Beijing at 15 *online discussions*
GENDER EQUALITY, DEVELOPMENT AND PEACE

Report of online discussion

Women and Health

Organized by WHO

23 November 2009 – 25 January 2010

The discussion on "Women and Health" was part of a series of United Nations online discussions dedicated to the fifteen-year review of the implementation of the Beijing Declaration and Platform for Action (1995) and the outcomes of the twenty-third special session of the General Assembly (2000); and was coordinated by WomenWatch, an inter-agency project of the United Nations Inter-agency Network on Women and Gender Equality and an unique electronic gateway to web-based information on all United Nations entities' work and the outcomes of the United Nations' intergovernmental processes for the promotion of gender equality and women's empowerment. For more information and other "Beijing at 15" online discussions, visit http://www.un.org/womenwatch/beijing15/

Women and Health: How far have we come since Beijing?

Report of an Online Discussion
23 November 2009 - 25 January 2010

Disclaimer: The views expressed in these discussions are those of the individual participants and do not necessarily represent those of the World Health Organization (WHO) or United Nations and other international organizations.

Contents

Acknowledgements
This report has been prepared by Subidita Chatterjee, the moderator and facilitator of the online discussion. Overall coordinator of the discussion was Peju Olukoya, World Health Organization. Weekly coordinators were Shelly Abdool, Avni Amin, Islene Araujo de Carvalho, Tonya Nyagiro, Peju Olukoya and Elena Villalobos, Department of Gender, Women and Health, World Health Organization as well as Alana Officer, Department of Disability and Rehabilitation, World Health Organization.

Introduction:

Internationally-agreed development goals on women and health

Fifteen years ago, in 1995, the Fourth World Conference on Women (FWCW) took place in Beijing, the People's Republic of China. The resulting Beijing Platform for Action (BPFA) highlights the role of gender equality, development and peace up to 2015 (or next 20 years from then). The BPFA reaffirmed the outcomes of the 1994 International Conference on Population and Development (ICPD) where reproductive health and the rights of women were brought to the fore. It furthermore identified twelve critical areas for priority action to ensure better lives for the women of the world. Women and health is one of these critical areas.

In 2000, the nations of the world adopted the Millennium Declaration and Millennium Development Goals (MDGs) at the 23rd special session of the United Nations General Assembly. It is generally believed that none of the health-related MDGs (in particular MDG 4 - child health; MDG 5 - maternal health; MDG 6 - combat HIV/AIDS) can be met without adequate and appropriate attention to MDG 3, which is to promote gender equality and empower women.

The online discussion on women and health

From 23 November 2009 to 25 January 2010, the World Health Organization (WHO) moderated an online discussion on "Women and health: how far have we come since Beijing?". The purpose was to contribute to the review of achievements, challenges, gaps, good practices and recommendations in the implementation of the BPFA from various perspectives.

The discussion was part of a series of United Nations online discussions on a variety of women-related topics, hosted by WomenWatch[1] in connection with the fifteen-year review and appraisal of the implementation of the BPFA and of the outcomes of the 23rd special session of the General Assembly. Hence, the present report is feeding into the deliberations at the 54th session of the United Nations Commission on the Status of Women (CSW54).

The online discussion on women and health was conducted through a community of practice under a forum run by the International Best Practice Initiative under WHO. This community has **326** members from **66** countries; **266** contributions from **28** countries were submitted over a period of nine weeks.

Participants included officials from the Ministry of Health (MOH) from a range of countries, United Nations, specialized and other international organizations, philanthropic foundations, health-care providers, programme managers, gender and other specialists and health-related practitioners and civil society from around the world.

Subidita Chatterjee was the moderator cum facilitator of the discussion and worked with a panel of experts comprised of staff of the WHO Department of Gender, Women and Health (GWH) in Geneva and a few invited guests. The moderator and the respective coordinator(s) for the weekly theme formed a 'Moderation team'.

At the beginning of each week, the Moderation team and additional experts, as necessary, prepared a short thematic introduction followed by questions to the participants to guide and focus the discussion. At

[1] (An inter-agency project of the United Nations Inter-agency Network on Women and Gender Equality and a unique electronic gateway to web-based information on all United Nations entities' work and the outcomes of the United Nations' intergovernmental processes for the promotion of gender equality and women's empowerment. (http://www.un.org/womenwatch)

the end of each week, the salient points were presented as a weekly summary that was posted on the forum.

More information on WomenWatch Beijing +15 online discussions:
http://www.un.org/womenwatch/beijing15/
More information on the online discussion on women and health:
http://my.ibpinitiative.org/public//womenandhealth
More information on gender, women and health:
http://www.who.int/gender/en
Recent WHO report on women and health:
http://www.who.int/gender/womenhealthreport/en/

Schedule of the discussion

Week	Date	Theme and subthemes
Week 1	23 - 29 November 2009	Gender & health: gender as a social determinant of health; making health systems work better for women
Week 2	30 November - 6 December 2009	Communicable diseases: tuberculosis, malaria, neglected tropical diseases such as schistosomiasis, onchocerciasis, filariasis and dracunculiasis; diarrhoea
Week 3	7 - 13 December 2009	Public health emergencies, humanitarian emergencies; climate change; influenza
Week 4	13 - 20 December 2009	Special populations: adolescent girls; older women
Week 5	21 December 2009	HIV/AIDS
Week 6	- 3 January 2010	
Week 7	4 - 10 January 2010	Reproductive and sexual health and rights: maternal health; unsafe abortion; contraception; infertility; harmful practices such as FGM and forced marriage
Week 8	11 - 17 January 2010	Noncommunicable diseases: cancers; cardiovascular diseases; diabetes; mental health; disabilities
Week 9	18 - 25 January 2010	Wrap-up; evaluation

Executive summary

Discussion process
From 23 November 2009 to 25 January 2010, the World Health Organization (WHO) moderated an online discussion on "Women and health: how far have we come since Beijing?"

The purpose was to contribute to the review of achievements, challenges, gaps, good practices and recommendations in the implementation of the Beijing Platform for Action (BPFA) from various perspectives and to feed into the deliberations at the 54th session of the United Nations Commission on the Status of Women (CSW54).

The online discussion community counted 326 members from 66 countries; 266 contributions from 28 countries were submitted over a period of nine weeks on eight themes and twenty-two subthemes, ranging from gender, communicable and noncommunicable diseases, public health emergencies, special populations and HIV/AIDS to reproductive and sexual health and rights.

The following summarizes the views expressed by the online discussion community; they do not necessarily represent those of the writer, the World Health Organization (WHO) or United Nations and other international organizations.

Political commitments
One of the most noteworthy achievements since the Fourth World Conference on Women (FWCW) in 1995 is that the resulting Beijing Platform for Action (BPFA) has proven to be an effective road map for meeting women's health needs. In addition, the Millennium Development Goals (MDGs) adopted in 2000, in particular MDG 3 - gender equality and women's empowerment; MDG 4 - child health; MDG 5 - maternal health; and MDG 6 - combat HIV/AIDS, have been other road maps for guiding public health decisions after Beijing. As a result, political commitments from heads of states and parliamentarians towards improving women's health have been remarkable in the past few years. Discussion participants called on donors to stick to their promises and pool together US$30 billion that could help meet the goals of MDGs 4 and 5.

Progress since Beijing
In each of the areas discussed, progress was visible. Some examples follow.

There has been a paradigm shift from a singular focus on curative medicine to mixed approaches that combine curative and preventive/promotive medicine.

Special populations, which were earlier neglected, such as adolescents, older women, disabled women and girls, HIV-positive women or women most at risk for HIV, ethnic minorities, immigrant/migrant women, refugees and internally displaced persons are now gradually being given more attention than before Beijing. Disability is now acknowledged as a condition and not a disease. It is also now acknowledged that a woman's health needs to be addressed throughout her life-course, from birth to older age. Interesting developments have started linking preventive and promotive interventions with intergenerational health problems such as how nutrition of a girl child today could determine whether her future baby will be at increased risk for type 2 diabetes.

Earlier, the focus was on maternal and child health (MCH) but after Beijing, diseases that were earlier sidelined from public health such as neglected tropical diseases or noncommunicable diseases (NCDs) are now being paid greater attention. More attention is being paid to mental health conditions of women. For instance, it is now acknowledged that women bear a greater burden of dementia and Alzheimer's compared to men.

Remaining gaps

Despite considerable progress, many challenges remain. Fifteen years after Beijing, preventable conditions like maternal mortality and unsafe abortions still go on unabated. Young unmarried and married women continue to die from both. Women continue to have unequal access to skilled birth attendants and timely emergency obstetric care – the rich having far better access than the poor. Legalization of abortion is a considerable political issue and women's health continues to suffer. In some countries, public health and the rights of women are even taking a backward turn where earlier liberal laws allowing abortion are now being cancelled, making abortion illegal. Bringing infertility management into the mainstream at the primary health care level and cutting down the cost of artificial/assisted reproductive technologies for women in resource poor countries was recommended. Violence against women and especially against marginalized women continues to influence the health of women. Some authorities turn a blind eye to this important public health challenge. Discussion participants questioned the reasons for this: "Is it corruption or negligence or both?"

There needs to be global concerted action against laws criminalizing women living with HIV such as the Model AIDS Law which is currently being enacted. Human rights abuses against HIV-positive women such as forced abortions or sterilizations were highly condemned. The health of widows and related issues such as food security or the property rights of AIDS widows should be included in global declarations.

Noncommunicable diseases (NCDs) are affecting the poor and the rich alike, and health systems find it difficult to cope with the increasing double burden of infectious diseases and NCDs. Breast and cervical cancer seemed to be a major challenge. Interesting recommendations included teaching girls about cancer in school and doctors using one minute of their consultation time to orient women about screening for cancer.

Humanitarian emergencies and climate change affect women's health adversely and the most economically vulnerable women are the ones most hardly hit. It was discussed how allowing poor women to emit greenhouse gases may be necessary to protect them during difficult emergency times.

Bringing an end to all kinds of divisive policies was stressed - be it HIV or cancer, family planning or maternal health - they would have to go hand in hand with an integrated approach, which has shown to be more cost-effective and to save more lives.

It was pointed out that in the gender and health context, issues of human rights have hardly been raised in the Beijing Platform for Action. Hence, health should be analysed through a human rights, gender and culture lens in Beijing +15 resolutions.

However, the agenda above could not be accomplished unless men and boys were engaged as partners so that women can enjoy community norms and health systems that are gender-sensitive, culturally sensitive and based on human rights.

It was thought that 15 years after Beijing, all policies that stood in the way of saving a woman's life should be discarded and a new social order welcomed. This would be a grassroots movement where every woman would stand up for her rights to change the health of women for the better.

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Chapter 1: Week 1, Nov 23-29, Gender and health

1. Subtheme: gender as a social determinant of health

Achievements: The Beijing Platform for Action has been the most comprehensive road map for the achievement of gender equality and women's empowerment for health so far. It has been followed by a number of declarations and goals, the most prominent of which are the Millennium Development Goals adopted in 2000.

Challenges: A few participants raised concern that a gender mainstreaming (GMS) approach in the health system has not been working as it should, or as it does in other sectors. Reasons raised for this included a lack of adequate understanding of GMS and insufficient training on GMS methods and approaches among and for health-care professionals, senior managers of health systems and health-related policy-makers. The lack of understanding was thought to contribute to health provider disinterest or apathy when dealing with women as they may perceive this to be the point of gender mainstreaming. Furthermore, they may perceive women-focused services to be unjust.

Gaps: Gender inequality and a lack of respect of human rights for health are evident in every stage of a woman's lifecycle.

Good practices: A conceptual framework has been proposed by the WHO Department of Gender, Women and Health to guide women and health programming. It is based on four pillars - gender equality, human rights, a life-course approach and engagement of men as partners - and open for discussion.

Recommendations: Health professionals need training to comprehend the concept of gender mainstreaming and imbibe it into their daily work. In addition, men should be engaged as partners in taking forward the women's health agenda.

> "…to frame them within a women's human rights perspective and carry out all recommendations through a human rights approach. This has been lacking since Beijing except in a few timid attempts and it's totally lacking in all the MDGs…"
>
> - Hélène Sackstein

2. Subtheme: making health systems work better for women

Achievements: There has been a paradigm shift from a singular focus on curative medicine to mixed approaches that combine curative and preventive/promotive medicine, including for the health of women.

Challenges: It was highlighted that health systems in most developing countries were not yet geared to face the transition from infectious to noncommunicable diseases.

Gaps: Health financing and health workforce planning are not based on gender equality and women's needs. Marginalized women of all types lacked access to health care in most countries.

Good practices: National commitments towards taking forward women's health seemed to be the single most important factor for success of women's health programmes. This would also ensure that a major portion of a country's gross domestic product was assigned to women's health.

Recommendations: Women need to be appointed in positions of power to make decisions about health system reforms to improve women's health; reform decisions are still controlled by men.

> "The power to bring about large-scale change (create impact) is, almost by definition, vested in governments/states and not, in spite of the rhetoric, in "the people". This may sound unduly pessimistic but is only meant as "realpolitik". Notwithstanding, it does occasionally yield dividends.
>
> In Iran, for example, possibly the most important reason measles, mumps and rubella (MMR) have dropped over the course of a generation from c.150 to less than 30-40 is that the government decided to build its primary health care system around maternal and child health and family planning services. No other actor or combination of actors could have duplicated such a result on a nationwide scale."
>
> - Ali-Reza Vassigh

Chapter 2: Week 2, Nov 30-Dec 06, Communicable diseases

3. Subtheme: women and tuberculosis (TB)

Achievements: Among all communicable diseases, TB is the first for which data has been disaggregated for age and sex both at national and subnational levels.

Challenges: Generating awareness among health-care providers, women and families of gender-related differences in this disease, building capacity of health professionals to manage the conditions, creating demand for women to seek care and educating men to support their partners were deemed important.

Gaps: It is not very clear why data routinely reported to WHO show that the sex distribution of notified TB cases varies across regions and countries but also within countries, provinces and districts.

> "The data routinely reported to WHO show that the sex distribution of notified TB cases varies not only across regions and countries but also within countries, provinces and maybe even within districts. The reasons for these differences need to be explained, and they are likely to result from various factors, including access to care, the HIV co-epidemic especially in Africa and similar high-prevalence settings, as well as other diverse biological, economic social and cultural variables."
>
> - M. Uplekar, D. Weil

Good practices: The WHO Gender, Women and Health Department and the WHO Regional Office for South-East Asia (SEARO) in collaboration with an NGO in Chennai, India have supported the "Gender-sensitive - Are you well (AYW) programme for HIV/TB" since 2009. It used radio promotion stories to boost the morale of female and male TB patients in hospitals, aiming at total TB cure by providing gender-sensitive health care and empowering women to be agents of change for prevention of TB. In addition, women are supported to be partners for men so that men comply better with treatment.

The WHO Stop TB Initiative uses enablers and incentives to help address patient-specific needs, public-private approaches and community TB care. By offering a choice of care providers, it helps women TB patients feel more comfortable and also helps address stigma. With 800 partner institutes, the initiative facilitates networking.

Recommendations: TB data should be analysed and the evidence used to design gender- and age-specific policies and programmes in view of greater uptake of services. Laws that prevent public sharing of smoking devices (e.g. water pipe) that can spread TB need to be implemented.

"WHO raised concerns about the role of water pipe (Shisha) smoking in transmitting TB among young adolescent girls especially and encouraged the government to put laws that regulate cafes' provision of these devices, but nothing has really happened in this concern."

- Dalia Abd El-Hameed

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4. Subtheme: women and malaria

Achievements: Malaria prevention has become an important element of antenatal care services and with 70% of African women now seeking antenatal care, this move should prove beneficial.

Challenges: In countries heavily affected by malaria, pregnant women and children under five are the most vulnerable populations. Inadequate supply of insecticide treated bed nets (ITNs) and medicines for malaria and inadequate and irregular attendance of antenatal clinics by women are impeding scaling up therapy.

"Pregnant women are four times more likely to contract malaria. Malaria in pregnancy leads to low birth weight and premature delivery, both are associated with an increased risk of neonatal death."

- Elena Villalobos

Gaps: Follow-up for malaria treatment in antenatal clinics is inadequate. Gender-sensitive preventive measures hardly exist at present and need to be developed.

Good practices: The Global Gender and Malaria Network consists of some 50 actors worldwide, including researchers, international organizations, NGOs, local grass-roots organizations and independent activists. Their project "Raising women's voices on malaria" has brought the issue of gender in malaria to the attention of decision-makers.

Recommendations: Malaria data is to be disaggregated by age and sex, and health-care providers need to be trained in gender analysis.
Education in schools and communities on malaria prevention and universal access to preventive measures. Long lasting insecticide impregnated nets (LLIN), intermittent preventive therapy (IPT) in pregnancy and indoor residual spraying (IRS) of insecticides are urgently required.

5. Subtheme: women and neglected tropical diseases

Achievements: Since Beijing (though not a part of the Beijing Platform for Action), attention to neglected tropical diseases (NTDs) such as schistosomiasis, onchocerciasis, filariasis and drancunculiasis have gradually increased. Also more attention is being paid to the effects of these diseases on women.

Challenges: NTDs impair reproductive health, increase the transmission of sexually transmitted infections (STIs), promote stigma and contribute to gender inequality.

Gaps: There is a tremendous lack of awareness of these diseases especially among women and of the fact that these can kill within months or even days if left untreated. As a result, many cases remain unrecognized and untreated.

Good practices: None reported.

Recommendations: Strengthening national health-care systems and building capacity to make primary health care more accessible for women suffering from NTDs is required.
Encouraging awareness and more active participation of women in advocacy and programme activities designed for the control of neglected tropical diseases, especially at community level, is needed.

"Women also face additional barriers to seeking, and often to receiving treatment. Furthermore, the consequences of stigma attached to many neglected tropical diseases are often more severe for women within their families and wider society. Deformities associated with leprosy, leishmaniasis and lymphatic filariasis can become so severe that patients are banished from their communities as well as the workforce." - Peju Olukoya

6. Subtheme: women and diarrhoea

Achievements: Current statistics show that the rate of distribution and access of oral rehydration salt (ORS) is practically the same for girls and boys. Also globally, boys and girls receive appropriate care for diarrhoea at similar rates.

Challenges: The gender differences observed in the management of diarrhoeal diseases in girls are found at the household level.

Gaps: There seems to be a lack of awareness among fathers of baby girls that neglecting diarrhoea can be fatal. Engaging men in programming is therefore key.

Good practices: The International Centre for Diarrhoeal Disease Research, Dhaka, Bangladesh trains mothers in self efficacy to handle diarrhoea at home. This institute discovered that using zinc with ORS could reduce the duration of diarrhoeal episodes and that patients responded better to treatment. Hence, it is giving it to every child with diarrhoea. It has encouraged the Government of Bangladesh to take up focused community-led approaches with behaviour change at its core.

Recommendations: Family and community education (including men) on how to manage diarrhoea at home with ORS/home-made fluids and scaled-up public services with a special focus on gender inequality.

Chapter 3: Week 3, Dec 07-Dec 13, Public health emergencies

7. Subtheme: women and humanitarian emergencies

Achievements: The Inter-Agency Standing Committee (IASC) on humanitarian assistance has brought UN and non UN partners together to produce a set of guidelines on mainstreaming gender in emergency situations. Using gender experts in this initiative has shown success.

Challenges: All kinds of humanitarian crises increase the vulnerability of women, adolescent girls and girl children. Their access to critical health-care services is often reduced and their exposure to sexual and other forms of gender-based violence (SGBV) is increased, often coming from aid workers themselves.

Gaps: Gender analysis and sex-disaggregated data is rarely available during humanitarian emergencies. Hence, the ways the responses are designed and funded seem to suffer.

Good practices: Since 1997, the Minimum Initial Service Package (MISP) has been the standard of care for reproductive health care in emergency settings. Practitioners are educated on how to implement the MISP standard on the ground.

***Recommendations*:** During humanitarian emergencies, aid workers need to protect women and girls from sexual and gender-based violence and nutritional deprivation by bringing more women and women organizations into the relief work. Attention to mental health and trauma after a humanitarian event is warranted especially for the adolescent girl and girl child.

8. Subtheme: women and climate change

Achievements: The debate on the impact of climate change on human health is taking up global attention more than before Beijing. In 2008, 193 WHO Member States voted at the World Health Assembly to pass a resolution that called for greater WHO support and stronger engagements by countries in relation to climate change.

Challenges: Common causes of death such as urban pollution, diarrhoea, lack of clean water and poor hygiene all become more unmanageable in higher temperature conditions resulting from climate change. There appears to be a negative correlation between trying to mobilize international political will for climate change and the poorest families becoming the hardest hit. This is because they need more energy to survive and release greenhouse gases.

Gaps: Women often lack basic survival skills such as swimming or climbing trees, and their flowing clothes often restrict mobility. This could have been one of the factors that put women at a disadvantage during disasters resulting from climate change (e.g. Tsunami in 2004).

Good practices: Good practices that could be beneficial include distributing 150 million improved stoves in India. This could reduce black carbon emissions and deaths of women and children caused by indoor air pollution. Two million lives could thus be saved from acute respiratory infections.

Recommendations: Poor women need to be given permission to increase their energy use and greenhouse gas emissions so that they are not subject to unjust compromises to limit climate change. To understand the implications of climate change, it is advisable to collect and analyse data disaggregated by sex and age, together with other stratifiers.

> "Global climate change illustrates, perhaps more than any other issue, the interdependence of natural and human systems, and the connections between populations in different parts of the world. Addressing this challenge will require more than just a technological fix; it calls for transformative change in socioeconomic systems, based on the principles of improving lives, protecting the weakest and fairness. These principles are equally relevant to climate change, to global health and to gender equality, and we should make these one common agenda." - Diarmid Campbell-Lendrum & Elena Villalobos

9. Subtheme: women and influenza

Achievements: Presently, the different types, classifications and nature of spread of influenza are quite clear. There is now vaccination and treatment for most of the strains including the newly emerging types of influenza H5N1 and H1N1.

Challenges: H1N1 Influenza is a challenge because its complications can lead to death and are affecting the relatively healthy and younger age groups and not necessarily the immunologically weak.

Gaps: There is a big knowledge gap on influenza, sex and gender. Also the differences in incidence, morbidity and mortality between men and women are not yet clear. Data disaggregated by age and sex is lacking. There has been no systematic data collection on treatment outcomes and safety during pregnancy.

Good practices: Norway decided to distribute antiviral medication over the counter for a limited period of time to reduce the burden on primary health care and increase access for patients.

Recommendations: Current recommendations are to treat pregnant women with influenza-like illness with antivirals. It is important to systematically gather knowledge from pregnant women who are taking antivirals during epidemics. This will help further research.

"Most people infected with H1N1 tend to recover on their own and do not suffer major problems afterwards. As a result of this, some people are tempted to dismiss the thinking that it is not serious. This, according to WHO, is a dangerous mindset. There is ongoing concern about current patterns of the H1N1, particularly because a sizeable number of people develop complications that have led to death. Serious complications are concentrated in the younger age groups rather than the older age groups. The complications are most often seen in people who have chronic, underlying health conditions and in pregnant women. " - Peju Olukoya & Martha Anker

Chapter 4: Week 4, Dec 13 - Dec 20, Special populations

10. Subtheme: the health of adolescent girls

Achievements: At present, sound public health, economic and human rights reasons have been established for investing in the health and development of adolescent girls.

Challenges: Early marriage, sexual exploitation, abuse and intimate partner violence still affect adolescent girls 15 years after Beijing. Maternal mortality remains five times higher among 15-19 year old girls than 20-24 year olds. Death from unsafe abortion remains four times higher among adolescent girls than among adult women in Africa.

Gaps: Adolescent girls (and the especially vulnerable) do not yet have access to both primary and secondary education, including comprehensive skills-based sexuality education and services. Policy-makers and parents are still against giving these human rights to adolescent girls for reasons of cultural beliefs. Very little data is available from developing countries on mental health, substance use, diet and physical activity of adolescent girls which lead to chronic health problems.

Good practices: There have been bold local efforts to tackle gender-based violence through community-based interventions engaging boys and men in South Africa and Brazil. Small projects, in India and other countries, have demonstrated interesting results tagging income generation with health and sexuality education for adolescent girls.

Recommendations: Policy-makers should be informed about the fact that for a comprehensive agenda for girls it is estimated that a complete set of interventions, with health services, communities and schools, would cost about US$1 per day for each girl in low- and low-middle income countries.

"Adolescents represent 1 in 5 of the world's population. There are sound public health, economic and human rights reasons for investing in their health and development. Adolescent girls are particularly vulnerable and deserve special attention. There are 600 million adolescent girls in the developing world. Achieving 6 of 8 MDGs (including those relating to reducing child mortality, maternal mortality and HIV) requires concerted attention to adolescent girls." - V. Chandra Mouli

11. Subtheme: the health of older women

Achievements: There is enhanced knowledge about the health conditions of older women, and leading causes of death have been identified. Also greater attention is being paid to the abuse of older women as a public health problem.

Challenges: As older women are often the caregivers of their ailing spouses, children or grandchildren, due to economic, social and health burdens, they often suffer from burnout and depression. Older women are also more likely to suffer from dementia, osteoporosis and vision loss compared to men, and diagnosis of certain diseases in women remain a challenge.

Gaps: There are no sex-specific treatment guidelines because of under-representation of women in mixed sex clinical trials.

Good practices: WHO has developed the Age-Friendly Cities Programme. This is an international effort to help cities prepare for the rapid ageing of populations and increase in urbanization. The programme targets the health and well-being of older adults and assesses the environmental, social and economic factors that influence their health and well-being. Home-based care with minimal intervention has been successful in sub-Saharan African countries with HIV/AIDS populations.

Recommendations: Older women need to be included in clinical trials to have age- and gender-specific treatment guidelines. Acting on the gender determinants of health throughout the life-course, with a preventive approach, could reduce the long-term treatment costs for health problems of older women.

"The stresses associated with long-term care, both in the home and in institutional settings, have been associated with neglect and abuse of older women. Until recently, the abuse of older persons was a problem that was hidden from public view. There is now growing evidence that elder abuse is an important public health problem that exists in both developing and developed countries." - Simone Powell

Chapter 5: Week 5-6, Dec 21 - Jan 03 HIV

12. Subtheme: women and HIV

Achievements: Attention to violations of the right of HIV-positive women to bear children has increased over the past years.

Challenges: HIV-positive women still hide their HIV status with medical practitioners even in developed countries such as the United Kingdom. This is because of bad experiences with lack of confidentiality and biased treatment.

Gaps: Sex workers and other most-at-risk groups of women are still criminalized and marginalized without access to basic health care. Most prevention of mother-to-child (PMTCT) programmes do not provide ongoing treatment to mothers after delivery.

Good practices: In 2007, the International Community of Women with HIV (ICW) started a project in Namibia that documented violations of sexual and reproductive health of HIV-positive women (including forced sterilizations and abortions). In India and Nepal, ICW is documenting access to antenatal services, contraception, abortion and sterilization.

Recommendations: HIV-positive women and girls need to be given their legal rights of access to safe abortion services or other options if they wish to terminate unwanted pregnancies or access to PMTCT services if they wish to have a baby. HIV prevention and sexuality education need to include HIV-positive young people (especially girls) in their paradigm.

HIV prevention programmes need to start targeting women in long-term relationships (especially in Africa and Asia).

There needs to be a global concerted action against laws criminalizing women living with HIV such as the Model AIDS Law currently being enacted.

"…the lack of a comprehensive approach to women's reproductive health rights, including in national HIV AIDS strategies. African women in the Regional Shadow Report on Beijing +15 have called for women's health - in totality - to be re-prioritized as a human rights issue and as a critical component of sustainable development in Africa." - Naisola Likimani

Chapter 6: Week 7, Jan 04- Jan 10, Reproductive and sexual health and rights

13. Subtheme: maternal health

Achievements: MDG 5 remains the foremost global advocacy and action objective which has become a constant reminder to expedite the reduction in maternal deaths worldwide. There have been unprecedented commitments by world leaders in recent years - US$5.3 billion for innovative financing mechanisms for global health and stronger health systems for maternal, newborn and child health (MNCH). Dr Margaret Chan, WHO Director-General, has launched the MNCH Consensus to achieve MDGs 4 and 5 - a framework for action and accountability.

It is now known that the most important interventions to save maternal lives are access to skilled birth attendants, timely emergency obstetric care, postnatal care for mothers and babies, and access to reproductive health services. Family planning, safe abortion/post abortion services and all reproductive health services should be adolescent friendly.

Challenges: The most important causes of maternal death from childbirth are severe bleeding (24%) out of which postpartum haemorrhage (PPH) remains the most crucial, infections (15%), unsafe abortions (13%), eclampsia (12%), obstructed labour (8%), other direct causes (8%) and indirect causes including violence against women (20%). Maternal nutrition, micronutrient supplementation and management of diseases in pregnancy such as HIV, TB, malaria, hypertension/eclampsia, diabetes and postpartum depression need greater attention. Better infrastructure and human resources, both in quality and number, are urgently required.

Gaps: Data on the actual number of maternal deaths and their causes are missing and this is an important loophole for measuring progress. In countries where MMR has been reduced, there may still not be adequate access to hospital delivery and technology. This is because of an imbalance between abuse of invasive procedures (too many caesareans/episiotomies) in some countries and serious lack of timely care in others (inadequate obstetric surgeons or facilities).

Good practices: Some countries that have started making progress for MDG5 very recently such as India (maternal mortality ratio being down from 327 to 256 in 2009) used additional interventions such as setting up blood storage centres in first referral units (FRUs) and blood banks in district hospitals as well as financial incentives for those below the poverty line to go for institutional delivery. Supported by WHO, they have also started maternal death reviews.

Recommendations: Data on the actual number of maternal deaths and their causes need to be documented urgently. Furthermore, indirect causes of maternal death such as from gender-based violence need to be included in the statistics.

To achieve MDG 5 (and 4) by 2015, it has been estimated that US$30 billion of new investment is required. Greater political leadership, community engagement and mobilization, with accountability at all levels, are required to achieve credible results.

14. Subtheme: unsafe abortion

Achievements: There have been legal reforms in some countries such as Pakistan where, in addition to saving the life of a mother, grounds for abortion now include “necessary treatment”, though this term is yet undefined. Regardless of the legal status of abortion, different activities have been identified in advocacy efforts. WHO’s “*Safe abortion: technical and policy guidance for health systems”* is an essential guide to provide safe, comprehensive abortion care to the full extent of the law so as to benefit women.

Challenges: Some challenges specific to eliminating unsafe abortion are destigmatization of pregnancy termination; training for health-care providers in safe abortion methods; and supportive health system

policies, apart from general challenges of health and related education for women that apply here as well. Other challenges include planning "wanted" pregnancies; preventing unwanted pregnancies; and safely ending those that occur from forced or coerced sex, failed or unavailable contraception or fetal malformations. Most crucially, legalizing abortion is another challenge, a step which those in positions of influence often evade, even though compelling evidence demanding attention and action exists.

Gaps: The international community limits their advocacy to cautiously recommending that abortion should be safe “when legal”. Technologies for safe abortion (including vacuum aspiration and medical abortion) are often not available, accessible and affordable.

Good practices: The WHO report “Women and health: today’s evidence tomorrow’s agenda” released in November 2009, highlights the fact that studies have shown that where there are broad legal grounds and access to safe abortion, mortality and morbidity are considerably reduced. A significant modification reported from India is that medical abortion should not be denied irrespective of a woman's decision to initiate postabortion contraception.

Recommendations: Governments, policy-makers and health-care providers must be urged to remove regulatory and other barriers to safe abortion. There is an urgent need to provide safe abortion services globally as evidence is compelling that safe abortion services can save maternal lives.

> “Continued efforts are needed to liberalize restrictive abortion laws. Recent successes in countries such as Mexico (Distrito Federal) and elsewhere demonstrate that reform is possible even in the face of political and religious opposition from some quarters. Unfortunately, backsliding in some countries that previously allowed abortion on at least some grounds (e.g. Nicaragua) or where hospitals and family planning organizations were permitted to provide safe services despite the law (e.g. Indonesia) remind us that continued efforts are needed not only to liberalize restrictive laws but to stop governments from adopting new laws that tighten restrictions and impose criminal sanctions on most or all terminations.”
>
> - Adrienne Germain

15. Subtheme: contraception

Achievements: The contraceptive prevalence rate for modern contraceptives has considerably improved in many countries since Beijing (reported from Pakistan).

Challenges: There is an obvious gender bias when it comes to permanent birth control methods in many countries. The tubal ligation which is performed on women is more popular than the vasectomy for men (reported from India).

Gaps: Information on contraceptive methods and their correct use is still widely unavailable to adolescent girls (and boys) because sexuality education is still a taboo in many developing countries (reported from India and Costa Rica).

Good practices: The United States Congress recently appropriated more than US$648 million in foreign assistance to family planning and reproductive health programmes.

Recommendations: The concern expressed by women for their future fertility preservation should be capitalized upon while developing advocacy messages to improve the appropriate use and uptake of contraception and to adopt healthy sexual and reproductive health behaviours. As in many societies, this is perhaps most applicable within the context of Africa and other developing countries where a woman’s worth is strongly judged by her ability to bear children.

Ensuring access to voluntary family planning could reduce maternal deaths by 20 to 35 per cent (and child deaths by 25 per cent) according to UNFPA.

16. Subtheme: infertility

Achievements: Infertility management has made rapid progress globally, especially with the greater acknowledgment of the role of men along with women in this disease of the reproductive system, and the emphasis of the link between infertility and the need for the prevention of sexually transmitted infections. To give access to underprivileged women/couples in resource poor countries, infertility specialist societies/communities in partnership with WHO have been discussing good practices in relation to reducing the costs for assisted reproductive technologies.

Challenges: High cost of advanced infertility management (especially assisted reproductive technologies), health insurance not covering assisted infertility treatments and public health systems not providing sophisticated treatments remain major barriers to gender equity and universal access to care for the infertile. Monitoring and surveillance of the health and well-being of women prior to and/or when they become pregnant, and also that of the child(ren) born, through assisted reproductive technologies. As women age, their ability to reproduce decreases at a more significant rate than in men, yet women are delaying their childbearing,and rates of childlessness are increasing in developed and developing countries.

Gaps: Education about infertility causes, prevention and forms of interventions is lacking. Infertility can be classified as a social issue which results in women being subjected to stigmatization and divorce. Men often require encouragement to recognize their responsibility in an inability to father a child (infertility is often referred to as a women's problem) and mechanisms are needed to encourage men to adopt healthy sexual and reproductive health-seeking behaviours for fertility preservation. Evidence and guidance are lacking on infertility interventions in resource poor settings. Recognition of the fact that any successful intervention results in pregnancy demonstrates the clear need to link infertility care management with both family planning, as well as maternal and child health care.

Good practices: In some cases, the HIV-positive discordant couples may now have access to simple and affordable techniques such as sperm washing and other medically assisted reproductive interventions.

Recommendations: There is a need to make infertility prevention and management available at the primary care level. For this to be successful, it would be appropriate to share infertility management tasks between the doctor, the midwife and the community health worker. Costs of assisted reproduction technologies, without jeopardizing quality of care, have to be drastically reduced to increase access in resource poor settings.

17. Subtheme: harmful practices such as female genital mutilation and forced marriage

Achievements: The international community has accepted that female genital mutilation (FGM) is a violation of a series of human rights, and principles and the silence around it has been broken.

Challenges: FGM, a practice deeply rooted in culture, is still surviving because communities feel it serves some purpose. More than 18 percent of all cases of FGM are performed by health-care professionals.

Gaps: Governments have no system of monitoring the spread and practice of FGM.

Good practices: 17 African countries, including Uganda very recently, have legislated against the practice in their national laws. FGM has been delinked from religion - Islam and Christianity - through workshops organized by IAC and documents published by the Population Council that highlight this point.

Recommendations: Advocate with governments of practising countries to legislate where there is no national law and to implement and enforce where a national law exists. However, legal instruments

cannot do it alone. There needs to be some reporting back from medical professionals whenever they come across a girl who has undergone genital mutilation or is at risk. A suggestion was to have medical genital examinations in pre-primary or primary school children to help identify FGM and sexual abuse.

"No doubt it is a complex situation but that is no reason for the international community to fold its hands. We need to go to Beijing +15 with a strong Call for Action to governments of practising countries to legislate where there is no national law, to implement and enforce where a national law exists; to the Human Rights Council and the World Health Assembly to enforce accountability through its reporting mechanisms and to the rest of the world interested in upholding the human rights of all to continue to advocate. This of course is not limited to FGM but to all harmful practices affecting the health of women and girls all over the world."

- Adebisi Adebayo

Chapter 7: Week 8, Jan 11 - Jan 17, Noncommunicable diseases

18. Subtheme: women and cancers

Achievements: In many developing countries and especially in African countries, there is more national commitment to combat breast and cervical cancer than before Beijing. Breast Cancer Day is regularly observed to encourage women and girls to go for screening/checkups while there is widespread information, education and communication about cervical and breast cancer.

Challenges: Cancer continues to kill women in high numbers; yet talking about it is still a taboo in many countries such as the United Arab Emirates. Human Papillomavirus (HPV) vaccination is too expensive for most families to access it (e.g. reported from Kenya where cervical cancer is a big killer).

Gaps: Screening tests such as Pap smear (for cervical cancer) or mammography (for breast cancer) are not accessible to most women. In some countries such as the United Arab Emirates there is no centralized cancer registry and so it is difficult to get up-to-date information or perform evidence-based services or awareness campaigns about cancer.

Good practices: Friends of Cancer Patients (FOCP) Society in the United Arab Emirates includes women living with cancer or who have cured their cancer (thanks to advocacy and education efforts), which gives hope and boosts the morale of others in a positive way. Hospice, an NGO in Uganda, provides free services to women with terminal diseases like cancer and ensures that they die with dignity and less suffering.

Recommendations: In the absence of mammography and Pap smear tests, breast self-examination and visual inspection with acetic acid (VIA) should be available and accessible methods for detecting breast and cervical cancer (reported from India).

"It is possible to launch a public health campaign about the signs and symptoms of cervical cancer and where they can access care. However, strengthening existing infrastructure to supply VIA and training the personnel to perform the test at primary health care level should be done simultaneously. The staff is already present; orientation is required… As for breast cancer, breast self-examination should be taught to all women as it involves no cost except for some training, and can be done at home. Mammography is cost and labour intensive, and will need heavy investments to make it universal - a distant possibility in the developing world."

- Sunanda Gupta

19. Subtheme: women and cardiovascular diseases

Achievements: The underlying markers are now clearly identified and this has paved the way for preventive and health promotion interventions not only for cardiovascular diseases (CVDs) but for all noncommunicable diseases.

Challenges: Diagnosis of some cardiovascular conditions remains difficult in women due to uncommon or unrecognized symptoms. Pregnancy induced hypertension is a grave condition that can lead to maternal death through eclampsia.

Gaps: Timely, affordable and accessible lifesaving health services for CVD are still out of reach of the poor (70 per cent of whom are women) in developing countries.

Good practices: WHO's Global strategy for NCD prevention and control (endorsed in 2008 at the 61st World Health Assembly), which is based on experience from high-income countries, consists of six objectives which would be applicable to CVDs as well.

Recommendations: Promoting interventions to reduce the main common risk factors for NCDs, including CVDs, which are tobacco use, unhealthy diets, physical inactivity and harmful use of alcohol.

20. Subtheme: women and diabetes

Achievements: Various initiatives are raising the profile of women and diabetes as a priority issue on the global health agenda. The International Diabetes Federation's (IDF) new women and diabetes programme is part of this movement, which builds awareness, the evidence base, capacity and political commitment towards women and diabetes.

Challenges: Neglecting the vicious cycle of poverty, food insecurity and malnutrition in girls and young women can cost heavily by their giving birth to low birth weight babies later in life, who will be at higher risk of developing type 2 diabetes in their lifetime.

> "The low socioeconomic, legal and political status of girls and young women in some societies results in a viscous cycle of food insecurity, malnutrition, chronic disease, and poverty… These young women then go on to give birth to low birth weight babies, which are at higher risk of developing type 2 diabetes. Investing in the nutrition of the girl child could break this vicious cycle and potentially improve the health and life chances of millions of infants." – Katie Dain

Gaps: There is a lack of consensus around diagnostic criteria for gestational diabetes mellitus (GDM) causing a controversy around screening protocols. Despite GDM being a public health issue of great importance, at present there is a paucity of GDM prevalence data. Awareness about the complications associated with diabetes in pregnancy and the necessity of planning for it beforehand is poor.

Good practices: The International Diabetes Federation (IDF) recently launched the first Global guidelines on pregnancy and diabetes. This is the first time there has been worldwide consensus about the identification, treatment and management of the pregnant woman with diabetes.

Recommendations: Investing in the nutrition of the girl child could improve the health of millions of infants by breaking the vicious cycle of giving birth to low birth weight babies who are at higher risk of developing type 2 diabetes.

There needs to be an agreed set of diagnostic criteria for GDM so that its prevalence can be accurately assessed.

Offering women services for diabetes during family planning and reproductive health care (including antenatal care) is a missed opportunity. It would, however, help reduce mortality from diabetes in the mother and the child.

21. Subtheme: women and mental health/substance use

Achievements: In recent years more attention has been paid to the human rights aspects of women's mental health.. Efforts have been made to prevent the risk factors and make mental health services more available and accessible to women at the global level. However, universally accepted principles need to be applied at the country level with due consideration of the local culture. Launching of WHO's mhGAP action programme in 2008 by the WHO Director-General provided an opportunity for scaling up mental health services, and this would provide better access for women as well.

Increased attention to smoking patterns among women across ages has yielded important information that can be used in health promotion and illness prevention campaigns.

Challenges: WHO assessment instruments show that women have greater needs for services in middle- and low-income countries yet have far less access to them than men.

Smoking increases the danger of cancer of the lungs, chronic obstructive pulmonary disease (COPD) and heart disease in women and reduces the birth weight of the newborn, if continued during pregnancy.

Gaps: Women are disproportionately hit by Alzheimer's disease and dementia. Yet services are under-resourced in high-income countries and almost absent in low- and middle-income countries. Violence against women and rape and its subsequent lack of attention from the authorities is a major cause of depression among women in some countries in Africa (reported from Uganda). In many countries (including in high-income countries) mental health services are less accessible to marginalized populations. On top of that, linguistic and cultural barriers remain for ethnic minorities.

Good practices: WHO has started its "maternal mental health" pilot programme in Eritrea and completed needs assessment for the same in Nigeria and Ethiopia. Suicide prevention pilot programmes have also started in Asia targeting control of pesticides (facilitating suicide) among rural women. In all above-mentioned programmes (including mhGAP), women have been involved at different phases from planning to implementation. Alzheimer's Disease International (ADI) is campaigning for more awareness, recognition and local solutions for better services in every country.

Recommendations: More attention needs to be paid to women-specific conditions such as postpartum depression.

Women who are not thinking of quitting smoking should be made aware of and educated about the pros and cons of quitting versus continuing smoking. In addition, those who quit would require ongoing support so as not to restart smoking.

22. Subtheme: women and disabilities

Achievements: After considerable advocacy, disability is now being considered as a condition and not a disease (even though it may occur as a consequence of a disease).

Challenges: Measuring progress remains a challenge as there is hardly any documentation about women with disability (WWD) and girls with disability (GWD) at the country level.

Gaps: State or NGO reports seldom mention WWD/GWD. WWD have much less access to assistants, sign language interpreters, information, buildings and facilities, guides or other support services compared to men with disabilities. There are gaps between human rights obligations towards WWD and the reality of many legal systems.

Good practices: Struti Disability Rights Centre, an NGO in Kolkata, India is strongly advocating to the local authority to document and act on the cases of violence against disabled women.

Recommendations: All governments that have ratified the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) and the Convention on the Rights of Persons with Disabilities (CRPD) should address the needs of WWD and GWD in their national policies and programmes. In particular, they should meet their needs concerning health care, both primary and advanced care, and secure informed consent from WWD/GWD before any treatment.

"Unfortunately, in their official national reports to the UN Commission on the Status of Women (CSW) and the reporting on the Beijing Declaration and Platform for Action, neither women's NGOs nor the UN system, nor different Governments effectively demonstrate these commitments to women and girls with disabilities. At most, these reports mention women and girls with disabilities in the context of other "marginalized groups", without any particular analysis of their specific needs. States show very little interest in the multiple discriminatory situations under which many WWD live. The Convention on the Rights of Persons with Disabilities (CRPD) recognizes that women and girls face particular and severe multiple discrimination, but this is not recognized in the report to the UN CSW on progress achieved since 1995." - Kicki Nordström

Chapter 8: Week 9, Jan 18-Jan 25, Wrapping up; Evaluation.

The participants thought that the discussion was useful and most of them would use the knowledge that they gathered in their daily work. About 50% preferred the daily digest and the other 50% preferred immediate e-mails as mode of communication. All except two participants thought that the technical content and the way the discussion was conducted were the best possible. Two participants thought it could have been better if the discussion had been announced much earlier. There would have been many more participants. Participants would also have preferred to being asked in the beginning about their expectations. But they understood that time was short compared to the vast scope of discussions.

Early on in the process, one of the participants sent out the weekly summary to relevant directors of her region (Asia) and these responded promptly by instructing their departments to include gender analysis in all programmes.

Conclusion

There was a strong demand from the participants of the discussion community for a progressive world order for the health of women. They denounced the negative attitudes of male decision-makers that halted progress and made the agenda move backwards. They thought there was a dual standard when it came to issues that concerned only women such as unsafe abortion, maternal health or contraception.

Health service providers needed to be sensitive to the needs of women across their life-course, including older women, women with disability, adolescent girls, most-at-risk groups of women, HIV-positive women, migrants, refugees, IDPs and widows.

With the global gag rule not in operation, it was time to move forward with legalization of abortion where possible, or alternatively, at least decriminalization of abortion.

The national governments and their development partners had to exercise leadership to end harmful traditional practices such as FGM, child marriage, female foeticide/infanticide and sexual and gender-based violence against women as all of these were causing harm to the physical and mental health of girls and women.

Natural disasters, climate change and influenza epidemics needed to be brought into the health paradigm.

National policy-makers and health planners needed to mobilize communities and hold all stakeholders accountable. If gender was mainstreamed into their accounting and data collection, analysis and reporting, evidence-based decision-making would allow to give women and girls their human right to health.

There were sound political, social and economic reasons to invest in the health of a woman over her life-course, i.e. the girl child, the adolescent girl, the adult woman and the older woman. The financial loss from not doing anything today was far larger than the economic loss in spending a tiny part of that amount today.

Donors were asked to stick to their promises and pool together US$30 billion that could help meet the goals of MDGs 4 and 5.

It was thought that 15 years after Beijing, all policies that stood in the way of saving a woman's life should be discarded and a new social order welcomed. This would be a grassroots movement where every woman would stand up for her rights to change the health of women for the better.

However, the agenda above could not be accomplished unless men and boys were engaged as partners. Only then would women indeed enjoy community norms and health systems that are gender-sensitive, culturally sensitive and based on human rights.

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