007).
- Bernstein, Stan with Charlotte Juul Hansen (2006). *Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals.* Millennium Project. This comprehensive and well-documented report provides a wealth of information on sexual and reproductive health across all MDG areas. www.unmillenniumproject.org/reports/srh_main.htm (accessed 24 June 2007).
- Cornwall, A. and Jolly, S. (2006). *Sexual and reproductive health and rights: Quick guide* through *the key issues.* UK: Eldis. This web-based 'issues guide' looks at policy definitions and discussions relating to sexual and reproductive health and rights. www.eldis.org/health/SRHR.htm (accessed 24 June 2007).
- UNFPA (2005). *State of the World's Population.* This report provides current information on sexual and reproductive health, as well as maternal health. www.unfpa.org/publications/detail.cfm?ID=248&filterListType= (accessed 24 June 2007).

Notes

[1] One of the major contributions of ICPD was the elaboration of a definition of a rights-based approach to sexual and reproductive health. "Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so.. Reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases." United Nations (1994). *Programme of Action.* Adopted at the International Conference on Population and Development, Cairo, 5-13 September 1994.

[2] General Assembly resolution S-23/2, para. 72 (a).

[3] General Assembly resolution S-23/2, para. 72 (g).

[4] General Assembly resolution S-23/2, para. 72 (j).

[5] For complete text of the article, see: www.un.org/womenwatch/daw/cedaw/text/econvention.htm#article12 (accessed 23 June 2007).

[6] For the full text of the General Recommendation, see the United Nation's Division for the Advancement of Women's website: www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm#recom24 (accessed 23 June 2007).

[7] www.africa-union.org/root/AU/Documents/Treaties/treaties.htm (accessed 20 March 2007).

[8] *2005 World Summit Outcome* A/RES/60/1, para 57 (g).

[9] *2005 World Summit Outcome* A/RES/60/1, para. 58 (c).

[10] United Nations (2005). *Report on the fiftieth session (22 March 2005, 27 February-10 March and 16 March 2006) Commission on the Status of Women*. Economic and Social Council E/2006/27 E/CN.6/2006/15.

[11] United Nations (2003). *World Fertility Report 2003*. New York: UN Department of Economic and Social Affairs Population Division. www.un.org/esa/population/publications/worldfertility/World_Fertility_Report.htm (accessed 27 June 2007).

[12] United Nations (2005). *Review of the implementation of the Beijing Platform for Action and the outcome documents of the special session of the General Assembly entitled "Women 2000: gender equality, development and peace for the twenty-first century." Report of the Secretary-General*. E/CN.6/2005/2, para. 154.

[13] Theobald, S. et al. (2005). "Engendering the Bureaucracy? Challenges and opportunities for mainstreaming gender in Ministries of Health under sector-wide approaches." *Health Policy and Planning* 20(3):141-149. Summary at www.id21.org/health/h1st3g1.html (accessed 23 June 2007).

[14] WHO (2005). *Gender in Tuberculosis Research:* www.who.int/gender/documents/TBlast2.pdf (accessed 25 June 2007).

[15] For more information see the Bureau's website: www.hc-sc.gc.ca/ahc-asc/branch-dirgen/hpb-dgps/pppd-dppp/bwhga-bsfacs/index_e.html (accessed 24 June 2007).

[16] de Oliveira Araújo, Maria José (1998). "The role of local authorities in implementing health care with the gender perspective: The case of the Women's Total Health Care Programme in Sao Paulo, Brazil." *UN CSW Expert Group Meeting on Women and Health, September 1998* www.un.org/womenwatch/daw/csw/role.htm (accessed 25 June 2007).

[17] United Nations (2005). *Review of the implementation of the Beijing Platform for Action and the outcome documents of the special session of the General Assembly entitled "Women 2000: gender equality, development and peace for the twenty-first centur.y" Report of the Secretary-Genera.*, E/CN.6/2005/2, para. 155-156.

[18] UNFPA (2005). *State of World Population 2005*. www.unfpa.org/publications/detail.cfm?ID=248&filterListType= (accessed 28 June 2007)

[19] United Nations (2005) *Review of the implementation of the Beijing Platform for Action and the outcome documents of the special session of the General Assembly entitled "Women 2000: gender equality, development and peace for the twenty-first century" Report of the Secretary-General*, E/CN.6/2005/2, paragraph 161

[20] United Nations (2005). *Review of the implementation of the Beijing Platform for Action and the outcome documents of the special session of the General Assembly entitled "Women 2000: gender equality, development and peace for the twenty-first century." Report of the Secretary-General*. E/CN.6/2005/2, para. 163 .

[21] WEDO (2005). *Beijing Betrayed: Women Worldwide Report that Governments Have Failed to Turn the Platform into Action*. www.wedo.org/files/gmr2005english.html (accessed 11 July 2007).

[22] Roudi-Fahimi, Farzaneh (nd). *Gender and Equity in Access to Health Care Services in the Middle East and North Africa*. Population Reference Bureau. www.prb.org/Articles/2006/GenderandEquityinAccesstoHealthCareServicesintheMiddleEastandNorthAfrica.aspx (accessed 28 June 2007).

[23] United Nations (2005). *Review of the implementation of the Beijing Platform for Action and the outcome documents of the special session of the General Assembly entitled "Women 2000: gender equality, development and peace for the twenty-first century." Report of the Secretary-General*. E/CN.6/2005/2, para. 167.

[24] United Nations (2005). *Review of the implementation of the Beijing Platform for Action and the outcome documents of the special session of the General Assembly entitled "Women 2000: gender equality, development and peace for the twenty-first century." Report of the Secretary-General*. E/CN.6/2005/2, para. 168.

[25] United Nations (2005). *Review of the implementation of the Beijing Platform for Action and the outcome documents of the special session of the General Assembly entitled "Women 2000: gender equality, development and peace for the twenty-first century." Report of the Secretary-General*. E/CN.6/2005/2, para. 172.

[26] UNFPA (2005). *State of World Population 2005*. www.unfpa.org/publications/detail.cfm?ID=248&filterListType= (accessed 28 June 2007).

[27] United Nations (2006). *The Millennium Development Goals Report*. New York. mdgs.un.org/unsd/mdg/Resources/Static/Products/Progress2006/MDGReport2006.pdf

[28] United Nations (2005). *Review of the implementation of the Beijing Platform for Action and the outcome documents of the special session of the General Assembly entitled "Women 2000: gender equality, development and peace for the twenty-first century." Report of the Secretary-General.* E/CN.6/2005/2, para. 170 – 181.

[29] United Nations (2005). *Review of the Implementation of the Beijing Platform for Action and the outcome documents of the special session of the General Assembly entitled "Women 2000:gender equality, development and peace for the twenty-first century." Report of the Secretary-General.* E/CN.6/2005/2, para. 182- 184.

[30] UNFPA (2005) *State of World Population 2005*. www.unfpa.org/publications/detail.cfm?ID=248&filterListType= (accessed 28 June 2007).

[31] Bernstein, Stan with Charlotte Juul Hansen (2006) *Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals.* Millennium Project. www.unmillenniumproject.org/reports/srh_main.htm (accessed 28 June 2007).

[32] UNICEF (2006). *Women and Children: The Double Dividend of Gender Equality. The State of the World's Children 2007*. New York. www.unicef.org/sowc07/docs/sowc07.pdf (accessed 28 June 2007).

[33] WHO (2004). *Unsafe Abortion: Global and Regional Estimates of Unsafe Abortion and Associated Mortality in 2000* , 4th Edition. Geneva. www.who.int/reproductive-health/publications/unsafe_abortion_estimates_04/estimates.pdf (accessed 29 June 2007).

[34] UNFPA (2005). *State of World Population 2005.* www.unfpa.org/publications/detail.cfm?ID=248&filterListType= (accessed 28 June 2007).

[35] United Nations (2006). *The Millennium Development Goals Report*. New York. mdgs.un.org/unsd/mdg/Resources/Static/Products/Progress2006/MDGReport2006.pdf (accessed 25 June 2007).

[36] The reference for the last point is WEDO (2005). *Beijing Betrayed: Women Worldwide Report that Governments Have Failed to Turn the Platform into Action*. www.wedo.org/files/gmr2005english.html (accessed 11 July 2007).

[37] United Nations (2005) *Review of the implementation of the Beijing Platform for Action and the outcome documents of the special session of the General Assembly entitled "Women 2000: gender equality, development and peace for the twenty-first century." Report of the Secretary-General.* E/CN.6/2005/2, para. 185.

[38] UNFPA (2005). *State of World Population 2005*. www.unfpa.org/publications/detail.cfm?ID=248&filterListType= (accessed 28 June 2007).

[39] United Nations (2005.) *Review of the implementation of the Beijing Platform for Action and the outcome documents of the special session of the General Assembly entitled "Women 2000: gender equality, development and peace for the twenty-first century." Report of the Secretary-General.* E/CN.6/2005/2, para. 188.

[40] United Nations (2005) *Review of the implementation of the Beijing Platform for Action and the outcome documents of the special session of the General Assembly entitled "Women 2000: gender equality, development and peace for the twenty-first century." Report of the Secretary-General.* E/CN.6/2005/2, para. 188.

[41] Messing, Karen and Piroska Östlin (2006). *Gender equality, work and health: a review of the evidence.* World Health Organisation. www.who.int/gender/documents/Genderworkhealth.pdf (accessed 28 June 2007).

[42] WHO (2005). *Gender in Tuberculosis Research* www.who.int/gender/documents/TBlast2.pdf (accessed 25 June 2007).

[43] United Nations (2005). *Review of the implementation of the Beijing Platform for Action and the outcome documents of the special session of the General Assembly entitled "Women 2000: gender equality, development and peace for the twenty-first century." Report of the Secretary-General*, E/CN.6/2005/2, para. 184.

[44] Hughes, Jessica (2004). *Gender, Equity and Indigenous Women's Health in the Americas.* The Gender and Health Unit, Pan-American Health Organisation. Washington, DC www.paho.org/English/AD/GE/IndigenousWomen-Hughes0904.pdf (accessed 28 June 2007).

[45] PanAmerican Health Organisation (PAHO) (nd). *Gender, Equity and Indigenous Women's Health in the Americas.* Fact Sheet produced by the Women, Health and Development Program. www.paho.org/English/AD/GE/IndigenousWomen.pdf (accessed 29 June 2007).

[46] Khattab, Hind, Nabil Yunis, and Huda Zurayk (1999). *Women, Reproduction, and Health in Rural Egypt, The Giza Stud.* Cairo: American University Press. Quoted in Farzaneh Roudi-Fahimi (nd) *Gender and Equity in Access to Health Care Services in the Middle East and North Africa*. Population Reference Bureau.

www.prb.org/Template.cfm?Section=PRB&template=/ContentManagement/ContentDisplay.cfm&ContentID=13832 (accessed 28 June 2007).

[47] WHO and IGWG (2005). *A Summary of the 'So What' Report: A look at whether integrating a gender focus into programmes makes a difference in outcomes*. www.who.int/gender/documents/SoWhatReportSept.05.pdf (accessed 28 June 2007).

[48] UNICEF (2006). *Women and Children: The Double Dividend of Gender Equality. The State of the World's Children 2007*. New York. www.unicef.org/sowc07/docs/sowc07.pdf (accessed 28 June 2007).

[49] WEDO (2005). *Beijing Betrayed: Women Worldwide Report that Governments Have Failed to Turn the Platform into Action*. www.wedo.org/files/gmr2005english.html (accessed 11 July 2007).

[50] Information for this section on health statistics is from United Nations, Department for Economic and Social Affairs, Statistics Division (2006). *The World's Women 2005: Progress in Statistics.*. unstats.un.org/unsd/demographic/products/indwm/wwpub.htm (accessed 28 June 2007).

[51] See the United Nation's Division for the Advancement of Women website: www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm#recom24 (accessed 28 June 2007).

[52] WHO and IGWG (2005). *A Summary of the 'So What' Report: A look at whether integrating a gender focus into programmes makes a difference in outcomes*. www.who.int/gender/documents/SoWhatReportSept.05.pdf (accessed 29 June 2007).

[53] This comparison is from Evers, Barbara and Mercedes Juarez (nd) *Understanding the Links: Globalsation, Health Sector Reform, Gender and Reproductive Health.* This document also has a useful set of questions to help analyse the state of sexual and reproductive health in health sector reform programming. www.fordfound.org/publications/recent_articles/docs/globalization/evers_juarez.pdf (accessed 28 June 2007).

[54] See the Millennium Project's website: www.unmillenniumproject.org/index.htm (accessed 28 June 2007).

[55] Bernstein, Stan with Charlotte Juul Hansen (2006) *Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals.* Millennium Project. www.unmillenniumproject.org/reports/srh_main.htm (accessed 28 June 2007).

[56] UN *Millennium* Project (2005). *Taking Action: achieving gender equality and empowering women.* Task Force on Education and Gender Equality. www.unmillenniumproject.org/reports/tf_gender.htm (accessed 26 June 2007).

[57] All these examples are from UNFPA (2005) *State of World Population 2005*. www.unfpa.org/publications/detail.cfm?ID=248&filterListType= (accessed 28 June 2007) .

[58] Accessed online: www.unfpa.org/gender/case.htm#1 (accessed 28 June 2007).

[59] Information on the MISP can be found at www.womenscommission.org or www.rhrc.org (accessed 28 June 2007).

[60] www.sphereproject.org (accessed 28 June 2007).

[61] WHO (2003). *Gender, Health and Tobacco.* Gender and Health Unit www.who.int/gender/documents/Gender_Tobacco_2.pdf (accessed 28 June 2007).

[62] See: www.unece.org/stats/gender/genpols/keyinds/health/tobacco.htm (accessed 28 June 2007).

[63] This section draws on Kvinnoforum and The Roll Back Malaria Partnership Secretariat (2007). *A Guide to Gender and Malaria Resources.* www.rollbackmalaria.org/docs/advocacy/gm_guide-en.pdf (accessed 24 June 2007).

[64] See the *Guide* referenced above the website for the Global Gender and Malaria Network: www.rollbackmalaria.org/globaladvocacy/networks.html (accessed 24 June 2007).

[65] This section draws on Maxwell, Jane et al (2007). *A Health Handbook for Women with Disabilities.* Berkeley, CA, USA: Hesperian. Available at: www.hesperian.org/publications_download.php#wwd (accessed 24 June 2007).

[66] The *Health Handbook for Women with Disabilities* (referenced above) includes many practical ways to do this.