NATIONAL MEETING ON WOMEN, HEALTH AND DEVELOPMENT

New Delhi, 21 October 1993

World Health Organization
Regional Office for South-East Asia
New Delhi, India

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Participants

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THE National Meeting on Women, Health and Development (WHD) was organized by the India Office of the World Health Organization (WHO) on 21 October 1993 at the Hamdard Convention Centre, Hamdard Nagar, New Delhi. In all, 40 participants attended the meeting, representing the Ministry of Health and Family Welfare and other bodies of the Government of India; health and educational institutions and non-governmental organizations from various States; WHO Offices for India and for the South-East Region; and UN and donor agencies. The list of participants is attached.

The overall purpose of the meeting was two-fold: (1) to provide an orientation on the Women, Health and Development initiative in WHO and the newly established Global Commission on Women's Health, and (2) to identify issues of major concern to the health of women in India and propose broad strategies for addressing the issues identified. It was intended that the outputs of the meeting would provide means for identifying priorities for country level WHO activities related to WHD as well as substantial technical inputs to the Global Commission on Women's Health.

The meeting was inaugurated by H.E. Mrs Margaret Alva, Minister of State for Personnel, Public Grievances and Pensions, Government of India. Dr D.B. Bisht, Acting Regional Director, Regional Office for South-East Asia, welcomed the participants on behalf of WHO.

INTRODUCTION

Dr Sally Ann Bisch, Chairperson, Women, Health and Development, WHO Regional Office for South-East Asia, presented an overview of the WHD initiative in WHO and recent developments, including the establishment of the Global Commission on Women's Health. The Commission consists of political, scientific and professional leaders throughout the world, the largest number of whom are women, who serve in their personal capacities. The Commission is expected to adopt a grassroots strategy whereby the technical groundwork, including inputs and follow-up actions, will be supported by

country and regional networks of individuals, institutions and organizations, both governmental and non-governmental, who are already actively involved in a broad range of women's health and related development issues. The Commission will soon convene its first meeting and is expected to provide a forum for consultation and dialogue on women's health, to advocate for women's health issues and to produce an agenda for action on women's health. She noted that the WHD initiative and the Commission are adopting a life-cycle approach in which women's health is conceived as encompassing their health throughout their entire life-span, not only through the reproductive years, and in all aspects of their lives. Facets of women's health deserving greater attention include health issues of women at work in the home as well as in the formal and informal work sectors, life-style related health conditions, health consequences of violence, and aging.

The participants continued the discussion in four working groups. The atmosphere of the group discussion was marked by enthusiastic dialogue and open debate on priority women's health issues and strategies. The participants welcomed the opportunity for a free exchange on a broad range of issues, although the time to address each issue was limited.

OUTCOMES

The issues that emerged from the group discussions fell into three main areas; (1) issues dealing with specific women's health concerns, (2) issues related to health services, and (3) issues related to macro-level policies affecting women's health. An overall theme that emerged was the endorsement of a life-cycle approach as the basic framework for addressing women's health and development issues. In fact, many of the specific women's health concerns that emerged followed this framework, i.e. from the concerns surrounding selective abortion of female foetuses and female infanticide; nutrition, education and child abuse in early childhood; early marriage, early pregnancy and sexual exploitation in adolescence; reproductive and sexual health, fertility regulation, occupational health hazards, overburden and stress-related disorders in the productive and reproductive age category; and menopause and emotional health associated with aging.

Issues	Broad Strategies
SPECIFIC WOMEN'S HEALTH CONCERNS	
1. General lack of accurate gender and age specific morbidity, mortality and disability data which is essential in order to have an understanding of a complete picture of women's health problems across their life-span and in all aspects of their lives.	Collect gender/age disaggregated data at all levels by national, regional and community-based organizations. Inculcate sensitivity on gender issues in health and development related research. Reorient research institutions and support research studies to focus on gender differentials, e.g. in communicable diseases like TB and STDs, with wide dissemination of findings.
2. Health issues of women at work in both formal/ informal (unorganized) sectors and in the house-hold. Lack of information about women's workload and impact on health, including exposure to environmental and work-related health hazards. Undervaluing of women's health complaints relative to work, especially sexual harassment and psycho-logical stress.	Stimulate and support small-scale studies by governments, NGOs, and women's, health and consumer groups. Provide resources to study new, less hazardous technologies. Impart health education in the workplace on workers' health and safety. Review and analyze existing occupational health laws and regulations and development of mechanisms to ensure their proper implementation. Institute mechanisms to provide pensions and social security for women.
3. Violence against women, including physical and emotional abuse in the home and the workplace, sexual harassment, rape, incest, dowry harassment, human rights violations. Lack of adequate information on the nature and extent of health consequences despite the increase in incidence.	Stimulate further dialogue by women and women's groups. Conduct seminars to inform and sensitize mass media. Use media, existing movements, networks and campaigns. Review and analyze existing laws and regulations. Support legal literacy. Promote economic empowerment of women (work and asset creation). Develop shelters for women through women's groups. Provide rehabilitation for women, including emotional support and work opportunities.

4. Impact of new contraceptive and reproductive technologies on women's health, particularly adverse side effects. Treatment of women as targets in family planning programmes contributing to continued low status of women.	Conduct more research on new technologies and their sideeffects. Disseminate widely debate on findings before large-scale promotion of technologies. Support development of safe, effective female-controlled technologies.
5. Psychological and mental health, i.e. low self-esteem; substance abuse.	Use available resources to create/promote positive images of women in society, i.e. mass media, education in the schools, changes in parenting practices. Make counselling and education services available and easily accessible. Advocate to create awareness and support. Mobilize women's self-help groups.
6. Special problems (e.g. health, social, legal) of aging/elderly women. Breakdown of traditional support system and increase in number of older women necessitating greater outside support to attend to their needs, but which is not being adequately addressed in the health care system.	Train personnel to care for elderly women in their homes through assistance of NGOs along with governments. Initiate health promotion programmes for older women to maintain health and well-being. Support families who have disabled older female members to enable them to obtain the health care needed.
7. STDs and AIDS, particularly negative messages and misinformation. View of women as vectors of the virus and responsible for the spread of HIV infection rather than as vulnerable recipients.	Widely disseminate information through health education and training involving local and community-based groups.

HEALTH CARE SERVICES	
1. Gender discrimination in health care as a reflection of society as a whole, insensitivity to women's perspectives, and distortions in health care expenditures.	Reorient and restructure the health care system (modification of PHC approach) to be sensitive to sociocultural milieus and to women's needs and priorities, i.e. timings and location of health facilities suitable to women's work/household responsibilities. Reorient and sensitize medical professionals to women's perspectives and concerns. Integrate gender/sexuality issues in existing curricula. Conduct participatory research involving women in the design, implementation and analysis of studies. Promote awareness-raising and advocacy using mass media on specific discriminatory practices, e.g. female foeticide/infanticide. Allocate appropriate health resources for programmes directly affecting women. Mobilize NGOs to create strong political lobby
2. Centralized health care system fostering inadequate involvement and consideration of choices of women. Limited local accountability, decision-making and control.	Decentralize health services planning and implementation to local level. Use Panchayati Raj for local planning and monitoring of health services. Strengthen local women's groups and organizations to develop and be responsible for local planning, implementation and monitoring of health services. Promote involvement of local female health functionaries. Restructure health care delivery from a vertical to an integrated, rational, humanistic approach. Link health services to other development programmes at local level, i.e. PDS, ICDS, education, employment, etc. Develop qualitative indicators for monitoring health services
3. Target approach in health services delivery, with women viewed as targets for specific purposes, such as population control.	Promote involvement of women as active participants in policy and decision making at national and local levels and in the formulation, implementation and monitoring of programmes. Redefine targets for health indices, e.g. MMR.

4. Women's health care including reproductive health and contraception.	Develop integrated female-oriented services which are nondiscriminatory, easily accessible and which provide sensitive counselling and education in addition to direct services. Expand reproductive health services to include RTIs, STDs, AIDS and common gynaecological problems. Promote research and innovative interventions which incorporate men's responsibility as well as women's (or families') for contraceptive use. Promote sexuality and lifestyle education in schools. Strengthen MTP services.
5. Lack of proper information for women on their own bodies and health, the health system, etc. Yet information and education can be empowering, leading to greater awareness and greater demand for services.	Produce and disseminate health education materials. Create forums for exchange of experiences on health matters, i.e. small group discussions, training. Use mass media.
6. Inadequate use of traditional wisdom and knowledge of women related to food, health, etc. and traditional practices.	Conduct research on traditional practices. Integrate of traditional and modern practices and resources.

POLICIES AFFECTING WOMEN	
1. Development of economic policies and programmes outside the health sector, i.e. structural adjustment, environment, etc., which often have adverse effects on women, e.g. erosion of food security, deterioration of nutritional status, destruction of natural resources, increase in prostitution, etc.	Implement short and long term strategies to work for mitigation and ultimate prevention of negative consequences, such as: assess and analyze effects on women; provide a health component in development projects; monitor effects at household level, e.g. food consumption; promote community-level management of development projects; dialogue and interlink among the various departments and sectors involved; strengthen women's representation in the Panchayat system; train women to be able to have effective influence; make health system sensitive to emerging problems and consequences of policies; mobilize various groups, e.g. UN/national agencies, women's groups, NGOs; create pressure groups at local, national and international levels; sensitize administrators, policy makers, researchers, media, NGOs, etc. to adverse effects of destruction of natural resources; widely disseminate information through campaigns and mass media to create awareness and support.
2. Population policies which are adversely affecting women's health and well-being.	Modify family planning programmes to: eliminate target approach, camps, incentives and disincentives, be user rather than provider oriented; ensure informed consent; provide appropriate, acceptable contraceptive technologies and essential back-up services.

CONCLUSIONS

A number of issues were discussed throughout the day. No attempt was made in the concluding session to arrive at a consensus on the top priorities. However, several key themes seemed to emerge again and again and thus pointed the direction for future action. These are:

- The need for more gender and age-specific data and research on women's health issues and related concerns.

- The need to sensitize policy and decision-makers, both men and women, to gender issues.

- The need for greater involvement of women and women's groups at all levels in policy-making and in the design, implementation and monitoring of health programmes.

- The need to reorient/restructure the health care system, including health personnel to be more sensitive to gender issues, humanistic and responsive to women's needs and priorities.

- The need to adopt a life-cycle approach to women's health so that health care strategies are designed to cover the broad spectrum of women's health problems through an integrated approach.

FOLLOW-UP

A number of suggestions were made for follow-up, including those which could be undertaken by WHO:

(1) Compile and review information already available on women's health from completed and ongoing research, even small-scale studies, in order to build on this knowledge base and identify priority areas for continued and/or new research.

(2) Critically examine the impact of national development and related policies on women's health.

(3) Set up processes for women and women's groups to continue the dialogue on women's health and share concerns, experiences and expertise.

(4) Disseminate information on women's health issues through a newsletter or other mechanisms.

(5) Develop a database to promote and support networking among NGOs, women's groups, government, and UN and donor agencies.

(6) Promote a multicentre study through a network of NGOs to identify areas of gender bias in the health care system and specific changes needed to humanize service delivery.

(7) Consolidate the contribution of NGOs and women's groups in women's health and health care, especially through local area networks.

(8) Promote a regional perspective on women's health.

(9) Develop qualitative indicators for monitoring.

In response to queries regarding the next step, the organizers indicated that the first follow-up action would be dissemination of the report of the meeting to the participants and other interested parties. The outcomes and suggestions would also be shared with the Global Commission on Women's Health and would serve to provide direction to the work of WHO in Women, Health and Development at country and regional levels. Some of the suggestions are already being taken up, such as the compilation of existing research on women's health as the basis for setting a research agenda and for the future development of a database and dissemination of information.

It was generally agreed that the dialogue during this meeting was productive, even though time was limited, and that the interest and enthusiasm generated should not end with this meeting. Participants expressed a desire for

continued networking, even though it was recognized that this would be difficult without a clear purpose and commitment from the group. Some of the follow-up actions identified could provide starting points, such as gathering information and reviewing research studies on women's health. Gender discrimination in macro-level policies and in the health care system seemed to emerge as a priority issue around which collective effort could be mobilized. The group welcomed this initiative by WHO and looked forward to further collaboration.