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Gender Mainstreaming in Health

*Report of the Technical Consultation
New Delhi, 6-8 November 2000*

WHO Project: ICP OSD 002



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CONTENTS

	<i>Page</i>
1. INTRODUCTION.....	1
2. OBJECTIVES AND EXPECTED OUTCOMES.....	2
3. METHOD OF WORK.....	2
3.1 Planning Process and Inauguration.....	2
3.2 Technical Sessions.....	3
3.3 Technical Discussions.....	4
4. THE OUTCOMES.....	6
4.1 Draft Regional Strategy for Gender Mainstreaming in Health.....	6
4.2 Gender Mainstreaming Tools.....	9
5. CONCLUSIONS.....	17

Annexes

1. List of Participants.....	18
2. Programme.....	20
3. Inaugural Address by Dr Uton Muchtar Rafei, Regional Director, WHO South-East Asia Region.....	22

1. INTRODUCTION

Women's health is of special concern. Women face disadvantages in access to services not only due to poverty but also gender-related inequity. Research shows that gender based inequalities adversely affect women's health in every phase of their lives. This aspect is also clearly highlighted in the publication "Women of South-East Asia: A Health Profile", published by the WHO Regional Office for South-East Asia, which was released in September 2000 by the WHO Director-General, Dr Gro Harlem Brundtland.

WHAT IS GENDER?

- The word "Gender" is used to describe the characteristics of women and men which are socially constructed. This is different from those which are biologically determined - female and male sex.
- People are born female and male but learn to be girls and boys who grow into women and men.
- This learned behaviour and attitude make-up "gender" identity.

The Twenty-third Special Session of the UN General Assembly on the Beijing Plus Five, 2000, overwhelmingly endorsed that gender mainstreaming should be taken as the key approach to attain gender equality in health, among others.

The Declaration on Health Development in the South-East Asia Region [SEAR] in the 21st Century [adopted by the Health Ministers in 1997], had identified investment in women's health, and elimination of gender discrimination, as two of the important areas of action for health sector reform. Following this, several activities were undertaken as part of the WHO/SEARO collaborative work. They included: introduction of the concept of the life cycle approach to women's health reflected in the Regional Health

Report - 1998; development and field testing of draft formats for collecting sex disaggregated data; compilation of women's health profiles at country and regional levels; and initiation of several intercountry programmes to highlight specific concerns like aging, violence and legal measures.

2. OBJECTIVES AND EXPECTED OUTCOMES

Objectives

- Critically review the draft strategy for gender mainstreaming in health for its relevance and applicability within SEAR countries.
- Review draft tools for gender mainstreaming for practical application in health policies and programmes at regional and country level.
- Propose actions to be taken at regional and country level to implement the strategy.

Expected Outcomes

- Draft regional strategy and tools for gender mainstreaming.
- Action plans for adapting strategy and tools for gender mainstreaming in health at regional and country level.

Participants

Seventeen participants from nine countries from the South-East Asia Region participated in the consultation. They included policy and planning persons from the ministry of health and women's health focal points, representatives from UNICEF, UNFPA, World Bank, and gender experts. The list of participants and the programme are given in Annex-i and Annex-ii respectively.

3. METHOD OF WORK

3.1 Planning Process and Inauguration

The Consultation was opened on behalf of the Regional Director, WHO South-East Asia Region, Dr Uton Muchtar Rafei, by Dr Rita Thapa, Acting Regional Director and Director, Department of Health Systems and

Community Health. She extended a warm welcome to the participants and delivered the inaugural address on behalf of the Regional Director. The Regional Director's address stressed the importance of the Consultation, being the first meeting of its kind in the Region. The Regional Director stressed that for too long gender concerns were ignored while formulating health policies and designing health programmes. The time had come for redressing this neglect. The full text of the address is given in Annex-iii.

Mr. Sheikh. Shafi Ahmed was elected Chairperson while Dr. Ardi Kaptininsih and Dr. Vinitha Karunarathne were elected Co-Chairperson and Rapporteur respectively for the Consultation.

3.2 Technical Sessions

The presentations during the Consultation dealt with conceptual issues related to gender mainstreaming and women's health. They covered a range of issues starting from WHO's policy on gender based inequalities and measures to deal with them, WHO's commitment to women's health as stated in the Beijing Plus Five and other documents, and finally the status of women's health in countries of SEAR and SEARO's perspective and activities to deal with the situation.

The first paper on "WHO Gender Policy" was presented by Dr. David Evans, GPE/EOC and Focal Point for Gender Analysis and Mainstreaming at WHO HQ, Geneva. He presented a framework for collecting scientific information related to sex, gender and other variables. He demonstrated that gender analysis requires interaction of many skills including epidemiology, biomedicine, anthropology, sociology, economics and political science, etc.

Dr. Nafsiah Mboi, Director, Women's Health, WHO/HQ, Geneva, presented a paper on "Implications of Beijing Plus Five for WHO's Women's Health Programme". She said that in preparation for the UNGASS Beijing +5, the Women's Health Department, WHO/HQ in collaboration with the regions had prepared a report entitled "Beijing Platform for Action - A Review on WHO's Activities" as well as government reports from the UN Secretary-General.

Dr. Rita Thapa, Director, CHS, WHO/SEARO, presented a background paper on "Women's Health in South-East Asia - The Need for Gender

Mainstreaming in Health". She stated that this subject is a matter of concern if we are to achieve health for all in the 21st century with minimum disparity among individuals and groups. She referred to health as a family-centred and multi-sectoral entity.

A video presentation depicting the panorama of women's situation across the ten countries of the SEA Region was also screened. The video presented factual information related to the impact of gender based inequalities on women's health throughout their life span.

Ms. Mercedes Juarez, STC on gender mainstreaming, WHO/SEARO, presented concept papers on formulating a strategy for gender mainstreaming in health.

Dr. M. Prakasamma, STP-WMH, WHO/SEARO, presented the background to the consultation. She briefed the participants about the work already done by WHO/SEARO on the subject.

3.3 Technical Discussions

The background papers presented during plenary sessions set the context for the technical discussions and provided a common perspective. The papers provided global as well as regional inputs related to gender concerns and women's health.

The Consultation took place in an interactive atmosphere with inputs from participants working in small groups. A series of plenary sessions interspersed with small group discussions formed the main process of the Consultation.

Interactions were focussed around the themes and concepts introduced during the background presentations and contained in the working documents. Small group interactions facilitated involvement and inputs from all participants.

Discussion and consensus building were used throughout the meeting. The issues raised during the small group discussions were presented and reviewed during plenary sessions at every stage: perspective building, strategy formulation and action plans.

Issues raised and discussed

The following are some of the important issues raised during the discussions:

- It is essential to understand clearly the difference between gender and sex. There is a tendency to mix up the two terms or use them loosely and interchangeably.
- Women's health is often equated with reproductive health. It is important to broaden the discussion to include the life cycle approach. Gender is a complex subject and goes beyond health.
- The formulation of a strategy for gender mainstreaming in health has to consider the social, economic, cultural and other perspectives. The strong interplay of biologically-determined sex and socially-decided gender roles in causing patterns of ill health have to be looked into. Gender sensitive indicators have to be developed.
- Different countries have their own specific problems with gender disparities manifested in different ways. A strategy for gender mainstreaming should be flexible for adaptation and application in different cultural settings.
- Both physical and mental health should be given importance.
- Though women live longer they tend to suffer more due to lack of understanding about gender and age specific problems.
- Various harmful traditional practices in relation to women's health need to be identified and addressed.
- Countries that have already formulated national plans of action should re-examine them to assess whether gender concerns have been addressed. Countries that are currently engaged in encompassing all those issues and those without action plans should take into account all such issues while formulating such action plans.
- Health for all in the 21st century must become a global concern with universal attainment of health and well being without any disparity.
- To understand the reality it is necessary to obtain disaggregated data. Available data should be reassessed to determine how gender sensitive they are, e.g. sex, age, urban, rural and special groups (micro-level data). Such micro-level analysis will need the involvement of NGOs, the private sector, indigenous health systems, and women's groups, etc.

- Women's health cuts across sectors, and hence cannot be addressed as a compartmentalized subject. The multisectoral nature of problems requires a multidisciplinary approach.
- Partnerships between WHO, UNICEF, UNFPA and the World Bank need to be strengthened to avoid overlapping and duplication.

4. THE OUTCOMES

The Consultation, through a participatory process resulted in a set of four concrete outcomes as follows: [i] *Draft Regional Strategy for Gender Mainstreaming in Health*, and three gender mainstreaming tools, namely, (ii) *Gender Analysis Matrix*, [iii] *Gender Mainstreaming Matrix*, and [iv] *Checklists for Monitoring Gender Mainstreaming*.

A detailed description of each outcome is described below:

4.1 Draft Regional Strategy for Gender Mainstreaming in Health

(1) Vision

Women and men have equal rights to be healthy through appropriate opportunity and access to preventive, promotive, curative and rehabilitative services. To this end, existing imbalances should be identified and redressed so that an enabling environment is created for maintaining optimum health and accessing and utilizing health services.

(2) Goal

The goal of the Regional Strategy on Gender Mainstreaming is to ensure that policies, programmes and projects create and maintain an environment of optimal health for both women and men of all ages (including children, adolescents and elderly) by addressing gender related constraints.

(3) Objectives

- To create an enabling environment for incorporating gender concerns into policy formulation, programme design, implementation and evaluation.

- To change mindsets/attitudes/behaviours and remove misconception among opinion leaders, policy makers, programme managers including service providers at all levels.
- To identify and address factors influencing gender disparities and constraints in health and quality of health care.
- To incorporate gender concerns into various aspects of health promotion and disease control programmes with special focus on the vulnerable and disadvantaged.

(4) Strategies

(1) *Building data base and providing evidence*

- Incorporating gender concerns into census and health information systems
- Collecting sex, age and spatial disaggregated data
- Identifying, documenting and disseminating gender specific information including best practice models
- Undertaking research and studies
- Strengthening health information and monitoring system

(2) *Advocacy and sensitization*

- Promoting effective participation of all stake-holders and all partners
- Undertaking communication and media advocacy
- Sensitizing health providers at various levels

(3) *Identifying and integrating gender concerns into priority health programmes*

- Analyzing priority programmes for their impact on health
- Identifying gender concerns in all major health programmes
- Incorporating gender concerns at programme implementation level
- Promoting gender sensitivity among service providers
- Placing special focus on vulnerable & disadvantaged women to improve their health status
- Focusing on men who are at a disadvantage or at risk.

(4) Mainstreaming gender into policies and programmes at all levels

- Developing/adapting appropriate tools.
- Analyzing existing policies from a gender perspective, identifying the lacunae and addressing factors influencing gender disparities and gender barriers (biological, socio-economic, cultural, rural-urban, and specific vulnerabilities).
- Proactively promoting the incorporation of gender into other sectors which have an impact on health (existing structures or creating new ones, whenever required).
- Formulating and enacting appropriate legislation.
- Financing, including budgetary allocation.
- Focusing, specially on areas of striking imbalance in health among men and women.

(5) Education and training

- Introducing/incorporating a gender component in curricula at all levels of education. (Schools, teacher training, vocational training, universities etc.).
- Educating medical, nursing and health personnel on gender concerns, gender analysis and incorporation of gender in services.
- Preparing gender training packages as appropriate to country/regional situation.

(6) Capacity building and operation of Gender Mainstreaming Strategies

- Establishing/strengthening gender focal points and enabling them with key staffing, roles and responsibilities.
- Instituting a mechanism for mandatory gender analysis as an inclusive process in all projects and programmes, planning and design at all levels.
- Ensuring that policy, decision and implementation strategies are translated into action.
- Establishing country specific indicators to measure gender perspectives of planned programmes and activities.
- Institutionalizing a mechanism to conduct evidence-based research for feedback into planning and programmes.

(7) Mobilizing Resources and Partnerships

- Identifying potential partners who are likely to support the process of gender mainstreaming.
- Networking with technical units to ensure that gender concerns are incorporated into programmes.
- Identifying local resources in terms of information, finances and resource persons.

(8) Monitoring and Evaluation

- Establishing an in-built mechanism for periodic monitoring and evaluation of gender- based issues included in planned programmes.

4.2 Gender Mainstreaming Tools**(1) Gender Analysis Matrix**

Biological and Social Variables	Research and Evidence			
	Exposure and Vulnerability	Outcomes and Impact	Access	Utilization
Biological: Age				
Social: class, caste, education, occupation, rural \ urban, tribal groups				
Qualitative analysis of observed differences for role of gender.				

Note: All information in each column and row should be given separately for male and female

The above tools can be used both for assessing the presence of a gender perspective within a health policy/programme and also for incorporating a gender approach while updating existing health policies and programmes or formulating new ones.

Gender analysis is the first step toward gender mainstreaming in health. Besides the biological differences, men and women face differences in exposure to diseases, access to health services and consequences of health problems. The matrices help in using sex desegregated epidemiological data systematically for diagnosing sex differentials related to a disease or problem.

Once this information is available it can be used to analyze and infer the role of gender in determining the sex differences.

Gender analysis is the diagnostic tool in gender mainstreaming. It provides the evidence for incorporating gender concerns into policies, programmes and services. The gender analysis matrix requires two components: collection of sex disaggregated data for a disease condition or health problem; and analysis of sex disaggregated data for the role of gender. The first component deals with quantitative data, whereas the second deals with qualitative analysis and inference.

Steps for using the Matrix

- Collect and use sex disaggregated information on biological and social variables from different sources: national level surveys, small-scale studies and even micro projects.
- The boxes in the first two rows must be filled with sex disaggregated data: exposure and vulnerability, outcomes and impact, access and utilization.
- Efforts should be made to fill every box in the four columns with data for both male and female. Whenever sex disaggregated information is not available, a note should be made in the cell indicating - "No sex disaggregated information".

Exposure and vulnerability

This refers to the epidemiological aspects of incidence and prevalence of diseases in men and women and information related to different levels of exposure.

Sex differences

- preclude certain health risks for males and females (e.g. prostate or ovarian cancer);
- lead to differential exposures (e.g., pregnancy-related conditions), and
- explain differences in risk of certain illnesses (e.g., hormone-related illness such as breast cancer, cardiovascular disease).

Gender roles

- lead to differential exposures (e.g., tobacco-related deaths, traffic accidents, exposure to cooking fires);
- lead to differences in vulnerability (e.g., domestic violence, depression, alcoholism), and
- affect the age of onset of certain diseases.

Outcome and impact

This refers to information on the sex differentials in severity, case fatality, duration, disability level, burden of disease and social implications of disease. For example, a disease may be less prevalent in women but once it occurs the progression of the disease and the severity may be higher.

Sex differences

- affect the severity of certain diseases (e.g., measles, mumps, gonorrhoea), and
- affect the age of onset and duration of certain diseases (e.g., allergies, autoimmune disorders).

Gender roles

- affect the social impact of diseases (e.g., skin diseases are more likely to affect marriage options for women than men, infertility often has a greater stigma for women than men).

Access and utilization

Access refers to the programmatic aspects in terms of treatment facilities available within reach. It includes the distance to be traveled and the time taken to provide services.

Utilization refers to the health seeking behaviour of men and women, delay in seeking treatment, utilization rates, compliance patterns, treatment completion rates etc.

Sex differences

- influence symptoms, leading to differential health seeking and visibility in clinic data (e.g., male STDs are more often symptomatic, leading to higher clinic registrations).

Gender roles

- affect access to information (via differences in literacy, access to schooling);
- affect targeting of technologies (e.g., targeting fertility regulation to women, using EKG more often on male than female patients);
- impact health seeking and access to care (e.g., men's reluctance to seek care, women's restricted mobility, and inability to control household resources);
- impact health-seeking and therefore visibility in hospital data (e.g., see above);
- impact public attention to a given health condition (e.g., choice of research or curative care priorities);
- affect choice of norms and standards (e.g., life expectancy in the DALY's), and
- influence subjective weighting of the burden of the condition (e.g., the burden attributed to infertility).

Analysis of sex disaggregated data

The third row is meant for inference from data in the first two rows. Observed differences attributable to sex at every level are to be carefully analyzed for the influence of gender. The differences should be questioned. Are the observed differences among male and female due to biological factors or to social and gender inequalities? Some of the differences may be explained because biological differences in risk or impact of a disease are known. Others may not be known.

Analysis of sex differentials in diseases requires the use of qualitative information from case studies and field projects because no epidemiological documentation is likely to be available. Gender roles and inequalities are also

culture specific and hence information from anecdotes and case reports should be used.

Sex disaggregated information and the inferences drawn through gender analysis should be summarized. This will form the evidence for introducing a gender perspective into the health programme. The information can also be used while designing a new health plan to ensure that gender concerns are incorporated.

(2) Gender Mainstreaming Matrix

Influence of gender roles in sex differentials	Actions to be taken			
	Policy/ Legislation	Budget allocation for gender activities	Programme and services: clinical, communication administrative	Information Systems: reports, monitoring and evaluation
Observations related to exposure and vulnerability				
Observations related to outcomes and impact				
Observations related to access to services				
Observations related to utilization				

Gender Mainstreaming is defined by ECOSOC (Resolution E/1997) as "the process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, in any area and at all levels. It is a strategy for making women's as well as men's concerns and experiences an integral dimension in the designing, implementation, monitoring and evaluation of policies and programmes in all political, economic and social spheres, such that inequality between men and women is not perpetuated".

Steps for using the Matrix

Gender mainstreaming requires that a programme takes into consideration and addresses the known differences between men and women for risk and vulnerability, for impact and outcome of a disease and access and utilization of services.

- Summarize the findings on differences, if any, between boys and girls and between men and women under the four components: Exposure and vulnerability, outcomes and impact, access and utilization.
- Enter this information into the boxes in the first column of the Gender Mainstreaming Matrix.
- Examine the existing policy, plan or programme systematically to assess the consideration given to such differences.
- If the policy or programme does not address the observed differences, specific actions have to be suggested in each of the columns.
- The specific actions suggested in the columns should be disseminated to policy-makers for prioritizing and inclusion in health policies and programmes, particularly in the on-going health sector reform.

(3) Checklist for collecting information for Gender Mainstreaming

The following questions will help to gather information that can guide activities towards gender mainstreaming. This checklist may be used as the first step in identifying gaps and target areas for intervention.

To create an enabling environment for incorporating gender concerns into policy programme design, implementation and evaluation.

- What are the gaps in gender issues regarding health policy?
- Have national health strategies, programmes and operational plans incorporated provincial and district priorities to cover major gender gaps?
- Has the Ministry of Health [MoH] accurately identified and addressed the needs and problems of rural and urban men and women of different ages?
- Has a Gender Advisory Committee (GAC) comprising representatives of Government, NGOs and development partners been established?

- Have Gender Focal Points (GFP) being appointed at MOH level and in the different health programmes?
- Have terms of Reference for GAC and GFPs been developed?
- Does the GFP/MOH network and co-ordinate with other government sectors?

To change mindsets/attitudes/behaviours and remove misconception of opinion leaders, policy makers, programme managers including service providers at all levels.

- Is there any conflict between international definitions and local traditions and concepts regarding gender issues that influence health?
- What is the level of awareness of gender issues among most influential opinion leaders?
- What is the current role of opinion leaders in circulating gender stereotypes?
- What is the potential of opinion leaders to inform and educate on gender issues in connection with health?
- Is there resistance to change, perpetuating gender stereotypes that result in health disparities between men and women?
- Are there any attempts made to address gender concerns within local health services?
- What agencies are involved in promoting and protecting gender equality and equity? At national, regional and village level: ministries, government departments, parliamentary initiatives, professional associations, NGOs and other civil society organisations?
- Are agencies established to promote gender equity aware of and sensitive to gender issues?

To identify and address factors influencing gender disparities and barriers in health and quality of health care.

- What specific factors from the economic, social, political, cultural and religious environment have implications for gender and health?
- What are the current gender relationships at community and household level that have a positive or negative impact on health?

- What are the established gender roles and how do they affect gender differences in incidence and early detection of diseases, health seeking behaviour, use of health services and compliance?
- Do women need permission from their husbands, fathers, mother-in-laws, brothers or others to use health services?
- Which policy and programme initiatives exist to meet the needs of specific groups (children, adolescents, men, women, elderly, displaced, disabled, etc.) in the health sector?

To incorporate gender concerns into various aspects of health promotion and disease control programmes with special focus on the vulnerable and disadvantaged.

- Who are the stakeholders?
- What mechanisms exist to involve primary stakeholders in the health sector and in specific health programmes?
- What are the mechanisms to facilitate access to appropriate health care by women and men from vulnerable groups?
- Who are the powerless groups that are particularly discriminated against and how does such discrimination or lack of power affect their health?
- Which disparities can be identified between men and women, boys and girls?
- Which disparities affect differently the health and wellbeing of men and women, boys and girls?
- Is there resistance to improve the inclusion of marginalised groups?
- Which disparities exist between different social groups and between women and men within those groups?
- Do health programmes address the needs of men, women and adolescents?
- What are the specific issues affecting men, women and adolescents in each of the health programmes?
- Which male/female attitudes and behaviour have a negative effect in girls'/boy's and women's/men's health?
- Have initiatives been developed to increase men's/women's responsibility and involvement in solving health-related problems?

- Which interventions would create opportunities for men/women, boys/girls to change their own high-risk behaviours?
- What mechanisms exist to involve men/women in promoting and protecting their own health as well as that of their partners and their communities?

5. CONCLUSIONS

Having successfully achieved the expected objectives and outcomes, the Consultation concluded on an optimistic note. The draft strategy and tools were carefully reviewed and modified through consensus.

The following recommendations were made by the participants:

- SEARO should support country efforts in developing a training package for gender mainstreaming in health by adapting the generic regional gender mainstreaming strategy and tools developed during the Consultation.
- Such a training package should be developed for the use of three groups of target audience, i.e., policy-makers, programme administrators and service providers.
- As part of their commitment, the participants would disseminate and utilize the outcomes of the meeting in their respective programme areas of work.

Annex 1

LIST OF PARTICIPANTS

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Mrs Vanaja Sundaresan
Senior Administrative Secretary

Annex 2 PROGRAMME

Monday, 6 November 2000

- | | |
|---------------|--|
| 08.30 - 10.00 | Registration |
| 10.00 - 10.30 | Inaugural Session |
| 10.30 - 11.00 | Group Photograph and Tea |
| 11.00 - 12.00 | Plenary session I
WHO Policy on Gender in Health - Dr David Evans
Implications of Beijing Plus Five for WHO's - Dr Nafsiah Mboi
Women's Health Programme
Women's Health in South-East Asia - The need for Gender
Mainstreaming in Health - Dr Rita Thapa |
| 12.00 - 12.20 | Video Presentation on Women's Health in South-East Asia |
| 12.20 - 1.00 | Plenary Session II
Background to the Consultation - Dr M. Prakasamma
Formulating a Strategy for Gender Mainstreaming - Ms Mercedes
Juarez
Discussion and Review |
| 02.00 - 2.15 | Presentation of Outline of Strategy - Dr. M.Prakasamma
Briefing for Group Work - Ms. Mercedes Juarez |
| 02.15 - 3.00 | Group work on Draft Strategy |
| 03.15 - 4.30 | Group work on Draft Strategy (continued) |

Tuesday, 7 November 2000 Revised Programme

- | | |
|---------------|---|
| 08.30 - 09.30 | Group work on Strategies continued |
| 09.30 - 10.15 | Plenary Session
Group presentation on Regional Strategy for Gender
Mainstreaming in Health |
| 10.30 - 11.30 | Discussion and reaching a consensus on Regional Strategy on
Gender Mainstreaming in health |

Plenary Session

- 11.30 - 12.00 Regional Tools for Gender Mainstreaming in Health with examples for their application in health programmes - Ms Mercedes Juarez
- 12.00 - 1.00 Group work on application of Tools for Gender Mainstreaming - within specific programmes - Tuberculosis, Malaria, HIV/AIDS

Plenary Session

- 02.00 - 3.00 Presentation of group work on application of tools in specific programmes
- 03.15 - 4.00 Group Work on application of Tools for Gender Mainstreaming within a programme for reduction of Maternal Mortality

Plenary Session

- 04.00 - 4.30 Presentation of group work on application of Gender Tools into programmes for reduction of maternal mortality

Wednesday, 8 November 2000

Plenary Session

- 08.30 - 9.00 Guidelines for Training in Gender Mainstreaming - Ms Mercedes Juarez
- 09.00 - 9.30 Draft Strategy on Gender Mainstreaming - Presentation by Sub Group on drafting Tools for Gender Mainstreaming - Presentation by Sub Group on Tools
- 09.30 - 10.0 Discussion and reaching consensus on Draft Strategy and Tools

Group Work

- 10.15 - 12.00 Preparation of Follow up Actions for Gender Mainstreaming in Health within countries of the Region - Country-wise Group Work

Plenary Session

- 12.00 - 1.00 Presentation of Country Follow up Actions
- 02.00 - 2.45 Group Work on Recommendations - Regional and Country level
- 02.45 - 3.00 Evaluation

Plenary Session

- 03.00 - 3.30 Draft report - Dr. Vinitha Karunaratne, Rapporteur
- 03.30 - 4.00 Closing session

Annex 3

INAUGURAL ADDRESS BY DR UTON MUCHTAR RAFEI, REGIONAL DIRECTOR, WHO SOUTH-EAST ASIA REGION

Respected Ladies and Gentlemen

It gives me great pleasure to welcome you to the SEAR Office to participate in the Technical Consultation on Gender Mainstreaming in Health for three days from 6-8 November 2000. This meeting is the first of its kind in the Region.

For long gender concerns have been ignored while formulating health policies and designing health programmes. We have paid dearly for this neglect. Nowhere else is the impact of gender inequity on health as striking as in this Region.

Evidences of gender-based imbalances in health

- Women in this Region disproportionately face inequity due to poverty and gender - two of society's most damaging inequities. Women's low health status is inseparably linked with these two issues. Women are poorer than the poor and suffer inequity in health throughout the life span. In four countries of the Region (Bangladesh, Indonesia, Maldives, Nepal) the female life expectancy at birth is the same or lower than male life expectancy. This is contrary to nature and reflects women's inequitable access to resources and services. Again, four countries of the Region (Bangladesh, Bhutan, India, Nepal) not even 40 % of the adult females are literate). Women's poverty and low social status are responsible for this.

Today's concern is to re address these inequalities

- Women's health is determined not only by biological factors but also socio-economic inequalities rooted in gender imbalances. Research evidence shows that gender based inequalities have adversely affected

women's health in every phase of their lives. This Region has 40% of the 585,000 of global maternal deaths every year.

- 38% of the eight million tuberculosis cases worldwide are in this Region. Women progress from infection to disease much faster than men, and suffer a higher fatality. Gender inequity hinders timely reporting and access to services.
- Women are more susceptible to HIV infection than men for biological and gender reasons. Unequal decision making role does not promote the adoption of protective measures.
- Women are at higher risk of mental illness than men. In a study in one Country of the Region the prevalence was 2.8 women and 1.1 men. Discrimination and violence put women at greater risk. Depression, anxiety, fear and sleeping disturbances are common long- term reactions to violence.
- Tobacco and alcohol have a greater impact on the health of women than men, and adversely affect the health of their babies.

Unless we address gender inequities, we cannot make improvements in health of the poor and disadvantaged a reality.

- Redressing gender inequities should start with legislative and financial measures. Health policies and programmes should incorporate gender concerns at the planning phase itself. Dr. Gro Harlem Brundtland, Director General of World Health Organization, while talking at the Beijing Plus Five Meeting in New York earlier this year said, "Investing in health makes good economic sense. Investing in women's health makes more sense".
- Investment in women's health and development is one of the top priorities for Health Sector Reform in this region to eliminate gender discrimination. There is compelling evidence for the need to accelerate investments on women's health. I hope this technical consultation will lay the foundation for the incorporation of gender perspectives into policy frameworks.

The World Health Organization carries out its commitment to the Beijing Platform of Action by incorporating the strategic health objectives in its core functions.

The WHO has a long history of focus on women's health. Promotion of maternal and child health and fostering the ability to live harmoniously in a changing total environment have been enshrined in WHO's constitution since its inception.

WHO Regional Office for South East Asia initiated the task of collecting and compiling disaggregated information by sex, age other variables for the Region in collaboration with governments, non government organizations and experts in the countries. Each Country has also compiled a National Profile on Women, Health and Development. The Regional and Country profiles provide baseline information to initiate women friendly programmes.

Gender mainstreaming is a process through which issues related to inequalities can be given special emphasis while making policies, designing programmes and providing services.

The first step towards providing equal opportunities in health is to compile information and evidences on equalities. The sex disaggregated data compiled through the country and regional profiles serves as baseline information for policy making and planning. But collecting and analyzing disaggregated data is only the starting point for re addressing existing women's inequity in health. Evidence from the ground should facilitate clear strategies for reducing imbalances.

The Women's Health unit at SEARO has been working towards a regional strategy for gender mainstreaming in health. The draft strategy and tools are before you for review and discussion. Your expert comments will provide inputs into developing working models for mainstreaming gender issues into health policies and programmes within SEARO and the Country offices.

I hope you have meaningful deliberations and that you will give recommendations on methods to mainstream gender concerns into health policies and programmes.

I wish you al a pleasant stay at Delhi.