GLOBAL ALLIANCE FOR WOMEN'S HEALTH

— REPORT —

HEALTH FOR ALL WOMEN IN THE 21ST CENTURY

How Do We Get There?

An Intersectoral Luncheon Seminar
in honor of

DR. GRO HARLEM BRUNDTLAND

Director-General

World Health Organization

with presentations by

Dr. Brundtland

Dr. Wanda K. Jones
Deputy Assistant Secretary, Women's Health
United States Department of Health and Human Services

Ms. Angela E. V. King
Assistant Secretary-General, United Nations, and
Director of the Division for the Advancement of Women

West Terrace, Delegates' Dining Room
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Global Alliance for Women's Health Report on Health for All Women in the 21st Century

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Executive Summary

by Dr. Elaine M. Wolfson, President of GAWH

This publication reports on "Health for All Women in the 21st Century: How do we get there?," an intersectoral luncheon seminar honoring Dr. Gro Harlem Brundtland, Director-General of the World Health Organization, and co-sponsored by the Global Alliance for Women's Health and the International Council of Women. The meeting was held on March 3, 1999 at the West Terrace of the United Nations Delegates' Dining Room. More than 170 invited guests from member states to the United Nations, the UN Secretariat, intergovernmental agencies, the international NGO community, academia, foundations, the private sector and the press participated.

The luncheon seminar was held during the 43rd Session of the United Nations Commission on the Status of Women (CSW). Women and health was one of the major agenda items of this session. The CSW is mandated to follow up the Fourth World Conference on Women and to report its "agreed upon recommendations" to the Economic and Social Council and the General Assembly.*

Dr. Brundtland gave the keynote address stressing the interface of women's health and development, and women's health and poverty. She underscored the

importance of partnering across all sectors especially among political decision-makers. "This is a message [referring to the notion that investments in both women and girls' education, and health were positive for development] which needs to be brought to decision-makers." Dr. Brundtland continued categorically, "We need to reach Presidents, Prime Ministers and Finance Ministers and remind them that they are truly health ministers themselves."

Dr. Wanda Jones, Deputy Assistant Secretary, Women's Health, United States Department of Health and Human Services spoke on several mechanisms used in the United States for improving women's health. She described implementation policies, from adolescent health - the Girl Power Campaign - to the targeting of the health needs of minority women in National Centers of Excellence. But she also cited the need for the United States to address "the challenges of meeting the health needs of an increasingly older, more diverse and more female population."

Angela King, Assistant Secretary-General, United Nations and Director of the Division for the Advancement for Women spoke of the multiple access points for addressing women's health in the United Nations. In addition to the Commission on the Status of Women, she cited the monitoring bodies of the International Conference on Population and Development, the Convention for the Elimination of all Forms of Discrimination against Women, and the Human Rights Convention. In short, women's health issues are addressed in various commissions. She lauded NGOs for being on the front lines of advocacy at the UN but stressed a powerful reality - that when all is said and done, "governments bear the primary responsibility for the implementation of the Beijing Platform for Action."

The luncheon achieved many of its goals. Among the most important, it brought together many of the sectors responsible for advancing women's health and it demonstrated to the larger constituency the widespread support that exists for addressing health for all women in expanded women's health policies. The participants' enthusiasm in honoring Dr. Brundtland and the good will were palpable. Indeed, the sponsors reported that many more NGOs wanted to attend the luncheon, but that regrettably their requests could not be accommodated because of space limitations.

* The United Nations Fourth World Conference on Women was held in Beijing in 1995. It was largest of the UN Conferences held during the 1990's. More than 30,000 NGOs concerned with women's issues attended the Beijing meetings and the NGOs concern for women's health was unambiguous. The delegates from the member states also shared this concern. The Platform for Action contained seventeen pages of strategic objectives and actions for women's health as compared to three pages on health and education in the Nairobi Forward Looking Strategies produced by the United Nations Third World Conference, Nairobi, 1985.

Global Alliance for Women's Health | 823 UN Plaza, Suite 712 | New York, NY 10017
tel 212 286 0424 | fax 212 286 9561 | www.gawh.org | contactus@gawh.org

Opening Remarks

by Dr. Elaine M. Wolfson, President of GAWH

The Global Alliance for Women's Health and the International Council of Women are very pleased to welcome you to this luncheon seminar on "Health for all Women in the 21st Century: How Do We Get There?" We are honoring Dr. Gro Harlem Brundtland, Director-General of the World Health Organization.

In planning this luncheon we probably faced a microcosm of the challenges that must be met by those who are working to advance women's health. We could not have prepared for this luncheon alone, so we sought partnerships from many quarters - governments, agencies, NGOs and the private sector. I am happy to report that these sectors are well represented by the more than 170 participants present here.

The luncheon seminar is significant for a number of reasons. First, it honors Dr. Gro Harlem Brundtland. Although it is important to note that she is the first woman to head the World Health Organization and the first woman elected to head any UN agency, it is much more important to note that her election by

member states of WHO and her presence here today are emblematic of WHO's expanding commitment to advancing the health of women throughout the world.

As President of the Global Alliance for Women's Health and as Chair of the UN NGO Health Committee, I can vouch for the widespread eagerness among many NGOs to work with Dr. Brundtland and the World Health Organization. And I think it is fair to say that most NGOs attending the CSW share this view - if we can use as an indicator the overwhelming number of requests from NGOs who wanted to attend this meeting. Regrettably, we could not accommodate them all in the limited space available.

Secondly, this luncheon seminar is important because our speakers will address the "how" of women's health policies, a component needing more attention. For example, Dr. Wanda K. Jones, Deputy Assistant Secretary for Women's Health, will tell us about several of the challenges and mechanisms used in the United States by the Department of Health and Human Services to improve women's health.

Thirdly, the venue and timing of the luncheon seminar are also crucial. We believed that it was important to meet during the forth-third session of the United Nations Commission on the Status of Women (CSW), while it is reviewing women and health. Subsequently the CSW will be reporting its conclusions to the member states at the Economic and Social Council and to the General Assembly. We are therefore fortunate to have Assistant Director-General and Director of the Division for the Advancement of Women, Angela King speaking today on women's health in the United Nations.

Finally your presence and participation at this luncheon seminar lends your voices in support of women's health. We at the Global Alliance for Women's Health know that women experience greater morbidity than men and we know that their health needs are frequently under served and under attended. Although we know that reproductive health and maternal and child health represent critical stages in women's lives, we also know that addressing only those health needs, while necessary, will never be sufficient to provide for the health of all women throughout their lives.

In other words, your presence here today helps to demonstrate to policy makers throughout the world that investing in women's health throughout the life span is perceived by all sectors as real and important. We hope that such a demonstration will also convince policy makers to invest in women's health. Families, children, nations and their development will reap the benefits of this investment.

On behalf of all of our partners, thank you for being here. Enjoy your luncheon. We will begin the presentations after the main course.

Introductory Remarks

Pnina Herzog, President of International Council of Women

Thank you Elaine Wolfson, energetic, dynamic partner in this seminar, distinguished members of our Panel, Ambassadors, Heads of Missions, Heads of UN Agencies, participants of Governments, NGOs, the private sector - all partners - at this seminar on "Women's Health in the Twenty-first Century".

It is a great privilege to welcome Dr. Gro Harlem Brundtland, Director-General of the World Health Organization, past Prime Minister of Norway and world-renowned, in addition to her other qualifications, for the "Brundtland Report on Environmental and Sustainable Development."

In the six months since her election to the position of Director-General of WHO, Dr. Brundtland has introduced structural changes in the organization, streamlining 50 programs into 9 clusters and setting priorities in WHO's work.

She did that because she felt that we have to look for innovative ways in order to speed up processes and achieve outcomes.

In 1948, when the World Health Organization came into being, the World Health Assembly set four priorities: malaria, tuberculosis, venereal diseases and health of mothers and children.

The importance of environmental hygiene and nutrition was also stressed.

Today, 50 years later, the issues are still with us and WHO's priorities are: tobacco, roll back malaria, tuberculosis, sexually transmitted diseases and HIV/AIDS (in the past, venereal diseases) and environmental issues and nutrition.

As we face the 21st century, we realize that there is much work ahead of us, and that the responsibilities lie on governments, communities, NGOs, the private sector, and individuals. By now, it is evident that true health extends beyond the Health Sector - other ministries, housing, builders, industrialists, food producers, young people, the elderly, the disabled, all need to be involved.

Women are the consumers and providers of health services to family members: they carry the major burden in society. Empowerment of women is the responsibility of governments and women's NGOs in partnership with the private sector.

There are no miracle cures for illness. Cures only too often, come too late. We must invest in prevention of disease and in health promotion and changes in lifestyles. Prevention is the answer to communicable diseases as well as to non-communicable diseases.

Disease knows no geographical borders or class distinction.

Whatever affects certain populations very soon affects us all.

Statement

by Dr. Gro Harlem Brundtland, Director-General, World Health Organization

Thank you for inviting me to speak today. I feel very much at home, having wanted to promote change and the rights of women as a doctor and a public health worker, as a cabinet minister, as a parliamentarian, as a Prime Minister and now on behalf of the World Health Organization.

"Health for all women in the 21st Century: How do we get there?" Certainly we all know: there is a long way to go!

Let us begin on a positive note. Broadly, the 20th century has been a century of remarkable progress for the rights of women. Progress in political rights. Progress in the right to take responsibility for our own lives. Progress in the right to lead a healthy life. We can remain profoundly grateful to those courageous women who led the fight a century ago. It paid off for many.

But the progress is so uneven. Millions of women are denied fundamental political rights and fundamental human rights. Millions and millions of women are denied the right to take responsibility for their own lives. And millions and millions lack the right to live a healthy life.

Too many women starve and go to bed hungry. Children are sick and do not have access to treatment. Too many women do not have the means to prevent an unwanted pregnancy. Too many women die in childbirth or suffer severe disability. Too many women are infected with HIV. Too many women die of AIDS.

Too many women do not control their own lives, do not have the means of empowerment and decision making in their lives and in those of their children.

Women are more vulnerable where poverty is endemic and human rights are violated every day. More than two out of three of the 1.3 billion people living in poverty are women. They live on insufficient food. Combined with child bearing and a staggering workload, this often leads to serious malnutrition. Globally, more than a third of all women suffer nutritional anemia. Malnutrition has a cumulative effect during an individual's lifetime with adverse effects on the health of the next generation.

Poverty still has a gender bias.

All this is a moral shame. But that alone, we know, will not make a change.

I believe we need to adopt an additional message, which is targeted right at the core of political decision-making: Poverty is bad economics. Investing in strategies that lead out of poverty is good economics. And it is not costly.

This message, underpinned with facts and evidence, is the message that WHO will send out in the years to come. My ambition is to place health at the core of the international development agenda. And in doing so I need to bring greater attention to women's health and the key role it plays.

For some years we have known that investing in education - particularly in the education of young women - is a solid investment in development. We are now

discovering that the same goes for investments in health - especially the health of women and children.

This is a message which needs to be brought to decision-makers. We need to reach Presidents, Prime Ministers and Finance Ministers and remind them that they are truly health ministers themselves. Many are getting the point and expenditure for health is generally increasing. But there are major exceptions. And there are important questions that are not being sufficiently answered: How do we spend money on health in a way which reaches those who need it most? How can we adopt health policies and systems which combat the growing inequities?

Today we know that poverty leads to ill health. Poor people get ill - from malnutrition, from communicable diseases such as tuberculosis and malaria. We know that the equation works the other way around - ill-health breeds poverty.

It is simple. People who are ill are not productive. Children who are under-nourished suffer damage to their brains and will never be able to make a real contribution. Areas which are haunted by poverty will not attract investment.

We also know that investing in health can contribute efficiently to the way out of poverty. The message of Health for All is a message of optimism. It pays to make basic investments in primary health care, and a lot can be saved in the long run if basic health services are delivered in an equitable fashion.

Investing in women's health leads directly to women making personal choices they could not otherwise make and it helps them to be more effective, whatever the roles they choose to play, whatever the tasks they undertake.

Today there are trends that create real obstacles. The health gap between rich and poor is widening and that creates severe health risks for women. They are more vulnerable. Their children are more vulnerable. National economic growth is not a guarantee for better health or higher status for women, as long as the benefits are not equally distributed. In three words what we need is redistribution of resources!

We need to turn our attention to the collapse or stagnation of health systems in many countries. This is an area that WHO has taken on as a challenge. I have said that unless what we do helps strengthen the health systems in all countries, we should consider not engaging.

For example - by providing tuberculosis treatment we help strengthen the district health system - and people will benefit long after TB is gone. When we

embark on our Roll Back Malaria project we will focus on the home as a major center for treatment and care. Families and communities will benefit.

As we move into the new millennium, we need to be aware of the new patterns of mortality and morbidity for both women and men, related to demographic and socio-economic factors. Depression amongst women is no longer isolated to the industrialized world but it is recognized also as a key health issue for women in developing countries. TB is on the rise. There is also an alarming increase in the prevalence of tobacco smoking among women. This will inevitably lead to a large increase in female morbidity and premature death. The WHO Tobacco Free Initiative has a special focus on tobacco and women. The partnership which has developed between the health sector and women's organizations will help us get the health messages across to our young people.

When I spoke at The Hague last month at the ICPD + 5 forum, I committed WHO to work for sexual and reproductive health and rights in the new century.

I will say more this afternoon at the Commission on the Status of Women about broadening the focus to view the different needs of women in the entire life span.

We need to reach out to our partners. Partners within the health sector. Partners outside it.

Without girls' education, we cannot hope to improve communication and shared responsibility between men and women on responsible parenthood, sexual and reproductive behaviors and the whole range of day-to-day health problems.

An intensified, intersectoral effort can yield good results.

We must talk to each other about best practices and learn from them. In Benin, the Ministry of Public Health now supports 200 small economic projects initiated by women and unemployed young people to earn money for financing community health facilities, a collaborative effort by WHO, ILO, the World Bank, UNDP, and several NGOs, including the Association des Femmes Beninoises pour le Development.

Another example is provided by the Indian Ministry of Health and Family Welfare, which introduced a project in rural areas of the country, working in partnership with non-governmental and voluntary organizations. Local women known as sahelis or "friends" are selected from among day care or nursery school workers as well as from primary school teachers. This network of "friends" is used to create awareness in the community of health issues facing families from

the moment that new families are formed. Sahelis are trained by their group leaders and keep in touch.

As the scheme produces more and more trained mothers who can help other newly-weds in their neighborhood, the need for sahelis disappears.

We - governments, the UN community, financial institutions, the private sector, and the non-governmental institutions - must learn from each other what works. Those present here today are an impressive example of this cooperation.

Four years ago in Beijing in my closing address, I talked about the empowerment of women through increased information and redirecting resources.

Those are the messages also today for health.

I am committed to ensuring the introduction of a gender perspective in WHO's work. I am committed to obtaining the information to make it work.

We also need constantly to reaffirm that the right to health and the goal of health for all apply equally to women. Indeed, health for all in the next century, or for that matter in the century after that is not an achievable goal until millions more women are empowered to promote and safeguard their own health, and consequently their own development. I thank you for your commitment and contribution, and I look forward to working with you to take new and decisive steps toward our common goals.

Thank you.

Statement

by Wanda K. Jones, Dr. P.H., Deputy Assistant Secretary, Women's Health, United States Department of Health and Human Services

It is a pleasure and honor to be part of this important roundtable.

In the U.S., we are pleased that women's health is now on the national agenda and our experiences may be helpful though I know we have much to learn. As American writer Judith Stern says, "Experience is a comb life gives you after you lose your hair." I hope by sharing some of our progress here, we can help you avoid at least some hair loss!

Why Women's Health?

Achieving "health for all women in the 21st century" means having to acknowledge that the face of the average woman is changing around the world. A recent report from UNESCO reminds us that in 1950, life expectancy across the globe was 47…now it stands at 66, including emerging market economies. It is true that ten million children in the world will never see their fifth birthday. Yet it is equally true that better public health and nutrition have raised longevity even in many relatively poor countries.

In 50 years, when the United Nations celebrates its 100th birthday in the middle of the 21st century…20 percent of the world population will be over the age of 65, compared with one percent 100 years ago. In the United States, in just 30 years, one in four women will be over the age of 65!

And the fastest growing segment will be adults living past 80, including more and more people living past 100. This has profound social, cultural and health implications. More and more of this aging population will be women living on their own, either through divorce or widowhood. Are we ready? For example:

Will longevity gains create a larger disabled population? How will we pay for the medical services needed for older citizens? Will housing arrangements change to accommodate multiple generations of family members? Will formal education end around the age of 22? Will we restructure universities to bring back students in mid-life? Will businesses adapt to maintain a productive work life for many years past the standard retirement age of 65? In America, our national landscape is blooming in myriad shades: by the year 2030, one in five American women will be of Hispanic heritage, one in eleven will be Asian, and the number of African Americans, and Native Americans (almost 1 in 100) will grow steadily. In fact, by the year 2050, non-Hispanic white women like me will represent barely half of the adult female population in America.

Status of Women's Health

So it is clear that our nation and the world face the challenge of meeting the health needs of an increasingly older, more diverse and more female population. Geographic borders are blurred by the changing faces of women around the

world, and by the technologies that help us reach each other more easily than ever.

Killers

For lack of time, I won't do much more than list the major killers of women in this country. Heart disease followed by the cancers: lung, breast and colorectal cancer in particular. But it's not just what kills us, it's how we live our lives.

Women who have had a live birth

Over 80 percent of U.S women have had a child by the age of 44, underscoring the fact that childbearing and childrearing remain major factors in women's health and are not to be discounted in their role in an older woman's health risks or her ability to attend to her own needs.

Unintended Live Births

Despite contraceptive technologies available to us, too many pregnancies are unintended…approximately 20% of women over 35 giving birth report that their pregnancy was unintended. This is not just a teen problem, and it reflects problems in lack of choices and lack of use of appropriate methods.

HIV/AIDS

I don't have to tell this group what a devastating problem HIV/AIDS is, even in this country, particularly for African American and Hispanic women.

Violence

More than 2.5 million U.S women are victims of violence each year and nearly 2/3 of them are attacked by someone they know.

Chronic Diseases

And the bonus years of life bring chronic conditions: osteoporosis, arthritis, diabetes and autoimmune diseases; not to mention the effects of surviving heart disease or breast cancer. We know we can prevent or at least delay these conditions - prevention has to be our investment if we expect to extend life and quality of life in the next century. Public Health Services Office of Women's Health Activities

Again, for lack of time, I can't give you in great detail what we're doing in the United States, but let me say our efforts are consistent with those of the

Department of Health and Human Services - eliminating racial and ethnic disparities in health. We support culturally sensitive educational and communications initiatives that encourage personal responsibility. Centers of Excellence

We fund National Centers of Excellence in women's health, some of which were selected for their excellence in serving the health needs of minority women.

Girl Power!

We have a Girl Power! Campaign which is designed to give girls, ages 9 to 14, the tools to practice healthy behaviors to last them a lifetime.

Minority Women

Special outreach efforts target minority women.

HIV/AIDS

We support a Collaborative Work Group of Women…to bring public and private groups together.

Violence

We fund the National Domestic Violence Hotline (1-800-799-SAFE) to help women.

Since its inception 3 years ago, the hotline has received almost 300,000 calls, the majority from women and men who had never before reached out for assistance. This response underscores the need for more outreach.

My office staffs the National Advisory Council on Violence against Women, which is embarking on a process of establishing a national agenda that increases the focus on prevention. The Department of Justice and HHS led by Attorney General Janet Reno and Secretary Donna Shalala are committed to eliminating VAW, and have undertaken a variety of efforts for women, for batterers, and, in recognizing the cycle of violence, for children. The Council is working toward a national agenda to end the scourge of domestic violence.

NWHIC

But we have not stopped there… we now have the tools of the information age. You have seen our web page displayed downstairs, but the National Women's Health Information Center has a toll-free phone line and a website that serve as a

national clearinghouse for both federal and private sector information on women's health.

The center acts as a "one-stop shopping" gateway for any and all women's health issues and links to all federal agencies and publications on women's health and to hundreds of government-screened private sector sites.

Health Insurance

Around the world, nations struggle with the problem of how to pay for the health care of their citizens. Some have national health insurance. In the United States, we have not yet been able to do that. Sixteen percent of American women have no health insurance, and those who do often have limited coverage. That may be our biggest challenge as we face a new century.

Closing

In closing, let me quote anthropologist Margaret Mead. She said, "A small group of thoughtful people could change the world. Indeed, it's the only thing that ever has."

I know that I am in a room filled with thoughtful people who have the power to make changes in the world. I wish you well as you change the world, today, tomorrow, and for all time.

Thank you.

Statement

by Ms. Angela E. V. King, Assistant Secretary-General, Special Advisor on Gender Issues and Advancement of Women, and Director, Division for the Advancement of Women, United Nations

I am delighted to have the opportunity to speak at this important luncheon on health for all women in the 21st century. As I speak on the theme of "United Nations and Women's Health", I am particularly conscious that our hosts, the Global Alliance for Women's Health and the International Council of Women, both non-governmental organizations in special status with the Economic and Social Council, have long advocated in the United Nations the importance of women's health throughout the life span.

I am also delighted to share this occasion with my colleague Dr. Gro Harlem Brundtland, Director-General of the World Health Organization, and I welcome her strong statement on the importance of gender sensitive health care. I am also very pleased to share this venue with Dr. Wanda Jones, Deputy Secretary of Health of the US Government.

We are now in the countdown to a hard nosed review of what governments, UN system organizations and civil society have achieved to implement the Beijing Platform for Action (1995) and the Programme of Action of the International Conference on Population and Development (1994) in the critical areas of women's right to health and their enjoyment of reproductive health and sexual rights.

Beijing puts forward a broad view of a life-cycle approach to women's health. It follows women and girls from the cradle to those critical years before the grave. It sets tangible targets:

Every woman and girl in the world should have appropriate, affordable and quality health care services

The risk of maternal mortality should be reduced by at least 50 per cent of the 1990 levels and a further one half by the year 2015.

Reproductive health care should be accessible to all women no later than the year 2015.

The Secretary-General in his reform of the United Nations, emphasized that gender issues must be one of the cross-cutting issues in all sectors including health and as such must be mainstreamed into each sector, policy and decision made by governments, international organizations, NGOs or civil society.

In the area of health I wish to share with you some of the steps in which the United Nations entitles and the Division for the Advancement of Women and the United Nations Secretariat have taken to mainstream a gender perspective into

the health care area at various levels, thus advancing the global agenda on women's issues.

The United Nations collaboration in this field is not new. Women's enjoyment of human rights, including the right to health has always been part of the work of the United Nations and the Division for the Advancement of Women, going back to the Charter and the Human Rights Covenants. The Division focuses on increasing Member States' awareness and advocating a woman's right to health. In its support for the Commission on the Status of Women and the Committee on the Elimination of Discrimination against Women it carries out research leading to new approaches to the advancement of women, and organizes seminars and expert group meetings dealing with various aspects of the advancement of women in many sectors, including health.

The reason why we are all here today is that health is the last of the 12 critical areas from Beijing to be reviewed by the Commission on the Status of Women before the five-year review of the platform at the Special Session of the General Assembly, to be held on 5 to 9 June 2000. Today we have a very interesting and provocative discussion with panelists regarding challenges that women face in the fields of health (reproductive health, prevention of HIV/AIDS epidemic, mental health and health sector reform).

Credit must be given to the UN as the Organization where on matters of health we can truly say, "We have come a long way, Baby." In Mexico and Copenhagen little was said specifically about the health issue. Today with the Nairobi and Beijing Conferences and the extremely useful inputs from the Vienna Human Rights and Cairo (ICPD) Population Conferences, women now can speak freely and openly in the UN forum of female genital mutilation, safe sex, female condoms, and the right of women as well as men to sexual enjoyment. Some of us who were here in the earlier days found a taboo on such matters. But women all over the world through the UN, through women's groups and NGOs' persistence can now talk freely of these issues. This empowerment places the issue squarely on the global agenda.

Second is the role of CEDAW. This year, we will celebrate the twentieth anniversary of the Convention on the Elimination of All Forms of Discrimination against Women which has been ratified by 163 States parties. The States parties report on progress and measures taken to address gender inequality in many areas, including health. For twenty years, the monitoring body under the convention, the Committee on the Elimination of Discrimination against Women (CEDAW) has reviewed States parties' yearly reports and made recommendations to Member parties on what they have to do to redress and eliminate discrimination against women in the area of health.

These have included suggestions for eliminating abortion as a birth control device, greater focus on the reduction of maternal mortality and dissemination of information on contraceptive methods, including the female condom. CEDAW has also made the critical link between the spread of HIV/AIDS and the use of contraception and sex education for girls and boys.

At its most recent session last month the Committee adopted its 24th general recommendation concerning Article 12 on Health. The recommendation sets out the Committee's understanding of the meaning of women's right to health. It affirms that access to general and reproductive health care is a basic right; and that States parties' compliance with Article 12 is central to the health and well being of women throughout their entire life span. The general recommendation will be available during the Commission on the Status of Women's current session and would be a useful guide for States parties. We hope that it will be endorsed.

Third, I am very pleased to see that the rights-based approach to health was discussed in depth in 1998, at a workshop organized in Rome by the Administrative Committee on Coordination (ACC) Inter-Agency Committee on Women and Gender Equality in cooperation with the OECD/DAC Gender Group. The workshop assessed the practical implications of a rights-based approach to gender equality, including implications for such sectors as humanitarian assistance, food, and health.

Another small step in the long march to women's equal access to health is the framework for designing national health policies with an integrated gender perspective for the 21st century. This came out of the Expert Group Meeting organized last September by the United Nations in collaboration with the World Health Organization, UNFPA, the Commonwealth Secretariat and the Government of Tunisia. Its title was "Women and Health - Mainstreaming the Gender Perspective Into the Health Sector", and the published report will shortly be available in the Commission's conference room.

One of the highlights of the meeting centered on mainstreaming a gender perspective into the structure and management of health system including health sector reform and health care financing; quality care; medical research and health service delivery. To this end, gender analysis needs to be applied to all reforms contemplated in the health sector to examine their potential differential impact on women and men. We also need to ensure that priorities are established in a gender sensitive way. Applying a comprehensive gender perspective would require that all health statistics be disaggregated by sex and age. These steps testify to the better understanding by Member States and civil society of the need

to address the causes rather than symptoms of women's persistent inequalities. And this progress is very encouraging.

However, today I would also like to take a serious look at challenges facing us in this and the next millennium. They are unlikely to disappear without concerted efforts by Governments, NGOs and other actors in society.

On reproductive health, the situation is appalling and shows signs of further deterioration. Nearly 600,000 women die each year from pregnancy or childbirth. In Africa one woman in 23 dies from a pregnancy related risk. In countries in transition which were part of the former Soviet Union, maternity related mortality rates have climbed by 14 per cent in Poland and by 10 per cent in Russia. Several countries continue to have laws requiring that a wife obtain her husband's consent for sterilization or abortion. Lack of sufficient family planning information, particularly among rural women and adolescents, and costs related to contraception have been leading factors in the high levels of abortion. Criminalization of and restrictive laws governing abortion resulted in a high number of clandestine abortions in unsafe conditions leading to thousands of deaths annually.

The issue of the mental health of women remains much neglected. Generations of women all over the world have been and continue to be blamed individually for their mental disorders and are often qualified as hysterical. Little has been done to alleviate the symptoms of women's mental health and to recognize the extent of their suffering, even in developed countries. Depression, anxiety and stress are more prevalent in women: 30 per cent of mental disability in women is from depression as compared with 13 per cent in men.

Occupational and environmental health is increasingly recognized by Governments and civil society as a contributing factor to economic and social development. Women generally are employed in jobs that are repetitive and monotonous. They have little control over workspace and methods. Job insecurity leads to stress. Even in mechanical jobs, most tools, machines and workstations are designed for the average male and are unsuitable for women from an ergonomic point of view.

Women represent the majority of workers employed in the agricultural sector. Highly toxic pesticides are one of the major factors of women's morbidity and mortality, as well as a cause of complications in pregnancy and childbirth. Women working in textile and plastic industries are more vulnerable than men to exposure to absorption of chemicals through the skin used in dyeing. This can lead to acute poisoning.

Even housewives are not spared from health hazards such as indoor air pollution from domestic cooking. More than half of the world's households cook daily with unprocessed solid fuels that release 50 times more noxious pollutants than cooking gas. Women's occupational and environmental health is so neglected that little has been done to identify the underlying gender discrimination and search for remedies that would lead to its elimination.

Communicable diseases such as tuberculosis, malaria, and, to a growing extent, HIV and AIDS are diseases of poverty. Poor women are especially vulnerable because of their low nutritional status, restricted access to education and gainful employment, and heavy workloads. The stigma for women attached to many communicable diseases is greater than for men, particularly those involving disfigurement. This often leads to hiding the diseases and a decrease in life opportunities, including work and marriage. Gender bias begins at a young age: girl children are less likely to be brought to health services for immunization and early diagnosis and treatment of communicable diseases than boys are.

I salute and recognize non-governmental, grass root and women's organizations and associations like the Global Alliance for Women's Health, which act as advocates for the protection of women's right to health. You are closer than other actors to the real needs of women and are the first to come with assistance and strategies for resolving issues. You play an important role in attracting public attention to women's health issues and are instrumental in conveying the message that the underlying cause of many women's' problems in getting access to health care is rooted in systemic gender discrimination.

As important as NGOs can be, political will at the highest level is a condition sine qua non. Governments bear the primary responsibility for the implementation of the Beijing Platform for Action.

A key part of our strategy to reach the many actors in the health care area is to create knowledge of women's human right to health. To this end, we intend to expand our Women Watch website and strengthen our cooperative venture with UNIFEM and INSTRAW. We look forward to the day that WHO will join UNESCO and the World Bank, UNIFEM and INSTRAW on our website.

As we see it, the challenges for the 21st century for the international community are:

ACKNOWLEDGE openly that gender inequalities exist in medical research and government funding;

ADMIT that results of research on men are not always applicable to women;

GET the private sector to fund research on women's health needs, including not just breast and cervical cancers, but some of the neglected areas in occupational, environmental and mental health I mentioned earlier;

REVOLUTIONIZE the way doctors treat female patients;

GET the information about health rights, need and care facilities to women at the grass roots and other levels in all countries;

PROMOTE a gender perspective in health budgeting;

ENCOURAGE ratification of CEDAW by the U.S.

There is a great role for advocates such as the Global Alliance for Women's Health. We look to you to give strong input into the policy recommendations coming from the CSW and support for the Special Session in 2000.

My best wishes to you and for our strong partnership with Governments and UN agencies. Let us together make the 1st decade of the 21st Century the Decade for Global Women's Health!

Thank you.

Speaker Biographies

Dr. Gro Harlem Brundtland

Dr. Gro Harlem Brundtland was born on 20 April 1939 in Oslo, Norway. She studied medicine at the University of Oslo and obtained her M.D. in 1963. She received a Masters Degree in Public Health from Harvard University in 1965. From 1965 to 1967, Dr. Brundtland served as medical officer at the Norwegian Directorate of Health. From 1968 to 1974, she was Assistant Medical Director at the Oslo Board of Health, Department of School Services. In 1974, she was appointed Minister of Environment, a position she held for five years. In 1981, Dr. Brundtland became Prime Minister of Norway, an office she held a total of three times. At the end of her third term of office in October 1996, she had been Head of Government for more than ten years. At the 101st session of the Executive Board of the World Health Organization, the board members passed a resolution nominating Dr. Brundtland for the post of Director-General of WHO. She became the first woman elected to the post and took office on 21 July 1998. Among her numerous international positions, Dr. Brundtland chaired the World Commission on Environment and Development, which formulated the concept of "sustainable development" and made recommendations leading to the Earth Summit in Rio de Janeiro in 1992. Dr. Brundtland is married and is a mother of four and a grandmother of seven.

Ms. Angela E. V. King

Ms. King joined the United Nations Secretariat in 1966 from the Permanent Mission of Jamaica and began working in the areas of human rights and social development. She worked in the Department of Economic Affairs and participated in the first United Nations conference on women in Mexico City in 1975 and the Conference for Social Development in Copenhagen in 1980. Beginning in 1987, Ms. King served at the director level in the Office of Human Resources Management, as Director of Recruitment and Placement and then as Director of Staff Administration and Training. From 1992-1994, she was on assignment as Chief of Mission of the United Nations Observer Mission in South Africa, one of only three women who have headed a United Nations peace and security mission. Most recently she was deputy to the Assistant Secretary-General for Human Resources Management and Director of the Operational Services Division. She represented the office at the Fourth World Conference on Women at Beijing in 1995. In 1997, Ms. King was appointed Special Adviser on Gender Issues and Advancement of Women at the level of Assistant Secretary-General. Ms. King also chairs the Inter-Agency Committee on Women and Gender and Equality of the Administration Committee on Coordination and continues to head the Division for the Advancement of Women Ms. King has a B.A (Hons.) in History from the University of the West Indies and an M.A. in Educational Sociology and Administration from the University of London, as well as further graduate studies in educational sociology at New York University. Ms. King has one son.

Wanda K. Jones Dr. P.H.

Dr. Wanda Jones is Deputy Assistant Secretary for Health /Women's Health of the United States Department of Health and Human Services. Before being selected for this position in February 1998, she was the Associate Director for Women's Health at the Centers for Disease Control and Prevention. Prior to that, she was the Assistant Director for Science in the Office of the Associate Director for HIV/AIDS. A Penn State graduate in medical technology, she has worked in an inner city hospital blood bank and in its hematology laboratory, in a small town hospital as its night shift technologist and then as its microbiologist, and for a state public health laboratory as a laboratory improvement consultant. After obtaining her doctorate in public health laboratory practice from the University of North Carolina, Dr. Jones joined CDC in 1987 as an HIV laboratory trainer. In 1990 she moved to the Office of HIV/AIDS, where she was active in policy issues related to HIV laboratory testing, women and AIDS, HIV vaccine development, and health-care workers. Dr. Jones is recognized for her leadership on women's health issues in Federal and state public health communities.

Pnina Herzog, Ph.C., M.R. Pharm.S.

Pnina Herzog is the President of the International Council of Women, the oldest existing women's international nongovernmental organization. She was First Vice Chairperson of the World Health Organization Executive Board in 1994-1995 and a member of the Board from 1993-1996. During her 34 year career as a civil servant, Mrs. Herzog worked for the Israeli Ministry of Health, where over the years she was in charge of registration of new drugs, intensive drug monitoring, clinical trials, and international relations. She retired from the Ministry of Health as Deputy Director General and Senior Advisor. Mrs. Herzog has a degree in pharmaceutical chemistry from Manchester University. She also studied microbiology, pharmacology, and public health at George Washington University, Ottawa University, and the School of Public Health in Jerusalem. At the International Council of Women, Mrs. Herzog was chair of the Health Committee in 1976-1986, activating national health committees in all ICW affiliates. She later became a member of the ICW board, then its vice president and in 1997 was elected its President.

Elaine M. Wolfson, Ph.D.

Dr. Wolfson is the president of the Global Alliance for Women's Health, chair of the UN NGO Health Committee and an international health policy consultant. She has been studying socio-economic and governmental parameters of women's health policy formation and implementation for over twenty years and is author, co-author and/or editor of articles, monographs, and reports on women's health. Dr Wolfson received a B.A. from Smith College, a Ph.D. from New York University and a Certificate in Business Administration and Management from the Wharton School of the University of Pennsylvania. She has taught public policy and organizational management in M.P.A. programs at New York University, Rutgers University, the State University of New York at Stony Brook and Baruch College of the City University of New York. Currently, she is an adjunct faculty member of the Division of Health Policy and Management, Columbia School of Public Health.