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The Western Pacific Regional Office of WHO responded to the ICPD Programme of Action (1994) and the Beijing Platform for Action (1995) with a series of publications and workshops on women’s health throughout the 1990s. These addressed reproductive health, women and development, women and ageing, women and lifestyles, gender-based violence, occupational health and women’s health in a social context. The United Nations Millennium Development Goals project (2000) provided another major impetus for concerted action in the WPR which led to a plethora of publications, workshops and intervention initiatives throughout the Region dealing with the nexus between poverty, gender and health.

Review of progress in meeting the targets of the MDGs at country and regional levels has shown that despite some significant gains in women’s health since 1990, substantial challenges remain. These challenges consist of a combination of persistent problems evident in the 1990s and new globalized risks such as the health effects on women and girls of global warming and the global financial crisis and pandemics of new infectious diseases. High rates of maternal and infant mortality, high fertility rates, endemic and epidemic communicable diseases, and low rates of female literacy and education persist in several low income countries of the Region. Gender-based violence, non-communicable diseases and lack of reproductive health services persist in all countries of the Region. These persistent issues, combined with the emergent challenges for women and girls in the Region urgently require new approaches, even before the 2015 target date for the MDGs.

Many of these challenges result from problems that were not addressed early in the lifespan, which have intergenerational effects. All have social, economic and cultural determinants which have yet to be adequately explored. It is imperative in meeting the health needs of women and girls in the twenty first century that interventions are developed which are as upstream as possible, both in terms of lifespan and social determinants. For this to be effective, sex-disaggregated and gender analysed data, and new ways of measuring health and well-being outcomes, such as quality of life, are key ingredients. It is important that not only are women’s lives extended, but that women and girls have optimal opportunity to live, fulfilled and contented lives.

The outcome document from the United Nations Summit on the MDGs, held in New York in September 2010, emphasizes that women’s health and well-being are pivotal to achieving all of the MDG targets. It also acknowledges the key role that women play as providers of health and decision makers in policy and provision of health services. Therefore, it is now more important than ever that WPRO and its member states renew our efforts toward maximizing the opportunities to achieve universal health and well-being for women and girls from all backgrounds and involve women in the process. The challenge is to develop a women and health agenda, both within the MDG target date and beyond 2015, to optimize opportunities for universal health and well-being for girls, women and their communities. This Report serves as a catalyst for that process.
ABBREVIATIONS

AIDS  Acquired Immunodeficiency Syndrome
ANC  Antenatal Care
ARH  Adolescent Reproductive Health
ARV  Antiretroviral therapy
BPFA  Beijing Platform for Action
DALY  Disability Adjusted Life Year
GDI  Gender Development Index
GEM  Gender Empowerment Measure
HALE  Health-adjusted Life Expectancy
HDI  Human Development Index
HIV  Human Immunodeficiency Virus
HPI  Human Poverty Index
ICPD  International Conference on Population and Development
IDU  Injecting Drug User
IEC  Information, Education, and Communication
IUD  Intra-Uterine Device
MARP  Most-At-Risk Populations
MDGs  Millennium Development Goals
MNCH  Maternal, Neonatal and Child Health
MPI  Multidimensional Poverty Index
MSM  Men-who-have-sex-with-men
NGO  Nongovernmental Organization
PMTCT  Prevention of Mother-to-Child Transmission
PPC  Post Partum Care
QA  Quality Assurance
QC  Quality Control
RH  Reproductive Health
RTI  Reproductive Tract Infection
STD  Sexually Transmitted Disease
SRH  Sexual and Reproductive Health
STI  Sexually Transmitted Infections
WHO  World Health Organization
WPR  Western Pacific Region
YLD  Years of life with Disability
YLL  Years of life Lost
CHAPTER 1

ACHIEVEMENTS AND REMAINING CHALLENGES FOR WOMEN'S HEALTH IN THE WPR

1.1. Why women's health?

The reasons for concentrating on women's health in the WPR mirror those expressed in WHO's global report Women and Health – Today's Evidence, Tomorrow's Agenda (2009). Significant advances in women's health have been enjoyed in the WPR over the past twenty years but major challenges remain which need to be met with new approaches and commitments. These challenges encompass persistent problems (maternal mortality and domestic violence) and emergent globalized risks (climatic, economic and viral) which have gendered implications. The health, social and economic costs of not addressing these challenges are unsustainable at global, regional, national and household levels. Women and girls in the Region, like those in the rest of the world, have particular needs and, in many cases, the health systems are failing them (Crossette, 2006). These needs are not just sex specific issues related to reproductive health, but also involve differential access to services and gender-differentiated general health experiences and outcomes.

The nexus between gender and health is a complex interaction among many factors. Social, economic, political, environmental and cultural processes contribute to women's health alongside biological factors. It is thus vital to adopt a comprehensive inter-sectoral approach to policy, human resources planning and service provision for health. Health is the sum total of the successful attainment of a state of wellness at earlier stages of life and the acquired capacity to resist disease at each stage of the lifespan. These cumulative effects make it important to look at the entire lifespan in examining the causes and consequences of women's health and illness outcomes.

1.2. What has been achieved in the WPR: Remaining Challenges

As the chapters to follow reveal, great strides have been made in achieving better health outcomes for women and girls in all countries of the Western Pacific Region over the past two decades. On most indicators of health and wellbeing, and of gender equity, countries in the Region have displayed significant improvements since endorsing the recommendations of the ICPD Program of Action (1994) and the Beijing Platform for Action (1995). However, regional and country level progress reports on the Millennium Development Goals point to major remaining challenges and barriers to achieving optimum health outcomes for all girls and women. Many of these challenges are eminently solvable, and many of the barriers removable, with political will, targeted resources and concerted effort from all sectors of society. The remaining challenges relate partly to the huge diversity of circumstances of member states in the WPR, and inequities between groups of people within member states.

The Region has some of the richest and most developed countries of the world and some of the poorest and least developed. The countries and areas also vary along many dimensions other than level of economic development including climate, terrain, population size, and ultimately health.
priorities. The Region contains both the most populated country in the world (China with a population of 1.4 billion) and the least populated countries, namely Niue and Tokelau with populations of 1,400 each. This diversity inevitably leads to differing health outcomes and priorities for health. Diversity occurs within countries too. Intra-country variations in economic, social, cultural and environmental circumstances can lead to significant disparities in health experiences and outcomes for women.

Although most of the countries and areas of the WPR were signatories to the ICPD Program of Action (1994) and the Beijing Platform for Action (1995), they have varied in their pace of response to these forums which were blueprints for action to improve women’s health and women’s role in health. The key factors in this diversity have been economic capacity and political will on behalf of all sectors of society. Evidence shows that improving women’s health experiences and outcomes benefits all members of society. Evidence, however, depends considerably on data that are reliable and useful, including data that are disaggregated by sex that allow male-female comparison. This is not always available. Having reliable sex disaggregated data is critical to understanding women’s health in the Region because only when such data are available can gender analysis be undertaken. Lack of sex-disaggregated data remains a problem in many countries in WPRO as well as on a worldwide scale. In the WHOSIS 2010 report, out of 156 indicators, less than 10% (only 14) are reported in a sex-disaggregated form. This is an improvement compared to ten years ago, when only about 3% of indicators were sex-disaggregated. However, this is still insufficient as the basis for comprehensive gender analysis and formulation of policies to further enhance women’s and girls’ health and well-being.

1.2.1. Demographic pattern - its relevance to women

Figure 1 shows the different stages of demographic transition for three countries of the Region. Japan, a developed high income country, clearly shows population ageing with a very small proportion of young people below 15 years of age. China, as a middle-income country in transition, displays a population pattern which is not as ‘top heavy’ as Japan’s but reveals a constricting under 20 years cohort and an expanding 60+ years group. Lao PDR, as a low income developing country, has a population profile which is still very ‘bottom heavy’ with a predominantly younger population. As the population ages, the proportion of women in the older age groups is larger than that of men. Population ageing is a feature of all countries of the WP Region, but the rate of ageing differs from country to country. The proportion of people aged sixty and more (Figure 2) is highest in Japan where more than a quarter (25.9%) of men and almost a third of women (31.6%) are in this age group. This is followed by Australia, NZ, Korea, Hong Kong, Singapore and China where more than 10% of the population (both male and female) are older than 60 years. These population profiles are a reflection of the crude death rate, crude birth rate and total fertility rate of the countries. High fertility in some countries also contributes to high maternal and infant mortality, and is a reflection of unmet needs for contraception. This underscores the importance of acceleration of actions in these countries towards the achievement of MDG5.
Figure 1  % population by Age group and sex, Japan, China and Lao PDR, 2010

Japan

Source: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat,
World Population Prospects
Figure 2 Percentage of Men and Women age 60 and over, by Countries, WPR, 2010

<table>
<thead>
<tr>
<th>Country</th>
<th>Percentage of Men</th>
<th>Percentage of Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Papua NG</td>
<td>4.2</td>
<td>6.7</td>
</tr>
<tr>
<td>Solomon Is</td>
<td>4.5</td>
<td>7.4</td>
</tr>
<tr>
<td>Brunei</td>
<td>5.2</td>
<td>7.4</td>
</tr>
<tr>
<td>Vanuatu</td>
<td>5.7</td>
<td>7.9</td>
</tr>
<tr>
<td>Lao PDR</td>
<td>6.1</td>
<td>8.8</td>
</tr>
<tr>
<td>Cambodia</td>
<td>6.4</td>
<td>8.8</td>
</tr>
<tr>
<td>Philippines</td>
<td>6.8</td>
<td>8.8</td>
</tr>
<tr>
<td>Samoa</td>
<td>7.9</td>
<td>9.9</td>
</tr>
<tr>
<td>Palau</td>
<td>8.8</td>
<td>9.9</td>
</tr>
<tr>
<td>Malaysia</td>
<td>8.8</td>
<td>9.9</td>
</tr>
<tr>
<td>Fiji</td>
<td>8.8</td>
<td>9.9</td>
</tr>
<tr>
<td>Viet Nam</td>
<td>8.8</td>
<td>9.9</td>
</tr>
<tr>
<td>Tonga</td>
<td>8.8</td>
<td>9.9</td>
</tr>
<tr>
<td>China</td>
<td>8.8</td>
<td>9.9</td>
</tr>
<tr>
<td>Papua New Guinea</td>
<td>8.8</td>
<td>9.9</td>
</tr>
<tr>
<td>R. Korea</td>
<td>12.7</td>
<td>15.9</td>
</tr>
<tr>
<td>Hong Kong</td>
<td>15.9</td>
<td>15.9</td>
</tr>
<tr>
<td>New Zealand</td>
<td>16.1</td>
<td>17.9</td>
</tr>
<tr>
<td>Australia</td>
<td>19.9</td>
<td>19.9</td>
</tr>
<tr>
<td>Japan</td>
<td>31.5</td>
<td>31.5</td>
</tr>
</tbody>
</table>


Life expectancy is generally higher for women than men, and this is true for virtually all of the countries of the WP Region. However, health-adjusted life expectancy (HALE\(^1\)) provides a more complete picture of health outcomes than life expectancy at birth. Figure 3 shows that HALE for women in the Region is between 70 and 80 in five high-income countries, and does not exceed 60 in many countries in the low income and lower-middle categories. The improvement between 2002 and 2007 is more marked in the lower income countries, while the high income countries with an already high HALE, as expected, have seen little change.

Figure 3 Female Health-adjusted Life Expectancy in 2002 and 2007, by Countries, WPR


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\(^1\) Health-adjusted life expectancy (HALE) attempts to capture a more complete estimate of health than standard life expectancy rates. HLE estimates represent the number of expected years of life equivalent to years lived in full health; therefore it is a measure of not only quantity but also quality of life.
1.2.2. Morbidity and mortality

Although women have higher life expectancies and HALE than men in all countries of the WPR, women have higher rates of morbidity, disability and lower objective conditions for quality of life. In Figure 4, the total Disability-Adjusted Life Years (DALY) ² of countries show this trend clearly with one extreme represented by Japan (7.34 years of life).

The ten leading causes of DALYs lost in the Region are shown in Table 1. For both sexes, the leading contributors to DALY losses are neuropsychiatric conditions and cardiovascular disease, with men having higher DALYs lost than women. Malignant neoplasm is the fourth largest cause of DALY loss for both sexes. Unintentional injuries (largely contributed by road traffic accidents) are the third cause in men and the fifth in women, with the DALY loss in men almost twice as high as in women. Intentional injuries are the tenth leading cause for women and do not appear in the ten leading causes for men. This is a clear indication of the socially-determined risk for women as victims of violence, with the underpinning factors of gender discrimination and disempowerment of women. It is also noteworthy that infectious and parasitic disease appears in the ten leading causes, ranking sixth for both men and women. This reflects the double burden of disease in the Region where a large number of middle income, and even low income, countries are undergoing epidemiological transition, moving from communicable to non-communicable diseases as the leading cause of death and disability, but retaining high levels of infectious diseases.

**Figure 4 Age standardised DALYs, females all ages by countries, WPR, 2004**

<table>
<thead>
<tr>
<th>Country</th>
<th>Age Standard DALY Rate (per 100,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Japan</td>
<td>7.34</td>
</tr>
<tr>
<td>Australia</td>
<td>6.21</td>
</tr>
<tr>
<td>Singapore</td>
<td>9.59</td>
</tr>
<tr>
<td>SD Korea</td>
<td>0.92</td>
</tr>
<tr>
<td>New Zealand</td>
<td>10.60</td>
</tr>
<tr>
<td>Brunei</td>
<td>12.99</td>
</tr>
<tr>
<td>China</td>
<td>14.67</td>
</tr>
<tr>
<td>Malaysia</td>
<td>14.84</td>
</tr>
<tr>
<td>Cook Is</td>
<td>15.07</td>
</tr>
<tr>
<td>Vietnam</td>
<td>15.63</td>
</tr>
<tr>
<td>Niue</td>
<td>16.23</td>
</tr>
<tr>
<td>Micronesia</td>
<td>16.71</td>
</tr>
<tr>
<td>Tonga</td>
<td>17.41</td>
</tr>
<tr>
<td>Fiji</td>
<td>17.45</td>
</tr>
<tr>
<td>Samoa</td>
<td>17.86</td>
</tr>
<tr>
<td>Philippines</td>
<td>18.39</td>
</tr>
<tr>
<td>Palau</td>
<td>18.96</td>
</tr>
<tr>
<td>Vanuatu</td>
<td>19.38</td>
</tr>
<tr>
<td>Solomon Is</td>
<td>19.97</td>
</tr>
<tr>
<td>Mongolia</td>
<td>19.99</td>
</tr>
<tr>
<td>Kiribati</td>
<td>22.08</td>
</tr>
<tr>
<td>Nauru</td>
<td>23.97</td>
</tr>
<tr>
<td>Marshall Is</td>
<td>24.54</td>
</tr>
<tr>
<td>Tuvalu</td>
<td>26.45</td>
</tr>
<tr>
<td>Papua NG</td>
<td>27.63</td>
</tr>
<tr>
<td>Vanuatu</td>
<td>31.18</td>
</tr>
<tr>
<td>Centrolia</td>
<td>33.64</td>
</tr>
</tbody>
</table>


² Disability adjusted life years (DALY) is a measure of overall disease burden; it is the sum of potential life lost due to premature mortality (years of life lost or YLL) and the years of productive life lost due to disability (years of life with disability of YLD).


Table 1  Top 10 Leading Causes DALYS, by sex, WPR, 2004 (Lopez and Murray, 2009)

<table>
<thead>
<tr>
<th>Causes</th>
<th>WOMEN DALYS</th>
<th>Causes</th>
<th>MEN DALYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neuropsychiatric conditions</td>
<td>22 820 242</td>
<td>Neuropsychiatric conditions</td>
<td>25 740 689</td>
</tr>
<tr>
<td>Cardiovascular diseases</td>
<td>14 217 061</td>
<td>Cardiovascular diseases</td>
<td>17 542 316</td>
</tr>
<tr>
<td>Sense organ diseases</td>
<td>12 874 869</td>
<td>Unintentional injuries</td>
<td>17 447 156</td>
</tr>
<tr>
<td>Malignant neoplasms</td>
<td>9 831 635</td>
<td>Malignant neoplasms</td>
<td>15 020 930</td>
</tr>
<tr>
<td>Unintentional injuries</td>
<td>9 183 375</td>
<td>Sense organ diseases</td>
<td>12 771 044</td>
</tr>
<tr>
<td>Infectious and parasitic diseases</td>
<td>8 186 639</td>
<td>Infectious and parasitic diseases</td>
<td>11 573 928</td>
</tr>
<tr>
<td>Perinatal conditions (e)</td>
<td>7 374 525</td>
<td>Respiratory diseases</td>
<td>10 775 204</td>
</tr>
<tr>
<td>Respiratory diseases</td>
<td>7 337 492</td>
<td>Perinatal conditions (e)</td>
<td>7 088 123</td>
</tr>
<tr>
<td>Musculoskeletal diseases</td>
<td>5 218 542</td>
<td>Digestive diseases</td>
<td>5 393 079</td>
</tr>
<tr>
<td>Intentional injuries</td>
<td>3 183 925</td>
<td>Musculoskeletal diseases</td>
<td>4 199 507</td>
</tr>
</tbody>
</table>


Countries also experience different levels of mortality, in the general population and between males and in females. Female mortality rates from all causes are high in the low income countries, while the upper income countries record lower mortality rates. These extremes are shown by Cambodia which has a female mortality rate of 1,369 per 100,000, and Japan with a female mortality rate of 261 per 100,000 as seen from the age-standardized mortality rates shown in Figure 5.

Figure 5 Age Standardized Mortality Rate (per 100 000 all causes, females by country WPR, 2004)

Figure 5 clearly shows three levels of mortality for selected countries in the Region - high rates for six low income countries, low rates for six high income countries, and medium rates for thirteen middle-income countries. While morbid conditions from communicable diseases, non-communicable diseases and injuries take a heavy toll on women's health, as they do in men, the burden can also be measured in terms of DALYs lost for risk factors.

Figure 6 Attributable DALYs from risk group, Females aged 15-59 Yrs, WPR, 2004

<table>
<thead>
<tr>
<th>Attributable Fraction (%) of DALYS for Mortality, Female All aged, WPRO, 2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Factors</td>
</tr>
<tr>
<td>Occupational risks</td>
</tr>
<tr>
<td>Lead exposure</td>
</tr>
<tr>
<td>Urban outdoor air pollution</td>
</tr>
<tr>
<td>Child sexual abuse</td>
</tr>
<tr>
<td>Unsafe health care injections</td>
</tr>
<tr>
<td>Unsafe sex</td>
</tr>
<tr>
<td>Low fruit and vegetable intake</td>
</tr>
<tr>
<td>High cholesterol</td>
</tr>
<tr>
<td>Sub-optimal breastfeeding</td>
</tr>
<tr>
<td>Iron deficiency</td>
</tr>
<tr>
<td>Underweight</td>
</tr>
<tr>
<td>Indoor smoke from solid fuels</td>
</tr>
<tr>
<td>Unsafe water, sanitation, hygiene</td>
</tr>
<tr>
<td>Physical inactivity</td>
</tr>
<tr>
<td>Alcohol use</td>
</tr>
<tr>
<td>Overweight and obesity</td>
</tr>
<tr>
<td>Tobacco use</td>
</tr>
<tr>
<td>High blood pressure</td>
</tr>
</tbody>
</table>


Figure 6 shows the attributable DALYs from specific risk groups in women aged 15-59 years. The risk factors that contribute to the highest loss of DALYs are high blood pressure, high blood glucose, tobacco use, overweight and obesity, physical inactivity, indoor smoke from solid fuels and occupational risks. The contribution of poor nutrition is also substantial. Suboptimal breast feeding, underweight and iron deficiency are attributable causes for lost DALYs in low income countries. At the other end of the spectrum, in high and middle income countries, overweight and obesity physical inactivity and low fruit and vegetable intake contribute significantly to DALYS lost.

Non communicable diseases are either an established or an emerging public health problem in the Region, with several countries facing the double burden of disease in their transition from developing to developed nations. However, the key priorities for women's health in the least developed and poorest countries of the Region remain maternal mortality and morbidity and the conditions that often accompany maternal illness such as malaria and anaemia. The risk of a woman dying from pregnancy and childbirth related causes is a major issue in some countries of the Region, and the maternal mortality ratios in these countries are unacceptably high. Each year, an estimated 30,000 mothers in the WPR still die during pregnancy or childbirth, and among those...
who survive, many of them experience lifelong health complications. Therefore there is need for several countries to step up their efforts, and for other member states in the Region to provide support, to achieve MDG5a to reduce maternal mortality for the entire WPR (Tulloch, 2005). This is closely linked to the challenge for all countries in the Region to achieve universal access to reproductive health as stipulated in MDG5b.

As outlined in Chapter 2 below, women's and girls' health needs and risks vary across the life-course, although some issues such as gender-based violence, substance abuse and smoking span several stages of life.

Reference

CHAPTER 2
WOMEN'S HEALTH ACROSS THE LIFE SPAN

2.1. Prenatal, infancy and girlhood

In the prenatal and early childhood stages of life, health inequities between, and within, countries are most prevalent. Pregnancy, birth, infancy and early childhood represent some of the safest points of life in the economically advanced communities of the Region, but the most vulnerable times for those living in the least economically advanced communities, including for marginalized groups in highly developed nations.

Historical, economic, political, social, cultural, geographical and environmental factors combine with physiological factors to contribute to these health inequities in the early stages of life. Socially constructed understandings of gender (leading to prenatal sex selection and differential nutrition and education between girls and boys) combine with differential physiological responses and predispositions to produce unequal health outcomes.

2.1.1. Equal rights to be born

The majority of countries in the WPR have male to female sex ratios at birth of between 1.04 and 1.05 which represents the slight biological skew in favour of boys at birth which later evens out as more female than male infants survive. A key recommendation of all international calls for action and conventions that deal with gender is that females have an equal right to be born as males. Given the tradition of son preference in some countries in the Western Pacific Region, one of the unintended consequences of well-meaning family planning policies on a national scale, in some of these countries, has been selective abortion of female fetuses, following sex determination, leading to an even more skewed demographic profile than that which occurs naturally. China, South Korea, Vietnam and Hong Kong continue to experience significant sex skewed demographic profiles in the younger age cohorts. South Korea has started to reverse this trend over the past decade and China is currently reviewing its population policy (Beijing Review, 2010).

In China the one-child policy was introduced in 1980 as an interim measure (for 30 years) to solve population pressures on resources. The unintended consequence of the policy, and its enforcement by the Family Planning Commission, has been a substantial sex skew. By 2009 there were 119 boys born for every 100 girls. In response to some of the unintended consequences of the policy, five provinces in China (Heilongjiang, Jilin, Liaoning, Zhejiang and Jiangsu) are set to relax the one-child policy in 2011 and this is likely to extend to the whole of China by 2014.

Throughout the 1980s and 1990s South Korea urged its population to restrict their families to only two children. Public campaigns during this period put pressure on mothers who already had two daughters to abort female fetuses. The resultant demographic sex imbalance had produced a 'bride shortage' by the turn of the twenty-first century. However, since then there has been a major policy
reversal and a resultant "rethink" among Koreans on son preference (Das Gupta, 2010). In a recent World Bank study Chung and Das Gupta (2007) identified South Korea as the first country in Asia to reverse the trend in sex ratios at birth. In the early 1990s its sex imbalance was as high as 116.5 boys for every 100 girls. Among mothers who had already borne two or more children, the ratio had soared to 206 boys to 100 girls, according to the Korea National Statistical Office. In 2006 the ratio in South Korea was 107.4 boys born to every 100 girls - still above the normal ratio of 105 but the trend has been towards greater sex parity since 2002 (Chung and Das Gupta, 2007).

2.1.2. Infant and under-5 mortality

Female infant mortality rates (IMR) have declined for all countries of WPR over the past 20 years. However, the female IMR range remains large, varying from 2 deaths per 1,000 live births in Japan and Singapore to 63 in Cambodia. In higher income countries (Japan, Brunei, Korea, Singapore, Malaysia, Australia, NZ), which already had a low baseline in 1990, the decline was minor, as expected. The effect of economic development on mortality is illustrated by the inverse relationship between infant mortality and GDP (Figure 7).

Figure 7 Comparing GDP with IMR in selected countries in WPR, 2007 (Log scale)

![Graph showing the inverse relationship between GDP and Infant Mortality (IMR) in selected countries in WPR, 2007 (Log scale)](source: World Health Organization, World Health Statistics 2009. www.who.int/healthinfo/statistics.)
Similarly the under-5 mortality rates have fallen over the past two decades, but in 2007 continued to show a vast difference between rich and poor countries. In most countries, the rate for boys is slightly higher than that for girls but for Niue, Samoa and Cambodia the rate for boys is substantially higher (figure 8).

**Figure 8** Under-5 mortality rate (per 1000 live births), by sex & country, WPR, 2007

![Under-5 mortality rate chart](chart.png)

**Source:** World Health Organization, World Health Statistics 2009. [www.who.int/healthinfo/global_burden_diseases](http://www.who.int/healthinfo/global_burden_diseases)

2.1.3. **Leading causes of morbidity and mortality**

When the data for 0-14 year old girls are disaggregated by age group, a clear picture of the difference between the 0-4 years and the 5-14 years cohorts emerges. The first five years of life remain risk-ridden for girls in the Region (predominantly in developing countries) whereas girls aged 5-14 have very low mortality rates. Communicable, maternal, perinatal and nutritional conditions are the major causes of mortality in the younger cohort while injuries are the leading cause of mortality in the older cohort (Figure, 9). The leading types of communicable, maternal, perinatal and nutritional conditions that cause death, illness and disability for female infants in the WPR are diarrhoeal diseases, neonatal infections, prematurity, low birth weight and post-neonatal acute respiratory infections.
Figure 9 Age-specific mortality rate (per 100,000), females 0-14 by major cause groups, WPR, 2004


2.1.4. Key health risks

(i) Malnutrition is the main health risk for young girls in all parts of the Region (Figure 10). Malnutrition covers under-nutrition (both voluntary and involuntary), over-nutrition and unbalanced nutrition especially where protein, iron, zinc and vitamin A are missing from the diet. As Figure 10 demonstrates, for girls aged 0-4 years, suboptimal breastfeeding and underweight are the two leading risks for lost DALYs. Deficiencies in Vitamin A, zinc and iron are the sixth, seventh and eighth leading causes of DALYs lost for this age group.

(ii) Environmental factors are the next largest set of risks for lost DALYs in young girls. Unsafe water, poor sanitation and hygiene (third leading cause), lead exposure (fourth leading cause), indoor smoke from solid fuels (fifth leading cause), climate change (tenth leading cause) and urban outdoor air pollution (eleventh leading cause) are problems throughout the Region including in indigenous communities in developed countries. The immediate risk effects of climatic change such as floods and tsunamis include high numbers of drowning, which, because of gendered cultural traditions such as not teaching girls to swim, modesty and restrictive clothing, places girls at a much higher risk than boys.
Figure 10  Attributable DALYs for selected risk factors, in girls 0-4years, WPR, 2004

Attributable DALYs for Selected Risk, Female Aged 0-4 Yrs, WPRO 2004

- High blood glucose: 3
- Unsafe healthcare injections: 14
- Illicit drug use: 19
- Alcohol use: 23
- Urban outdoor air pollution: 24
- Global climate change: 54
- Unsafe sex: 61
- Iron deficiency: 89
- Zinc deficiency: 279
- Vitamin A deficiency: 315
- Indoor smoke from solid fuels: 416
- Lead exposure: 564
- Unsafe water, sanitation, hygiene: 1462
- Underweight: 1558
- Sub-optimal breastfeeding: 1655

Thousands


2.2. The Adolescent Girl

Adolescence is, under most circumstances, the healthiest time in an individual's life and the burden of disease in this stage of the life span is the lowest. However, many of the behaviours and experiences of this period have long term consequences at subsequent stages of life.

Data to depict the health status of adolescents (boys and girls) are limited because data collection agencies use different age groupings to the conventional definition of adolescence as 10-19 years. Most of the data shown in this section are for 15-29 years age group; and in some cases, the age group used is 15 years and above. Thus there is an overlap with adult women.

2.2.1. Morbidity and mortality

For WPR girls aged 10-19 years by far the highest source of mortality is unintentional injuries, followed by intentional injuries, infectious diseases, malignant neoplasms, cardiovascular diseases and maternal conditions (Figure 11). For adolescent boys the main source of mortality and burden of disease (14%) is road 'accidents'. As young women’s and men’s lifestyles converge, it is likely that the sex differential in burden of disease from road collisions and other injuries will reduce (WHO, 2004, 2008).
In the least developed countries of the Region, the leading causes of death for girls aged 15-19 years are complications during pregnancy and childbearing as well as lower respiratory tract infections. Early marriage and adolescent pregnancy are a major issue in some countries, for example in Lao PDR 37.3% of married women have their first baby before 18 years of age (Committee for Planning and Investment, 2007) and 29% of all first pregnancies are unintended. Knowledge of contraception is very low in rural and remote areas of the low income countries and access to family planning services and products is limited. Non-fatal disabilities associated with early age of first parity (e.g. obstetric fistula and low birth weight) significantly contribute to the burden of disease. Aboriginal populations in several high income countries (notably Australia and New Zealand) experience levels of teenage pregnancy and maternal and infant mortality and morbidity two to three times the national average (Rudd, 2010), as do adolescent girls in refugee and other marginalized communities in these countries (Fritsch, 2004).

**Figure 11** Mortality rates per 1,000 by causes among females 15-29 years, WPR, 2004

Age Specific Mortality Rate (per 1000 pop.) by Priority Causes Female age 15-29 Yrs, WPRO 2004

<table>
<thead>
<tr>
<th>Cause</th>
<th>DALYS 2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutritional deficiencies</td>
<td>0.002</td>
</tr>
<tr>
<td>Musculoskeletal diseases</td>
<td>0.004</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>0.005</td>
</tr>
<tr>
<td>Respiratory diseases</td>
<td>0.007</td>
</tr>
<tr>
<td>Endocrine disorders</td>
<td>0.006</td>
</tr>
<tr>
<td>Digestive diseases</td>
<td>0.009</td>
</tr>
<tr>
<td>Genitourinary diseases</td>
<td>0.012</td>
</tr>
<tr>
<td>Congenital anomalies</td>
<td>0.012</td>
</tr>
<tr>
<td>Respiratory infections</td>
<td>0.018</td>
</tr>
<tr>
<td>Neurpsychiatric conditions</td>
<td>0.020</td>
</tr>
<tr>
<td>Maternal conditions</td>
<td>0.039</td>
</tr>
<tr>
<td>Cardiovascular diseases</td>
<td>0.045</td>
</tr>
<tr>
<td>Malignant neoplasms</td>
<td>0.065</td>
</tr>
<tr>
<td>Infectious diseases</td>
<td>0.067</td>
</tr>
<tr>
<td>Intentional injuries</td>
<td>0.112</td>
</tr>
<tr>
<td>Unintentional injuries</td>
<td>0.179</td>
</tr>
</tbody>
</table>


2.2.2. Risks to health of adolescent and young girls

Adolescence is the stage in life characterized by risk-taking behaviour. Figure 12 shows the DALYs for risk factors in young females in the WP Region in 2004, and the highest DALYs are contributed by anaemia, alcohol use, unsafe sex, child sexual abuse, unmet contraceptive need and illicit drug use. It is noteworthy that occupational risk also contributes substantially to the DALYs lost, largely because some adolescents are legally and productively employed and others are illegally used as child labour. Tobacco use is of particular importance for adolescent women, globally and in the WP Region, given that they are currently the key target market for tobacco companies.
Figure 12 Attributable DALYS from selected risk factors in young females, WPR, 2004

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>DALYS (Thousands)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead exposure</td>
<td>3</td>
</tr>
<tr>
<td>Global climate change</td>
<td>12</td>
</tr>
<tr>
<td>Low fruit and vegetable intake</td>
<td>30</td>
</tr>
<tr>
<td>Unsafe health care injections</td>
<td>41</td>
</tr>
<tr>
<td>Physical inactivity</td>
<td>73</td>
</tr>
<tr>
<td>Illicit drug use</td>
<td>172</td>
</tr>
<tr>
<td>Unmet contraceptive need</td>
<td>235</td>
</tr>
<tr>
<td>Unsafe water, sanitation, hygiene</td>
<td>245</td>
</tr>
<tr>
<td>Occupational risks</td>
<td>290</td>
</tr>
<tr>
<td>Child sexual abuse</td>
<td>411</td>
</tr>
<tr>
<td>Unsafe sex</td>
<td>420</td>
</tr>
<tr>
<td>Alcohol use</td>
<td>438</td>
</tr>
<tr>
<td>Iron deficiency</td>
<td>458</td>
</tr>
<tr>
<td>High blood glucose</td>
<td>140</td>
</tr>
</tbody>
</table>


(i) Tobacco and other substance abuse - Tobacco, alcohol and other substance use is a growing problem in all countries of the Region. Although not specifically mentioned in the attributable DALYS in Figure 12, exposure to tobacco in adolescent girls is one of the major risks to the future health of women for a variety of diseases including lung and breast cancer, and circulatory and cardiovascular morbidity and mortality. The emancipation of women and advancement in women's rights throughout the WPR over the past 50 years has brought about many positive outcomes. However, one of the negative consequences has been young women 'catching up' to males rates of substance abuse-particularly alcohol and tobacco. Fig. 13 shows 2004 data for 11 countries in the WPR, demonstrating a clear convergence between men's and women's smoking rates in Australia. It must be noted that this data includes a wide age range (15 years and above) and is therefore not specific to adolescence or young people. More recent data shows that in New Zealand, girls' smoking prevalence increased from 23.9% in 2007 to 39.9% in 2009 (WHO, WPRO, 2009). An earlier study in China, Malaysia, Fiji and Australia (Stewart et al, 1998), using a variety of methodologies to elicit 'honest' data, revealed much higher levels of smoking, and a lower level of perceived risk, in girls than official figures suggest. Alongside the aggressive marketing of tobacco to adolescent girls via attractive packaging, coloured and flavoured cigarettes, marketing of new products, such as smokeless tobacco and Shish pipes especially target women and girls. Passive smoking has the same short and long-term health effects as active smoking. For adolescents and young people, the early age of exposure means the longer accumulation of the negative effects of tobacco. Exposure to second-hand smoke is a major public health concern especially in China, Lao PDR, Malaysia, Mongolia, Nauru, Republic of Korea, Samoa, Tonga, Vanuatu and Vietnam where
tobacco use is widespread throughout national populations and few restrictions on use in public are enforced. The Global Youth Tobacco Survey (Warren, 2008) shows that 50% of girl students, aged 13 to 15 years, are exposed to second-hand tobacco smoke in their homes and 64% are exposed in public places. The long-term consequences of exposure to passive smoke at an early age are the same as for active smoking, namely breast and lung cancer and cardiovascular disease and women develop lung cancer more rapidly than men at lower exposure to smoking.

**Figure 13 Smoking rate in females and males 15 yrs and over, selected countries WPR, 2004**

![Figure 13: Smoking rate in females and males 15 yrs and over, selected countries WPR, 2004](image)


Substances other than tobacco, and other ways of consuming tobacco, are also prevalent and increasing among adolescent girls. The Palau Youth Tobacco Survey reveals that in Palau, ‘53.7% of girl students currently use other tobacco products, including chewing betel nuts with tobacco, increasing the risk of oral cancer’ (WHO, WPRO, 2010:1). In rural Lao a variety of dried leaves are smoked as a routine part of life by villagers of all ages, including adolescent girls (Figure 14).

**Figure 14 Children smoke from toddler stage: Sekong, Lao PDR (photo courtesy of E. Eckermann)**
(ii) Alcohol - Alcohol use is the second highest risk for DALYs lost for women aged 15-29 years. The patterns of alcohol use during adolescence set the stage for this outcome. The sequelae of adolescent alcohol abuse reverberate beyond the immediate problems (liver damage, unsafe sex and intentional and unintentional injury), to impact on the individual’s physical, social and mental well-being at later stages in life. Major impacts are also felt in the community. Because data on alcohol use for specific age groups are available in few countries, the risk from alcohol consumption is elaborated in the next section on the adult women (2.3.2) but the same arguments apply to adolescent girls.

(iii) Nutrition and diet - Poor diet and physical inactivity are increasing problems for young women in all parts of the WPR. In low income countries under-nutrition and imbalanced nutrition cause stunting and a variety of debilitating health problems which are transferred to the next generation, including low weight babies, goitre and anaemia. Iron deficiency stands out as the leading risk factor for DALYs lost for women in the WPR and this problem is not confined to low income countries. In high income countries, and increasingly in middle income areas, over-nutrition and inappropriate nutrition cause high levels of obesity and consequent diabetes, heart disease and renal failure in adolescence and early adulthood. This is particularly problematic in several Pacific Islands (Table 2). Again it has to be noted that the age captured in this data set is 15 to 59 years and this therefore applies to the adult women as well.

The mean value Body Mass Index (BMI) exceeds 30 in seven countries (all of them are PICs which also rank highest globally). It is between 25 and 30 (the cut-off point for obesity) in 9 countries (six are PICs) and is less than 25 in ten countries (none is a PIC). Vietnam and Cambodia have the lowest mean BMI in the Region. Although debate continues about whether Pacific Islands people generally have larger skeletal frames and greater bone density, regardless of height and weight (Grant et al, 2005), the increase in BMI over the past 30 years reflects changed diets towards more tinned, processed and refined foods and reduced physical activity causing higher levels of cholesterol and blood sugars alongside the obesity (Hughes & Marks, 2010). Just as mean BMI show variances among countries, the prevalence of obesity also differs among countries (Figure 15) with Cambodia, Vietnam, Japan, China and Singapore having the lowest prevalence, and the PICs having the highest.

Eating disorders such as anorexia nervosa and bulimia are no longer confined to high income economies. The epidemiology of these conditions shows increasing rates among adolescent girls in Malaysia, Philippines and the Pacific. 90% of diagnosed anorexia and bulimia occurs in adolescent girls. Although anorexia and bulimia contribute to only a small proportion of the total burden of disease for young women, it is estimated that subclinical and undiagnosed prevalence is substantial in several countries of the WPR causing substantial morbidity and compromised quality of life. Problems with bodily perceptions and identity plague the 21st century teenage girl throughout the world, including the WPR. Unrealistic expectations of body weight, shape and size in an era where increased nutrition should lead to acceptance of a wider range of acceptable body shapes, continues to put pressure on adolescent girls as they struggle with self-identity (Eckermann, 2009).
Table 2 Ranking of mean BMI (kg/m²) of Female age 15 and over in WPR by country, 2005

<table>
<thead>
<tr>
<th>Rank</th>
<th>Country</th>
<th>Mean Value (kg/m²)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Nauru</td>
<td>36.5</td>
</tr>
<tr>
<td>2</td>
<td>Tonga</td>
<td>35.7</td>
</tr>
<tr>
<td>3</td>
<td>Micronesia</td>
<td>34.7</td>
</tr>
<tr>
<td>4</td>
<td>Cook Is</td>
<td>34.0</td>
</tr>
<tr>
<td>5</td>
<td>Niue</td>
<td>32.1</td>
</tr>
<tr>
<td>6</td>
<td>Samoa</td>
<td>31.8</td>
</tr>
<tr>
<td>8</td>
<td>Palau</td>
<td>30.9</td>
</tr>
<tr>
<td>11</td>
<td>Kiribati</td>
<td>28.8</td>
</tr>
<tr>
<td>17</td>
<td>Fiji</td>
<td>27.6</td>
</tr>
<tr>
<td>17</td>
<td>New Zealand</td>
<td>27.6</td>
</tr>
<tr>
<td>19</td>
<td>Mongolia</td>
<td>27.4</td>
</tr>
<tr>
<td>22</td>
<td>Brunei</td>
<td>26.9</td>
</tr>
<tr>
<td>23</td>
<td>Vanuatu</td>
<td>26.8</td>
</tr>
<tr>
<td>26</td>
<td>Tuvalu</td>
<td>26.5</td>
</tr>
<tr>
<td>38</td>
<td>Marshall Is</td>
<td>25.3</td>
</tr>
<tr>
<td>40</td>
<td>Solomon Is</td>
<td>25.1</td>
</tr>
<tr>
<td>43</td>
<td>43 DPR Korea</td>
<td>24.8</td>
</tr>
<tr>
<td>44</td>
<td>44 Lao PDR</td>
<td>24.7</td>
</tr>
<tr>
<td>53</td>
<td>Malaysia</td>
<td>23.7</td>
</tr>
<tr>
<td>60</td>
<td>Papua NG</td>
<td>22.9</td>
</tr>
<tr>
<td>61</td>
<td>China</td>
<td>22.8</td>
</tr>
<tr>
<td>61</td>
<td>Philippines</td>
<td>22.6</td>
</tr>
<tr>
<td>67</td>
<td>Singapore</td>
<td>22.2</td>
</tr>
<tr>
<td>69</td>
<td>Japan</td>
<td>21.9</td>
</tr>
<tr>
<td>74</td>
<td>Cambodia</td>
<td>21.2</td>
</tr>
<tr>
<td>76</td>
<td>Viet Nam</td>
<td>20.6</td>
</tr>
</tbody>
</table>


Figure 15 Prevalence of Obesity (BMI = 30+ kg/m²) females 15+, WPR by country, 2005

(iv) Mental health - Neuropsychiatric conditions (e.g. uni-polar depressive disorders, schizophrenia, bipolar disorders) constitute a large share of the burden of ill-health for adolescent girls, as does suicide. Suicide attempts are higher amongst adolescent girls than boys but suicide completion rates are higher in boys, except in rural China where deadly pesticides are readily available on farms, increasing the 'completion' of suicides by young women and making the rate for women higher than for men (WHO, WPRO, 2006). Depression accounts for nearly 42% of the disability from neuropsychiatric disorders among women compared to 29.3% among men and these depressive disorders often first manifest themselves in late adolescence. The particular issues of identity construction for teenage girls referred to earlier, contribute to the onset of depressive disorders.

(v) Trafficking, sexual exploitation - One of the most serious manifestations of loss of power, and loss of identity, for girls is commercial sexual exploitation. Abuse and maltreatment of girls is evident in countries where girls as young as 10 are traded as sex workers and young children are sold to families in the West. The sexual abuse and exploitation of children, including rape and incest, are challenges that demand urgent action. Sexual exploitation, which includes, but is not limited to prostitution, trafficking and pornography, is on the rise in Asia and the Pacific (ARROW, 2009). Child pornography has risen exponentially due to the increase in new technologies and the lack of laws to counter this new phenomenon of sexual exploitation of children in cyberspace, including cyber bullying. The lucrative nature of the sex industry, together with a demand for commercial sex, puts children at continual risk of coercion, particularly children from impoverished communities across Asia and the Pacific.

The mental health consequences (see Fig 16), alongside the physical consequences of early pregnancy, HIV and other STI infection, bruising and tearing, makes this the most scarring of experiences for the lifetime of the individual. The DALYs lost by childhood sexual abuse are attributable (in order of magnitude) to panic disorder, unipolar depressive disorders, post-traumatic stress disorder and self-inflicted injuries in women aged 15-29 years. The repercussions continue into later adulthood with these conditions, as well as substance abuse, seriously compromising quality of life. These problems become more common in communities in crisis. Poverty reduction, along with strictly enforced laws, must be the upstream solutions. Lack of knowledge is a contributing factor. There is a close relationship with illiteracy, lack of education, and lack of income generating opportunities, so poverty alleviation and effective educational programmes are essential for prevention of both abuse and the consequent sexually transmitted infections.

Domestic violence and other forms of gendered violence (sexual and non-sexual) are also major issues for adolescent girls but data are scarce give the ethical barriers to conducting research with young women under 18 years of age. However, the issues covered in the section on gendered violence against adult women (Section 2.3.2 (v) also apply to adolescent girls.
Figure 16 Attributable DALYS lost: mental disorders as consequences of child sexual abuse in females 15-44 Yr, WPR, 2004


2.3 The Adult Woman

Reproductive health issues are addressed in detail in Chapter 3. Health concerns of adult women extend far beyond reproductive matters to cover injuries (intentional and unintentional) and gendered violence, malignant neoplasms, chronic conditions, infectious diseases and mental health problems. Many of these problems emerge from exposures and experiences earlier in their lives.

Although women in all countries in the Region have longer expectancies than men, they suffer higher levels of reported morbidity and lower objective conditions of quality of life. Furthermore, where the same conditions are experienced by men and women, often the symptoms will manifest themselves differently in women, women will react differently to them and the response of health systems will differ between the sexes. Examples of such gendered differences are presented below.

2.3.1. Morbidity and mortality

Figure 17 shows the DALY and death per 1000 by country of the Region for women aged 15-59 years. Adult women in Lao PDR, PNG, Cambodia Marshall islands, Tuvalu and Nauru have the highest DALYS lost; these same countries also have the highest death rate of adult women. At the other end of the spectrum are the high income countries (Australia, New Zealand, Japan and Singapore), while moderate values are seen in Malaysia, China, Brunei, Vietnam and Philippines. As was observed for the adolescent age group, mortality among adult women is dominated by injuries, (unintentional and intentional), malignant neoplasms and cardiovascular disease, although
infectious diseases and maternal conditions still prevail. However, there are large discrepancies across countries and within countries of the WPR in adult female mortality and morbidity rates as well as DALYs. In developing countries, adult women face the double burden of persistent infectious diseases and emergent non-communicable diseases and injury. Life expectancies are low, morbidity is high and social, economic and physical challenges abound. As is the case with adolescents, maternal mortality and pregnancy-related morbidity and disability are a major source of the burden of disease for women in the reproductive years in Cambodia, Lao PDR, PNG, the Philippines and several Pacific Islands. Vietnam and China have started to turn the corner in controlling some infectious diseases and maternity related illness and death, and both these countries are on track to reach the MDG5 goal of reducing maternal mortality by three quarters between 1990 and 2015.

Figure 17 DALY and death per 1000 females aged 15-59 years by country, WPR, 2004

Comparing DALY and Death (000) by country – Female age 15-59 by country


In the majority of countries, intentional and unintentional injuries (including traffic accidents), HIV/AIDS and chronic non-communicable conditions such as cardiovascular diseases and cancer, are starting to replace TB, malaria and chronic respiratory diseases as the leading causes of death, illness, disability and compromised quality of life. Mental illness and associated abuse of pharmaceuticals are also adding to women's reduced well being. Suicide appears to be a growing matter for concern. Much of the skew in suicide rates for women is produced by statistics from China which makes up a large proportion of the population of the WPR. The high rates of suicide among adult women in China and other parts of the WPR, compared to other regions of the world,
suggest that quality of life is severely compromised for women in the 20-59 age group (WHO, WPRO, 2006).

Cancers of the cervix and of the breast are of particular concern for women worldwide. There has been a clear epidemiological trend for countries undergoing socio-economic development, to experience a decline in cervical cancer but a rise in breast cancer. This trend is seen in WPR as shown in Figure 18 where in 2004, the DALY attributed to breast cancer is twice that attributed to cervical cancer. The other two cancers of the female reproductive organs – uterine and ovarian cancers – also contribute significantly to DALYs lost in adult women, but to a much lesser extent. For the non-reproductive cancers, women have a much lower morbidity level compared to men for stomach, colorectal cancer, as well as for cancer of the trachea, bronchus and lungs. But it is to be noted that trends of the latter needs surveillance as more women are now smoking especially with the aggressive promotions, directed at girls, by tobacco companies.

**Figure 18 DALYs attributable to cancers for men and women in WPR countries, 2004**

2.3.2. Risks to health of adult women

(i) Risk factors for chronic diseases - High blood pressure, blood glucose and cholesterol; overweight and obesity, physical inactivity and tobacco use are prevalent across the whole of the WPR. As the health transition progresses, health services and health promotion programmes in low income and middle income countries will need to be re-oriented to account for rising chronic illness among adult women. As was shown earlier, teenage and adult women’s smoking rates are now approaching male rates in China, Vietnam, Australia and Japan. Obesity was discussed under adolescents with data shown on the ranking of countries of the Region by mean BMI and the prevalence of obesity in countries. The same observations made earlier can be applied to the adult women as well, the PIC’s have the highest prevalence of obesity and also the highest mean values for the BMI for women 15 years and over.

(ii) Tobacco - The risks associated with tobacco and alcohol use have been described earlier under the adolescent girl because the data available captures women in both stages of the life span. In Figure 11, it was seen that the smoking rates differ among countries; and that all countries report higher rates among men than among women. This gender differential is most significant in China which has the highest smoking rate among men but has a relatively low rate among women even comparing with other countries. Malaysia and Vietnam which have lower smoking rate compared to China, also show a substantial male-female differential. In Australia, Japan, Lao and Tonga, women have relatively higher smoking rates, although these are still far below the rate for men, except among younger women.

(iii) Alcohol - Although women’s alcohol consumption levels are not as high as males, the short and long-term effects on women are greater. Although women are more likely to abstain from alcohol than men, the convergence between men’s and women’s rates of substance abuse are most evident amongst adolescents and the impact on women of any level of alcohol consumption differs substantially from that for men. Women who drink run the risk of getting breast cancer and that risk is directly related to the amount of alcohol they consume. Females face more brain damage and memory loss than men who drink the same amount for the same period of time. Women not only get drunk on less alcohol than men but they also suffer worse hangovers. Compared to boys and men, girls and women become addicted to alcohol, nicotine and illegal and prescription drugs, and develop substance-related diseases at lower levels of use and in shorter periods of time. Women who have more than 15 drinks a week have an increased risk of experiencing mental illness, specifically depression and anxiety. Female alcoholics experience more severe cardiovascular effects from heavy alcohol drinking than male alcoholics and these effects are noted at an earlier stage of drinking and at a lower consumption level. Liver cirrhosis develops faster in women. Women who are married to alcoholics are three times more likely to abuse alcohol themselves, compared to wives of non-alcoholics. Alcohol and drug use during pregnancy may have severe repercussions for the child.
Figure 19 shows the impact on DALYs of the sequelae of alcohol consumption in women aged 30-44 years. Alcohol consumption leads not only to immediate alcohol related disorders but also to road traffic accidents, self-inflicted injuries, unintentional injuries, liver cancer, epilepsy, drowning, cirrhosis of the liver and breast and oesophageal cancer.

Figure 19 DALYs of diseases attributed to alcohol consumption in female adult, WPR, 2004

<table>
<thead>
<tr>
<th>Disease</th>
<th>DALYS (000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oesophageal cancer</td>
<td>22</td>
</tr>
<tr>
<td>Breast cancer</td>
<td>23</td>
</tr>
<tr>
<td>Cirrhosis of the liver</td>
<td>34</td>
</tr>
<tr>
<td>Drownings</td>
<td>35</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>37</td>
</tr>
<tr>
<td>Liver cancer</td>
<td>40</td>
</tr>
<tr>
<td>Other unintentional injuries</td>
<td>51</td>
</tr>
<tr>
<td>Self-inflicted injuries</td>
<td>54</td>
</tr>
<tr>
<td>Road traffic accidents</td>
<td>96</td>
</tr>
<tr>
<td>Alcohol use disorders</td>
<td>100</td>
</tr>
</tbody>
</table>


(iv) Early detection of cervical and breast cancer - A protective lifestyle factor for these cancers is early detection through screening. Until recently the scope and opportunities for primary prevention for these two diseases was limited with unclear causal factors. This has changed for cervical cancer for which specific types of the human papilloma virus (HPV) has been identified as the cause, and a vaccine against these types of HPV has become available, although the high cost remains a barrier to most countries of the Region. The feasibility of early detection has made screening an important programme in the prevention of these cancers. For preventing cervical cancer, most countries use cervical cytology by the Pap smear test although other modalities have been found to be useful such as visual inspection of the cervix and HPV-DNA test. For early detection of breast cancer, physical examination (including self breast examination) has been promoted for several years, and there are also programmes using imaging methods such as mammography and ultrasound. Figure 20 shows the percentage of women who undergo Pap smear tests in selected countries, (but using data from different years), and there is a clear association with level of socio-economic development with New Zealand (77%) and Australia (61%) having the highest rates of screening.
In Figure 21, the same pattern is observed for the coverage of mammography; New Zealand (63%) and Australia (57%) show the highest screening rate for breast cancer.

Figure 20 Percentage of Women who have had a pap smear in WPR, 2002-2004


Figure 21 Percentage of Women who have had mammography in WPR 2002-2003,


(v) Violence and abuse - Violence against women is a major cause of compromised quality of life throughout all countries in the Region (WHO, 2002, 2005; WHO, WPRO, 2006). Mental and physical health are undermined by exposure to work-based and domestic violence, long hours of combined paid and unpaid labour, conflicting commitments between work and family, and occupational hazards such as repetitive strain and exposure to chemicals. In 1998, in response to calls from country delegates and NGO representatives at the 48th session of the WPR RCM of September 1997, a review of domestic violence in the 37 countries of the WPR was conducted by WHO, WPRO (1998). The study revealed the dearth of data on the topic because of problems of
definition, the sensitivity of the topic and cultural taboos surrounding discussion of it, the 'normalcy' of domestic violence in many countries, and the lack of public authority recognition, until recently, of violence as a public health issue worthy of investigation. The situation has not improved much in terms of data availability over the past 12 years (ARROW, 2009). Many countries still do not systematically gather data on the problem and several countries still have not enacted anti-domestic violence laws (WHO, 2005; WHO, WPRO, 2006). Major anti-domestic violence laws have recently been enacted in Cambodia, China, Lao PDR, the Philippines and Vietnam. The Domestic Violence Act has been in place in Malaysia since 1994, and the one-stop crisis centres established in all major government hospitals in Malaysia have proven to be an appropriate model for the management of victims of violence including rape and domestic violence. In northern China, domestic violence against pregnant women has been identified as a major cause of depression and psychiatric disorders as well as suicide. In a 2005 study in northern China, researchers reported a prevalence rate of domestic violence before during and after pregnancy of 12.65% and that this was just the tip of the iceberg (WHO, WPRO, 2006). The research points to poor obstetric outcomes and postnatal depression as the most common sequelae of domestic violence just prior to, during and just after pregnancy.

2.4. The Older Woman

The global phenomenon of population ageing has special relevance to women; one significant feature of population ageing is the "feminization of ageing" by which women have a longer life expectancy than men and there are more women than men in the age group above 60 years. The developed countries have "become richer before they get older", while the developing countries have "become older before they get richer". Ageing is experienced not only by the high income countries but by the low income countries, and often more rapidly in the latter. Women over 60 years of age currently make up over 31% of the population of Japan. By 2015 this is likely to increase to over 35% so substantial planning and resources will be needed to maintain the health and well-being of older women. Other countries are following the same trend so this has become a Regional challenge for the next few decades. These trends have far-reaching implications on health status and heath care needs of women.

Despite the trend to greater longevity for most women, particular groups of women never reach old age or are regarded as 'older women' at a much earlier chronological age. In the most developed countries of the Region, there are huge disparities in longevity between indigenous and non-indigenous populations. For example, in Australia the life expectancy gap between indigenous and non indigenous men and women has closed slightly over the past few years but still remains at 11.5 years for men and 9.7 years for women (Rudd 2010).

2.4.2. Morbidity and mortality in older women

Despite the longevity experienced by most women, the final decades of life are often lived with morbidity and disability that seriously undermine the quality of life of older people. The major
conditions which women live with, and which ultimately cause their deaths, are cardiovascular disease, respiratory diseases, malignant neoplasms, respiratory infections, digestive diseases, and diabetes (Fig. 22). In old age the causes of death and disability tend to converge between men and women and between countries, with ischaemic heart disease and stroke being the two main causes of death in low, middle and high income countries. As countries develop economically, cancers (breast, lung, colon and rectal) tend to replace lower respiratory tract infections as the next largest causes of death in women over 60 years. The risk factors associated with these causes of death (Fig 23) are often laid down in childhood, adolescence and early adulthood. For example the largest attributable causes of DALYS lost, high blood pressure and high blood glucose levels, relate largely to lifetime nutritional patterns, as do the sixth and eighth leading risk factors, namely overweight and obesity, low fruit and vegetable intake and high cholesterol.

The top five causes of disability among women over 60 years also converge across levels of economic development. Alzheimer’s disease and other dementias are the main source of years lost to disability for middle and high income countries and second in low income countries. Refractive errors and hearing loss appear in the top 4 causes of disability for all levels of development in the WPR. Cataracts emerge as the anomaly, featuring in the top 4 causes of disability for low and middle income countries, but appear way down the list of causes in high income countries given the ready availability of surgery for cataracts. However, in some marginalized groups within high income countries, cataract surgery is still inaccessible.

**Figure 22** Age-specific mortality rate (per 1000) in women 60 years and older by cause, WPR, 2004

<table>
<thead>
<tr>
<th>Disease Category</th>
<th>Rate (per 1000)</th>
<th>Female age 60+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Congenital anomalies</td>
<td>0.01</td>
<td>WPRO 2004</td>
</tr>
<tr>
<td>Skin diseases</td>
<td>0.014</td>
<td></td>
</tr>
<tr>
<td>Nutritional deficiencies</td>
<td>1.604</td>
<td></td>
</tr>
<tr>
<td>Other neoplasms</td>
<td>0.093</td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal diseases</td>
<td>1.433</td>
<td></td>
</tr>
<tr>
<td>Endocrine disorders</td>
<td>0.188</td>
<td></td>
</tr>
<tr>
<td>Intentional injuries</td>
<td>0.471</td>
<td></td>
</tr>
<tr>
<td>Genitourinary diseases</td>
<td>0.615</td>
<td></td>
</tr>
<tr>
<td>Psychiatric conditions</td>
<td>0.745</td>
<td></td>
</tr>
<tr>
<td>Infectious and parasitic diseases</td>
<td>0.857</td>
<td></td>
</tr>
<tr>
<td>Unintentional injuries</td>
<td>0.858</td>
<td></td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>0.921</td>
<td></td>
</tr>
<tr>
<td>Digestive diseases</td>
<td>1.03</td>
<td></td>
</tr>
<tr>
<td>Respiratory infections</td>
<td>1.059</td>
<td></td>
</tr>
<tr>
<td>Malignant neoplasms</td>
<td>5.99</td>
<td></td>
</tr>
<tr>
<td>Respiratory diseases</td>
<td>7.742</td>
<td></td>
</tr>
<tr>
<td>Cardiovascular diseases</td>
<td>17.39</td>
<td></td>
</tr>
</tbody>
</table>

### Figure 23 Attribute DALYS of selected risk factors in women 60 yrs and over, WPR, 2004

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>DALYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global climate change</td>
<td>3</td>
</tr>
<tr>
<td>Lead exposure</td>
<td>5</td>
</tr>
<tr>
<td>Unsafe water, sanitation, hygiene</td>
<td>72</td>
</tr>
<tr>
<td>Child sexual abuse</td>
<td>82</td>
</tr>
<tr>
<td>Iron deficiency</td>
<td>142</td>
</tr>
<tr>
<td>Unsafe sex</td>
<td>143</td>
</tr>
<tr>
<td>Alcohol use</td>
<td>239</td>
</tr>
<tr>
<td>Unsafe health care injections</td>
<td>240</td>
</tr>
<tr>
<td>Occupational risks</td>
<td>401</td>
</tr>
<tr>
<td>Urban outdoor air pollution</td>
<td>790</td>
</tr>
<tr>
<td>High cholesterol</td>
<td>1,601</td>
</tr>
<tr>
<td>Low fruit and vegetable intake</td>
<td>1,810</td>
</tr>
<tr>
<td>Overweight and obesity</td>
<td>2,413</td>
</tr>
<tr>
<td>Physical inactivity</td>
<td>2,780</td>
</tr>
<tr>
<td>High blood glucose</td>
<td>1,297</td>
</tr>
<tr>
<td>Indoor smoke from solid fuels</td>
<td>1,735</td>
</tr>
<tr>
<td>Tobacco use</td>
<td>2,573</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>8,416</td>
</tr>
</tbody>
</table>


#### 2.4.3. Quality of life for older women

Women's longevity advantage in all countries of the WPR may not necessarily represent a health advantage. The DALY measure was developed in recognition of the fact that mortality is only one of many indicators of wellbeing. Morbidity, disabling conditions (such as blindness, arthritis and depression), social exclusion and poverty may seriously undermine women's quality of life. Other measures of quality of life are increasingly being used by governments and researchers in countries of the Western Pacific to assess quality of life (Cummins et al, 2009). The results can be sex disaggregated and gender analysed to establish whether policies, programs, services and interventions are systematically disadvantaging either sex. Women are often left alone in old age and this creates problems as their health deteriorates. Abuse and neglect of older women occurs in both family and institutional settings. Australia has a Network for the Prevention of Elder Abuse and New Zealand established a National Elder Abuse and Neglect Advisory Council but these bodies have only advisory, rather than regulatory, roles so they have no power to change laws and community standards. Often abuse or neglect of older women in nursing homes (for example malnutrition, bed sores, ignoring symptoms, accidents, physical restraint) or their families' homes (for example withholding medical, social or economic support) is hidden.

Older women and men want to maintain independence and dignity despite failing health but given that women outlive men, it becomes a gendered issue (Eckermann, 1997). Telemedicine, tele-health and tele-care opportunities can allow women to remain in their own homes and keep their
independence (and freedom for them and their families from the public disgrace of 'abandonment') while providing a life-line for emergencies. In many richer countries in the Region this is already happening with the use of a variety of phone, television, email and other computer linked technologies such as personal alarms connected to a central alarm monitor for emergency services, and 'smart' pill boxes that will alarm a central monitoring station if medications are not taken (Bensink et al, 2007).

2.5. Summary – Issues and the way forward

Despite significant improvements in women’s health over the past two decades, many challenges remain and new challenges have emerged for women at every stage of life. Addressing these challenges involves developing broader understandings of the causes of persistent gender inequality, including upstream factors that impinge on health and wellbeing, and devising novel interventions which incorporate such understandings. This chapter has highlighted the importance of adopting a life-course approach to meeting these challenges and to improving the health and wellbeing of women and girls of all ages. The following chapters emphasize the priority of reproductive health as the key remaining challenge for women in the WPR (Chapter 3), women’s experiences of health care and their role in health care provision (Chapter 4) and the importance of recognizing that social determinants (such as good education and economic prospects for girls) are as important as good nutrition, sanitation and health care in ensuring health and well-being across the lifespan (Chapter 5).

References


3.1. Sexual and Reproductive Health and Rights of Women Across the Lifespan

The reproductive and sexual health of girls and women are especially relevant in examining remaining health challenges in the WPR given slow progress for some countries to reduce maternal mortality (MDG5 Target 5A) and for all countries to achieve universal reproductive health (Target 5B). While the HIV epidemic in the WP Region is not as serious as that in Africa, some countries need to halt and reverse the transmission of, and ensure universal access to treatment for, HIV/AIDS (MDG 6 Target 6B).

It is a convention in health literature to regard women from 15 to 44 years as the female ‘reproductive cohort’. However, given the age profile of reproducing women in the WPR, and the age range of victims of sexual abuse, the full lifespan may be more appropriate for considering reproductive and sexual health issues. In relation to sexual health, in some rural communities, first sexual encounters regularly happen by an early age (National Statistics Centre, 2007) and most countries of the Region are faced with the problem of sexual abuse of young girls. At the other end of the lifespan, many women over the age of 50 still have to negotiate safe and consensual sex and deal with the physical, psychological and social consequences of menopause and prior sexual and reproductive experiences. As the age of menarche gets earlier and technology expands the reproductive possibilities, most of women’s and girls’ lives are influenced by sexual and reproductive opportunities, challenges and choices.

Reproductive and sexual health and rights were defined by the ICPD. The ICPD Plan of Action further defines the constituents of “reproductive health services” (See Annex 1). There are a range of important reproductive and sexual health challenges, identified by the ICPD, that need addressing across the Region. The three most urgent reproductive health issues in the WPR are (i) the continuing high rates of maternal mortality in several countries of the Region, (ii) the lack of universal access to sexual and reproductive health services for all countries and (iii) the growing epidemic of HIV/AIDS in parts of the Region. The urgency of these three issues is reflected in MDG5 and MDG6. However, other reproductive and sexual issues, such as teenage pregnancy, gender-based violence (including sexual abuse and trafficking of girls and women) STIs and reproductive cancers, are major concerns for all countries in the Region and also require urgent intervention at policy, service provision and attitudinal levels (Eldis, 2009).
3.2. Progress in meeting MDG5 in the WPR

The countries and areas of the WPR have differing prognoses in terms of meeting both of the targets of MDG5 (target 5a to reduce MMR by three-quarters between 1990 and 2015, and target 5b to achieve universal access to sexual and reproductive health). The overall 2.4% reduction in MMR (from 120 to 82 per 100,000 live births) for the Western Pacific Region between 1990 and 2005 (Islam & Yoshida, 2009) has not been evenly distributed across the Region. MMR estimates vary from 7 per 100,000 live births in Australia to 660 in Lao PDR and above 700 in PNG. In the WPR the lifetime risk of maternal death is as low as 1 in 13,300 in Australia and as high as 1 in 33 in Lao PDR, and even higher in PNG. In relation to Target 5B, no country has yet achieved universal reproductive coverage but some are lagging further behind than others. Several factors limit access to, and use of, services for sexual and reproductive including maternal health. Case studies from three countries in the WPR are used to illustrate differing circumstances leading to unique reproductive and sexual outcomes. Furthermore, progress on MDG5 in several WPR countries, which have been closely tracked by the Asia Pacific Research and Resource Centre for Women (ARROW, 2009), is reported to provide up-to-date data on how selected countries in the Region are addressing maternal and reproductive health issues.

3.2.1 MDG5a: reducing MMR

The maternal mortality ratio reflects women’s basic health status, access to health care and the quality of care that has been provided. Thus maternal mortality serves as the best summary indicator of the health status of all citizens, and of the strength, responsiveness and effectiveness of the health care system in meeting the health needs of the entire population. Maternal mortality remains unacceptably high in some countries of the WPR and amongst marginalized groups within many countries. Every year there are 40 to 50 million pregnancies with 30 500 to 50 000 maternal deaths in the Western Pacific Region and several countries still have MMRs over 300. Even these high MMRs are likely to underestimate the actual levels of maternal death in poorer countries of the Region where systematic recording of deaths is hampered by economic, geographic, cultural, language and workforce training factors.

Two indicators, the MMR and the proportion of births attended by skilled health personnel, are applied to monitor MDG5a. Among the 37 countries and areas in the Region, 10 do not have 1990 data on MMR, while 18 do not have data on percentage of births attended by skilled health personnel in 2005 so trend data are difficult to estimate. For the whole of the WPR, an average annual rate of reduction of 5.4% was required to achieve the target of three-quarters reduction in 25 years. Figure 24 shows that the overall MMR for the Region was not significantly different from the targeted MMR during the initial seven years in the 1990s. After that, however, the trend line shifted direction until 2000 when it began to plateau. Information pertaining to the last 8 years had not yet been collected when Figures 24 was developed. However, MDG progress reports are available for more recent developments in MDG5a.
By 2000, seven priority countries were identified by WHO, WPRO as in need of major impetus to achieve MDG5a. They were Cambodia, Lao PDR, PNG, Vietnam, Mongolia, China, and the Philippines. Figure 24 shows the reduction from 1990 to 2002 for the entire WPR. Over the past eight years, since Fig 24 was compiled, there have been significant improvements in the MMR in Mongolia, China and Vietnam. Five years before the target date; these countries are on track to achieve MDG5a. However, in 2010, Lao PDR, Cambodia and PNG are all still far off target and need major initiatives to reach a 75% reduction in MMR by 2015. Of the Pacific island countries, the Solomon Islands need major improvement initiatives to achieve this MDG and the Philippines is unlikely to meet its 2015 target of 52 (see Figure 24a). The recent MMR levels in the Philippines are contested but whether one accepts the 2006 Family Planning Survey 2006 MMR estimate of 162, or the UN Statistics Division 2005 estimate of 230, it is generally agreed that the MMR plateaued and stagnated after 2006 making the Philippines unlikely to achieve its MDG5a target of 52 or less maternal deaths per 100,000 live births. The cause of 40% of maternal deaths are unclassified, but it is clear from the 2003 Philippines Health Statistics that ‘hypertension (27%), hemorrhage (18%) and unsafe abortion (11%) are the three major causes of maternal mortality’ (http://philippines.unfpa.org/read_more.php?id=14).
Figure 24a Trend in MMR and projected trend 1990-2015 for the Philippines using 2006 Family Planning Survey data

![Maternal Mortality Ratio](image)


Table 3: Recent progress on MDG5a: 6 countries of WPR

<table>
<thead>
<tr>
<th>Country</th>
<th>MMR estimates 2005</th>
<th>Lifetime risk of maternal death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cambodia</td>
<td>472-540 (range of estimates)</td>
<td>1 in 48</td>
</tr>
<tr>
<td>China</td>
<td>45</td>
<td>1 in 300</td>
</tr>
<tr>
<td>Lao PDR</td>
<td>405-660 (range of estimates)</td>
<td>1 in 33</td>
</tr>
<tr>
<td>Malaysia</td>
<td>62</td>
<td>1 in 560</td>
</tr>
<tr>
<td>Philippines</td>
<td>162-230 (range of estimates)</td>
<td>1 in 140</td>
</tr>
<tr>
<td>Vietnam</td>
<td>150</td>
<td>1 in 48</td>
</tr>
</tbody>
</table>

Source: UNDP Country Progress Reports on MDGs, 2010 www.mdg5watch.org

As Table 3 reveals, by 2005 the MMRs and the lifetime risk of maternal death were still extremely high in Cambodia and Vietnam and very high in the Philippines and Vietnam. Malaysia and China are likely to meet their MDG5a targets but intra-country discrepancies in MMRs suggest that there are still significant challenges in both these countries despite favorable national statistics (www.mdg5watch.org 2010).

Estimates of Cambodia’s MMR in 2005 ranged from 472 in the Cambodian Demographic and Health Survey 2005 (NIPH/NIS, 2006) to 540 (UN, 2005) per 100,000 live births. The Health Survey found that ‘maternal deaths accounted for 17% of all deaths for women aged 15-49’ which translates to ‘one in six Cambodian women who died in the seven years preceding the survey.'
(having) died from pregnancy or pregnancy-related causes' (NIPH/NIS, 2006:17). The lifetime risk of maternal death is 1 in 48 and unsafe abortion causes 14% of all maternal deaths. For Lao PDR there are also discrepancies in 2005 reported MMR between the Lao Reproductive Survey 2005 figure of 405 and WHO, UNICEF and UNFPA estimates of 660 (WHO, UNICEF & UNFPA, 2007). These figures provide further evidence to suggest that Lao PDR, Cambodia and PNG are still well short of meeting the 2015 target for MDG5 (www.mds5watch.org 2010).

MMR is of course correlated with the adequate and quality care provided in pregnancy and especially during childbirth. This care is to be provided by a skilled health professional (or skilled birth attendant [SBA]), and the coverage rate (or SBA rate) is the second indicator for the MMR target. Table 1 presents MMR in relation to skilled birth attendance rate in 2005 compared to the MDG 5a targets.

**Table 4  MMR and proportion of births by skilled personnel in selected WPR countries, 2005**

<table>
<thead>
<tr>
<th>Country</th>
<th>SBA %</th>
<th>SBA % target</th>
<th>MMR /100000</th>
<th>MMR target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solomon Is</td>
<td>85.5</td>
<td>100.00</td>
<td>196</td>
<td>90</td>
</tr>
<tr>
<td>Lao PDR</td>
<td>19.4</td>
<td>50.00</td>
<td>405-660 (est)</td>
<td>260</td>
</tr>
<tr>
<td>Cambodia</td>
<td>43.8</td>
<td>80.00</td>
<td>472-540 (est)</td>
<td>140</td>
</tr>
<tr>
<td>PNG</td>
<td>42.0</td>
<td>75.00</td>
<td>470</td>
<td>274</td>
</tr>
<tr>
<td>Philippines</td>
<td>59.8</td>
<td>90.00</td>
<td>162-230 (est)</td>
<td>52</td>
</tr>
<tr>
<td>Vietnam</td>
<td>85.0</td>
<td>100.00</td>
<td>150</td>
<td>70</td>
</tr>
<tr>
<td>Mongolia</td>
<td>99.7</td>
<td>100.00</td>
<td>46</td>
<td>30</td>
</tr>
<tr>
<td>China</td>
<td>82.8</td>
<td>100.00</td>
<td>45</td>
<td>24</td>
</tr>
</tbody>
</table>


Comparing the coverage of SBA for childbirth in the priority countries (Figure 25), there was little change between 2000 and 2004 for countries that have achieved relatively high rates (Mongolia, China and Vietnam) and more significant increase in Philippines. The change in PNG is minimal and Cambodia recorded a small decrease. Lao PDR remains the one country with the most challenging task to meet the 2015 target of 50% SBA given its 2005 estimate of less than 20%. Increasing skilled birth attendance is the primary strategy adopted by all national and international agencies and NGOs working to reduce maternal mortality.

However, use of skilled birth attendants does not explain all of the MMR variance. Other factors such as the quality of training of skilled attendance and the large proportion of the MMR related to abortion deaths play a part in differential maternal outcomes. The anomaly in several PICS’s such as the Solomon Is. results from statistical artefacts caused by the small size of the population.
Despite, the poor reliability of the MMR as an accurate reflection of maternal deaths (Abou Zahr, 1996; WHO, UNICEF & UNFPA, 2007), it is evident that there are large variations across the Region, putting MDG targets for MMR beyond the reach of some countries. As mentioned earlier, Mongolia, China and Vietnam have achieved dramatic declines in their MMRs since 1990 and these countries are likely to achieve MDG5a, but they have very uneven gains within their borders. In the western provinces of China the MMR is significantly higher than the national estimates. The more remote rural areas of China experience MMRs two to five times higher than urban areas. In Vietnam, in 2001, the national MMR of 165 per 100,000 live births masked MMRs in Cao Bang Province in the northern mountains (411 per 100,000) and Binh Duong Province near Ho Chi Minh City of only 45 per 100,000 (IRIN, 2010). The four countries identified by the WHO, WPRO as still having special needs in relation to meeting the MMR targets are Cambodia, PNG, Lao PDR and the Solomon Is. Not only are MMRs still high in these countries, but the lifetime risk of maternal death is also elevated because of high fertility rates. For instance in Lao PDR, the lifetime risk of a maternal death is 1 in 33, in contrast to Malaysia where the lifetime risk in one in 560 and in China where it is one in 1,300 (Table 3). In all four countries there are a variety of economic, geographical, social and cultural barriers which make meeting MDG5a a particularly daunting task.

3.2.2. MDG5b: Universal access to reproductive health

Although some countries have impressive national figures on provision of sexual and reproductive services, no country yet has achieved universal access. Referring to the ICPD list of reproductive health components, no country in the WPR can claim “universal” coverage on all components.

(i) Contraceptive prevalence and unmet need for planning - Contraceptive prevalence rate (CPR) data are generally unreliable given that contraceptive use is regarded as a private issue in many cultural contexts. Figure 26 shows estimated CPR since 1970 for selected countries of the Region. The trend in Japan has been steady and constant over the past three decades, with the CPR around 60% which is the highest in this series of data. Vietnam shows an increasing CPR since 1995, reaching almost 80% in 2004. PNG, with a very high MMR, has very low CPR, and what is...
even more worrying is that it fell from 20% in 2000 to 9.55% in 2004. In the Philippines, family planning has been a subject of much debate between concerned parties, with a strong influence of the Catholic Church. The trends in Figure 26 show an encouraging jump from 1970 to 1975 until 1985 to reach 42.4%, but after that a gradual decline, and in 2004, the CPR was 33.4%.

Figure 26 Trend of CPR 1970 – 2004 in selected countries of WPR

<table>
<thead>
<tr>
<th>Year</th>
<th>Japan</th>
<th>Fiji</th>
<th>Vietnam</th>
<th>Malaysia</th>
<th>Cambodia</th>
<th>PNG</th>
<th>Kiribati</th>
<th>Philippines</th>
</tr>
</thead>
<tbody>
<tr>
<td>1970</td>
<td>60</td>
<td>50</td>
<td>30</td>
<td>40</td>
<td>30</td>
<td>20</td>
<td>10</td>
<td>50</td>
</tr>
<tr>
<td>1975</td>
<td>60</td>
<td>50</td>
<td>30</td>
<td>40</td>
<td>30</td>
<td>20</td>
<td>10</td>
<td>50</td>
</tr>
<tr>
<td>1980</td>
<td>60</td>
<td>50</td>
<td>30</td>
<td>40</td>
<td>30</td>
<td>20</td>
<td>10</td>
<td>50</td>
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<tr>
<td>1985</td>
<td>60</td>
<td>50</td>
<td>30</td>
<td>40</td>
<td>30</td>
<td>20</td>
<td>10</td>
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<tr>
<td>1990</td>
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<td>40</td>
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<td>1995</td>
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<td>2000</td>
<td>60</td>
<td>50</td>
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<td>40</td>
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<td>10</td>
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<tr>
<td>2004</td>
<td>60</td>
<td>50</td>
<td>30</td>
<td>40</td>
<td>30</td>
<td>20</td>
<td>10</td>
<td>50</td>
</tr>
</tbody>
</table>

Source: Health in Asia and the Pacific (SEARO&WPRC, 2008)

Since the 1994 (ICPD) there has been increasing emphasis on providing a better informed and wider range of choices for contraception. However, contraceptive use is governed by country policy and law. Of particular concern is the absence of unmarried women from official statistics, therefore the exclusion of many sexually active teenagers, from the denominator in the CPR calculations. Women throughout the Region are taking primary responsibility for contraception. Generally female methods predominate with male sterilization below 1% in most countries (Table 5) and condom use below 10%. The exceptions are the Republic of Korea, where male sterilization makes up 29.6% of the CPR and condom use 14.8%, Singapore (23.9% male sterilization, 10% condom use), Mongolia (19.6% male sterilization, but only 6% condom use), China (9.6% male sterilization and 31.7% condom use) and Hong Kong where condom use makes up 32.2% of the CPR. By 2005 it (was) projected that at least one out of every three married women of reproductive age would undergo female sterilization in China. In addition, projections for 2005 indicated that a considerable proportion of women (18%-26%) continue to use traditional methods of contraception in Malaysia (26.4% of CPR), the Philippines (18.4%) and Vietnam (18.1%). In Vietnam, the IUD is the contraceptive method of choice for women (43.3% of CPR) and in China it is the second method of choice (31.7% of CPR) after female sterilization (33.6%) (WHO, WPRO & SEARO, 2008)
The level of awareness of contraceptive methods among teenagers is variable, for example, awareness of condoms among married adolescent girls in WPR varies from 96.3% in Vietnam and 88.3% in Cambodia to 63% in Malaysia and 50% in Lao PDR. Awareness levels are even lower amongst unmarried adolescents. Use levels are lower still than awareness levels for married adolescents 15-19 years old. In Cambodia only 20.9% of married adolescents use contraception, in Vietnam the figure for married adolescents is only 22.8% and in Philippines 25.6% (WHO, WPRO/SEARO, 2008).

(ii) Antenatal care - Contraception prevents unwanted pregnancies. When pregnancy does occur, whether planned and wanted or unplanned and unwanted, adequate antenatal care must be provided. Figure 27 shows that Lao PDR and Cambodia need to accelerate actions to improve this service coverage indicator. Comparing the average figures between the two decades (1990-1999 and 2000-2009) countries generally show an increasing trend; those already with high rates show minimal increase (China, Mongolia) while those with moderate rates show bigger changes (Cambodia, Vietnam). It is important to bear in mind that the number of antenatal visits alone does not reflect good care, the quality of care given at each of these visit is equally, if not more, important.
(iii) Adolescent birth rate - Young people’s sexual activity outside of marriage is increasing and there is also some evidence to show that young people are becoming sexually active at an earlier age. Sexual behaviour in this young age group is often unsafe due to lack of knowledge about sex and relationships, sexuality and reproductive health, and how to practice safe sex. Many adolescents are poorly informed about their bodies and few have access to contraception. Sex is often unplanned in this age group and young women in particular lack negotiation and refusal skills. A recent national study in Vietnam showed 50% of sexually active young people used no contraception at first sex and 65% used none at their most recent encounters (Nguyen et al, 2006).

Adolescent pregnancy puts girls at high risk of spontaneous abortion, premature labour, still births, obstructed labour and related injuries as well as death, and this carries through to the next generation as the child of an adolescent girl is at higher risk of infant mortality and morbidity. Figure 28 shows that among the more populous countries, adolescent birth rates are highest in Lao PDR, PNG, and Philippines, the highest being in Lao PDR and Papua New Guinea. On the other hand, China, Malaysia and Mongolia with low MMR have by far the lowest levels of adolescent fertility. The rates in the less populous Pacific Island countries tend to be somewhat higher but with less variability across countries, and in these countries, while the rates are high, the absolute numbers are low.
iv) Abortion - Unsafe abortions add dramatically to maternal mortality and represent a large portion of unreported maternal deaths. Globally about 13% of maternal deaths are due to unsafe abortion. In the WPR, data are not available for a reliable estimate of the proportion of maternal deaths caused by unsafe abortion, especially since abortion laws are very restrictive in many countries, and illegal in the Philippines and PNG. Although abortion rate is not an indicator for MDG 5b, it is pertinent to examine the situation, because abortion is often the consequence of unmet need for planning and low contraception use, and it is a contributor to maternal deaths. High abortion rates in women 15 - 49 years old are found in several countries: 57 per 1,000 in Vietnam, 49 per 1,000 in Cambodia and 66 per 1,000 in Mongolia. This represents a serious unmet need for contraception, and probably also reflects the liberal abortion laws in these countries. In the Philippines, abortion-related complications are one of the leading causes of hospital admissions; and a hospital-based study showed that 36% of those cases are among young women aged 15-24 years. In Lao PDR, a similar study revealed that of 390 cases of abortion-related complications, seven were unmarried adolescents under age 17, and 36 were unmarried students (National Statistics Centre, 2007). In Vietnam in 2000, it was estimated that approximately 37% of pregnancies in the 15-24 age group resulted in abortion (Nguyen et al, 2007). The Republic of Korea and Malaysia have moderate rates of abortion, and in these countries while abortion is legal, the law is restrictive allowing it only for specific indications. Official rates are low in Singapore and China (despite abortion being legal and liberal in China and services easily available).

3.2.3. Achieving MDG5 in the WP Region : 3 Case Studies

To portray some of the effective responses to reproductive and maternal health challenges in the Region, three case studies are presented.
**Case Study 1: Lao PDR: Targeted interventions to improve maternal and child health**

Targeted interventions such as pilot and demonstration projects in several areas have shown significant benefits for reproductive health. Progress is evident in the Xayaboury Province where an AusAID funded Primary Health Care Project has concentrated training and resources over the past 15 years and the reported reduction in mortality and morbidity for all age groups has been dramatic. In 2003 the reported MMR for Xayaboury was 110 (which exceeds the 2015 MDG5 target) compared to a national average of 530 (Perks, 2006).

WHO supported the Lao PDR government in 2009 to implement in two districts the Integrated Package of Maternal, Neonatal and Child Health Services. This involves interventions that place a strong focus on district and health centre levels management, build supportive environments including multi-sector work, and promote community participation. This initiative has begun to enhance strong political commitment and ownership; develop a micro-plan by each health centre to deliver an integrated package of services; train village health volunteers to collect and report key information; conduct an assessment on social and cultural barriers; strengthen capacity in planning, management and service delivery; and encourage subsiding of women and children to access essential services. WHO also built two maternity waiting homes with outreach clinics (in Bolikhhan in the east of Lao and Bokeo in the north west) to encourage women in remote areas to use trained birth attendants (Eckermann, 2005).

The maternity waiting home concept has been expanded by the NGO, Sai Mai Lao project, in collaboration with the Lao Ministry of Health, to develop an intersectoral approach to improve maternal and infant outcomes and alleviate poverty in the poorest provinces in the south of Lao PDR (Attepu, Sekong and Salavan). The 17 Silk Homes serve as maternity waiting homes as well as centres for income generating activities such as silk and cotton weaving (Eckermann & Deodato, 2008).

**Case Study 2: PNG and Cambodia: obtaining more reliable data through household surveys**

Getting reliable data on maternal health and mortality is a challenge in almost all countries. In the 1970s and 1980s, the WHO drew up a mathematical model to assist developing countries in working out what their MMR might be. It is especially difficult to accurately measure the MMR in a country that does not have quality vital registration systems. The figure that the WHO MMR predictive model calculated for PNG was 900 maternal deaths per 100,000 live births. The PNG figures make for a completely different attitude towards pregnancy and risk in the minds of ordinary people. In 1996, a demographic health survey (DHS) calculated the MMR in PNG to be 370 and the latest DHS in 2006 estimated PNG’s MMR at 733 maternal deaths per 100,000 live births.

In Cambodia, currently the Health Information System only captures a very small proportion of the number of expected maternal deaths. The Maternal Death Surveillance & Response System (MDSRS) has been set up to link communities, local authorities, health facilities, operational
districts, provincial health departments, and the central MOH through a weekly reporting system on maternal deaths occurring in communities and health facilities. Information is collected through a multiple reporting system including a simple one-page notification form to be filled in immediately upon initial report of a death. The database is updated weekly to permit intensive monitoring. The information is then displayed on maps highlighting locations of maternal deaths by commune and linking these to the location of health facilities and availability of EmONC care, road infrastructure and transport networks. Besides the Maternal Death Notification system, this initiative also strengthens the follow-up of maternal deaths. It reviews specific cases and ensures nationwide implementation of maternal death audit system. It crosslinks local information with the vital registration system and shares epidemiological information on maternal deaths across sectors.

**Case Study 3: Mongolia: Telemedicine as a solution to the tyranny of distance**

Mongolia has made great leaps in maternal and reproductive health coverage over the past decade and has already achieved its MDG5a target for MMR. Of the maternal deaths that still happen, ‘over 60% occur among herd women and unemployed and therefore extra attention to these vulnerable groups is needed. UNFPA works closely with the government to address this issue while implementing the third National Reproductive Health Programme of Mongolia (2007-2011) and the Maternal Mortality Reduction Strategy (2005-2010). Strategic areas of cooperation include improving the quality of Reproductive Health services through capacity building of health staff, behaviour change communication to improve knowledge of, and positive attitudes towards, reproductive health issues and policy dialogue at national and sub national level (http://mongolia.unfpa.org/2009/06/04/905/what_we_do/#1).

Geographical barriers represent a major challenge for achieving the MDG5b target on universal reproductive health provision in rural Mongolia, especially given the long distances between hospitals in remote provinces and the major central hospitals in Ulaanbaatar. Tele-medicine is now expanding across the country to address this problem. The well-structured Mongolian health care system with its comprehensive programmes and strategies, such as the National Reproductive Health Programme of Mongolia and the Maternal Mortality Reduction Strategy, provides ideal conditions for a successful introduction of telemedicine as a supporting element for improving maternal and child health care in the whole country, especially pregnancy support, deliveries and postpartum care. Through internet connections, telemedicine allows exchange of diagnostic and therapeutic skills and know-how between non-experts and experts anywhere in the world and particularly between specialists at the Health Sciences University of Mongolia (HSUM) and doctors in Aimag (province) hospitals. An additional application of this technology is tele-teaching (i.e. distance learning) for student training and continuous education of medical personnel and midwives. The strategic objectives of this telemedicine-project are to: increase capabilities for clinical decision-making and for distance learning; improve preoperative diagnosis and postoperative care and develop virtual campuses for distance learning.
3.2.4. Unmet reproductive health needs in developed countries

This chapter has described the situation and challenges for achieving MDG5 in developing and low income countries of the Region. In the developed countries, the key sexual and reproductive issues for mainstreaming women and health are very different to those in developing countries and marginalized groups within developed countries. The main concerns that women in these situations face are infertility (often after prolonged use of contraceptive pills), postnatal depression, breast and reproductive cancers, STIs, and teenage pregnancy. Lack of access to sexual and reproductive health services, and domestic violence are persistent challenges, especially among women from marginalized communities. Legal barriers to access to safe abortions pertain in many developed countries of WPR and the social stigma attached to abortion and seeking contraceptive advice, services and products provide major hurdles, especially for adolescents. Stigma attached to reproductive tract infections and STIs cause many women to delay seeking early treatment. Retroviral drugs are not always available for women living with HIV/AIDS even in developed countries. Breast and cervical cancer screening are readily available in most developed countries in the WPR but back-up counselling for positive test results, false negative and false positive diagnosis and post-treatment counselling are often lacking.

Postnatal depression is now well recognized and well-researched in most developed countries but often treatment does not apply the full range of research findings. Pharmaceutical solutions to postnatal depression predominate in treatment regimes rather than taking account of economic, social and cultural factors that may also contribute to the solution. For example, a study found postnatal depression to be high among Hmong immigrants in Australia and this is largely due to culturally determined difficulties faced by these women in a western health care system (Liamputtong-Rice, 2000).

3.3. HIV/AIDS and MDG6 in the WPR

Globally, HIV is a leading cause of mortality among women of reproductive age, but this is not the case for the WP Region. The epidemiological pattern of HIV in the WP Region is quite unlike that in Africa or South Asia. There is no generalized epidemic but rather varying degrees of severity between countries. The HIV epidemic stabilized across the Region between 2001 and 2008, with the exception of Papua New Guinea which is the only country in the Region with a generalized epidemic. In PNG the number of women and children living with HIV has been on the rise over the past two decades and current prevalence rates range from 1.7 to 2%. In 2000 in the Port Moresby General Hospital in Papua New Guinea, 0.9% of antenatal women aged 15-24 were reported as having HIV positive status (http://www.hivpolicy.org/Library/HPP000768.pdf).

In the other PIC’s the prevalence is low. Cambodia, China, Malaysia and Viet Nam have concentrated HIV epidemics in people with high-risk behaviour. The epidemics in these five countries (including PNG) make up the bulk of HIV burden in the Region. HIV transmission in the region is driven primarily by high-risk behaviour. The predominant focus in Member States within
the Region targets concentrated epidemics among most at-risk populations (MARPs), namely men having sex with men (MSM), injecting drug users (IDUs), and commercial sex workers.

The size of the problem of HIV/AIDS among women in the WP Region is embedded in the figures for total DALYs lost (and deaths) due to all communicable diseases and maternal conditions. Figure 9 shows that only 1.48% of DALYs due to communicable diseases and maternal conditions is contributed by HIV (the other STI contribute 1.62%) among females of all ages. This places HIV relatively low in the hierarchy of leading causes of DALYs lost. On the other hand, the contribution of HIV/AIDS to death is more substantial. Figure 10 shows that HIV/AIDS is the fifth biggest contributor to deaths attributed to communicable diseases and maternal conditions, accounting for 1.47%, after birth asphyxia and trauma, neonatal infections, meningitis and upper respiratory infections.

Achieving MDG 6 Target 6a requires stronger efforts to halt and reverse the spread in the countries where this is a problem, while target 6b is to achieve by 2010, universal access to treatment for HIV/AIDS for those who need it. Both have particular relevance to women. The first target would imply the need to prevent women from being infected. The second target has particular relevance in programmes in preventing mother-to-child transmission (PMTCT). The Sixtieth Session of the Regional Committee Meeting for the Western Pacific in 2009 outlined several areas where HIV/AIDS programmes need to be further strengthened. The key issue is mother-to-child transmission of HIV and paediatric HIV. Prevention is an essential and high-impact strategy, but must be linked to other programmes such as reproductive health and interventions for adolescent, maternal, newborn and child health. In terms of reproductive programmes and services, prevention of mother-to-child transmission (PMTCT) is the focus of activity in many countries. The Regional UN agencies in 2008 released "Asia-Pacific Operational Framework for Linking HIV/STI Services with Reproductive, Adolescent, Maternal, Newborn and Child Health Services" (WHO, UNICEF, UNFPA, UNAIDS, 2008) which provides useful guidelines for member states in implementing recommended policies and programmes.

Table 6 displays the status of HIV testing in pregnant mothers and the provision of treatment to mother and newborn. Coverage of testing is relatively high in Malaysia (75%) but low in Cambodia (29%), Vietnam (24%), and PNG (22%). The treatment rate for mother and newborn is variable across countries with Cambodia and Vietnam reporting high rates followed by Malaysia.
### Table 6 Preventing mother-to-child transmission of HIV: low- and middle-income countries, 2008

<table>
<thead>
<tr>
<th>Country</th>
<th>Number tested (coverage)</th>
<th>Number needing ART</th>
<th>Number receiving ART</th>
<th>Est. % received ART</th>
<th>Infants born to women living with HIV (coverage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cambodia</td>
<td>103 768 (29%)</td>
<td>1400</td>
<td>777</td>
<td>...</td>
<td>35</td>
</tr>
<tr>
<td>China</td>
<td>1 824 624 (10%)</td>
<td>...</td>
<td>980</td>
<td>...</td>
<td>...</td>
</tr>
<tr>
<td>Lao PDR</td>
<td>1171 (1%)</td>
<td>&lt;200</td>
<td>21</td>
<td>...</td>
<td>8</td>
</tr>
<tr>
<td>Malaysia</td>
<td>410 332 (75%)</td>
<td>1100</td>
<td>189</td>
<td>...</td>
<td>10</td>
</tr>
<tr>
<td>Papua New Guinea</td>
<td>44 580 (22%)</td>
<td>1900</td>
<td>257</td>
<td>13</td>
<td>9</td>
</tr>
<tr>
<td>Philippines</td>
<td>1736 (&lt;1%)</td>
<td>&lt;200</td>
<td>1</td>
<td>...</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Viet Nam</td>
<td>351 625 (24%)</td>
<td>3300</td>
<td>1 354</td>
<td>...</td>
<td>27</td>
</tr>
</tbody>
</table>

Source: Progress report 2009 by WHO, UNAIDS, UNICEF

### 4. Summary – What next?

Maternal mortality remains high in a few countries. A plethora of geographic, economic, legal, social, political and cultural factors explain persistence of maternal mortality and reproductive ill health. These are being addressed as witnessed in the four case studies presented in this chapter. However, further measures are needed to accelerate the decline in maternal mortality and to address the other reproductive health problems that plague women in Region including:

1. Ameliorating economic barriers to sexual and reproductive health which require redirection of government, donor, NGO and international funds to more upstream causes of such ill health such as female illiteracy and innumeracy, lack of female formal education, lack of income generating options for women, and lack of social welfare and health insurance.

2. Social, political and cultural solutions include enacting and enforcing anti-discrimination laws in all fields of economic and social life (including anti-domestic violence laws), using the rights-
based approach, and affirmative actions that reduce the disadvantages faced by women in the area of sexual and reproductive health including HIV/AIDS.

(3) Addressing distance and difficult terrain by building the capacity for Tele-health infrastructure for health advice, especially for antenatal, postnatal and birthing care. Reducing the digital gap among economies and promoting ICT investment is the responsibility of all countries in the WPR. Collaborative relationships between public and private sectors to reduce the digital gap have been successful in improving health outcomes for Aboriginal communities in Queensland, Australia (Smith & Gray, 2009; Armfield et al, 2009). In the case of Lao, Cambodia, Mongolia and PNG, maternity waiting homes have been effective in improving access to quality care (WHO, 1996; Eckermann, 2006).

(4) Correcting the lack of accurate information about reproductive and sexual issues among adolescent girls (compared to adolescent boys) which is a major gap in health education and health promotion services and infrastructure. This gap contributes to substantial reproductive and sexually-related burden of disease amongst teenage girls including unwanted pregnancies, unsafe abortions, sexual abuse and STIs and HIV/AIDS.

(5) The lack of reliable data, especially the paucity of disaggregated data by relevant variables. This requires improvement of health information systems and in many countries, the national vital registration system needs strengthening.

Annex 1 - Reproductive and sexual health, and rights defined at the International Conference on Population and Development (ICPD) at Cairo in 1994.

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capacity to reproduce and the freedom to decide, if and when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant." In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, technique and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling, and care to reproduction and sexually transmitted diseases (ICPD, 1994).
Sexual health means that people should be able to have safe and satisfying sex lives. Gender relations should be equal, responsible and mutually respectful. Sexual health encompasses behaviors essential to countering sexually transmitted diseases (STD’s), including HIV/AIDS. Sexual health aims at the enhancement of life and personal relations, and sexual health services should not consist merely of counselling and care related to reproduction and sexually transmitted diseases.

Reproductive rights include the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so. It also includes their rights to make decisions concerning reproduction free from discrimination, coercion and violence, as expressed in human rights documents.

Sexual rights include the human rights of men and women to have control over and decide freely and responsibly on matters related to their sexuality including sexual and reproductive health, free of coercion, discrimination and violence.

The constituents of a SRH service includes the following:
- family-planning counselling, information, education, communication and services; -
- education and services for pre-natal care, safe delivery and post-natal care;
- prevention and appropriate treatment of infertility;
- prevention of abortion and the management of the consequences of abortion;
- Information, education and counselling on human sexuality, reproductive health and responsible parenthood;
- further diagnosis and treatment for complications of pregnancy, delivery and abortion,
- infertility, breast cancers and cancers of the reproductive system, reproductive tract infections; sexually transmitted diseases, including HIV/AIDS and
- active discouragement of harmful practices, such as female genital mutilation.
References

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CHAPTER 4.
WOMEN AND THE HEALTH SYSTEM

4.1. Women’s experiences in the health system

Given the diversity of characteristics (demographic, economic, social, cultural, political, religious and geographic) of the countries of the WPR it is hardly surprising that national health systems also vary widely in resources, governance, and responsiveness to the needs of women and girls. Health systems are shaped by local norms and social policies, demographics, education and the financial and human resources available. The report Health in Asia and the Pacific (SEARO & WPRO, 2008) highlights challenges faced by countries in the Region which include:

(1) Poor and inequitable health outcomes for women. Continuing high rates of maternal mortality and morbidity in Lao PDR and PNG, and in rural and remote and ethnic minority communities even in developed countries (like Australia), indicate that the health systems are failing women and not adequately addressing economic, geographic and ethnic and racial inequalities.

(2) Girls’ and women’s lack of access to care. Women who live in remote areas, have language and cultural differences from health providers, possess little social power and have limited economic resources, and in many countries in the WPR, cannot access health care.

(3) Lack of quality, continuity and integrated services for girls and women. When women do gain access to health care, the quality of that care is often sub-standard. Facilities are often dilapidated and non-functional and care is uncoordinated.

(4) Poor responsiveness to girls’ and women’s needs and demands. Health staff can be aloof and uncaring, especially towards ethnic minority and poor women. Often health care providers take no account of deeply held cultural values of women, especially in cultural rituals around pregnancy, childbirth and postnatal care.

One aspect of the unequal treatment within health systems is the way women with an illness are managed differently from men with the same illness. The differential treatment for women with cardiovascular disease in the Australian health system serves as an example of this situation. Cardiovascular disease is often perceived as a ‘man’s disease’ and that the impact on women is perceived to be less of a threat. Yet, more than one in three women who died in Australia in 2006 did so as a result of a cardiovascular disease’ and many of these deaths were premature. Coronary heart disease and stroke are in the 10 top causes of poor health and disability among Australian women. Despite this, it has been observed that women are less likely than men to be diagnosed early; women hospitalized with cardiovascular conditions are significantly less likely to have several diagnostic tests and treatments than men; prescriptions differ by sex, women are
more likely to be supplied diuretics, calcium channel blockers and rennin-angiotensin system agents, whereas for men, supply rates are higher for anti-thrombotics, cardiac therapy medicines and lipid-lowering medicines. It is also common to have some modalities of treatment, including pharmacological interventions, based on clinical trials that used only men as subjects, and this can render the modalities unsuitable (or even harmful) for women. To respond to these issues, the Heart Foundation of Australia has begun an initiative called the "engaging women" strategy to increase awareness and get a clearer picture of the situation.

4.2. Women as health care providers

Women play the key role of carers in both the formal and informal health sectors in virtually all parts of the world. The informal carer role starts very early in life for young girls and continues through to old age as grandmothers and great grandmothers care for successive generations of children. In between these phases, adult women in the 20-60 age group often play a dual role as informal and formal health care providers. And this has its own challenges.

4.2.1. Girls and adolescents

Throughout the countries of the WPR girls start playing the caring role in families at a very early age which disrupts their education and their opportunities to enjoy childhood. In most societies, girls are socialized into a nurturing role and often play a role as assistant, or even substitute, parent for their siblings for much of their childhood and adolescence. This partly relates to the lack of paid, or even unpaid, parental leave in most countries of the Region so women return to work soon after their babies are born and often leave their new offspring in the care of siblings. Less than one third of the countries in the WPR have any paid or unpaid maternity leave and only two provide paid or unpaid paternity leave. When they grow up, this role that girls and adolescents play as carers tends to pervade both the work and home environments. The absence from school, while caring for siblings, and their identification with the caring role, affect their options for occupations and careers and their expectations of domestic life.
4.2.2. Adult women as health care providers

The World Health Report 2006 estimated a global shortage of 2.3 million physicians, nurses and midwives to meet the workforce levels required to strengthen health systems and accelerate progress towards attaining the health related Millennium Development Goals. Globally, although women make up about 42% of the estimated global paid working population within the health sector, in many countries, women comprise over 75% of the health workforce, making them indispensable as contributors to the delivery of health care services. In the WPR adequate data on sex distribution of health workforce are not available. China has the largest health workforce in the world. Of the estimated 6,169,050 health workers 64.3% are women. In the Republic of Korea 71% of the health workforce are women and in Japan women represent 75% of overall health occupations. In Mongolia, health care in all occupational groups (including physicians and pharmacists) is highly feminised with women making up over 90% of the total health workforce. Nurses and midwives comprise the largest portion of the health workforce in most countries which explains the gender skew. They deliver core services at all levels of the health system and across the continuum of care to promote health, and to improve patient care, service delivery and health outcomes.
In many countries, women still tend to be concentrated in the lower-status health occupations, and to be a minority among more highly trained professionals. In particular, the distribution of women by occupational category tends to be skewed in favour of nursing and midwifery personnel and other ‘caring’ cadres such as community health workers. Women are often poorly represented in other categories, e.g. physicians, dentists, pharmacists and managers. As the proportion of women in medicine trends towards parity in many countries of the WPR, and the proportion of men in nursing increases, the nature of the gender balance, and the relationship between doctors and nurses have changed dramatically. The 2009 CHIPS data estimate that 78% of current physicians and 92% of current pharmacist are women. However, women were still regarded as the primary carers in the home, so as in other countries of the WPR, they were subjected to the ‘double shift’ of paid work in the public sphere plus housework, childcare and responsibility for the wellbeing of the family in the domestic sphere.

Although women and men are moving towards equity in the public sphere of work, there is a slower trend towards shared caring roles in the domestic sphere of the home. This is partly an outcome of the reality of women outliving men. For women the slogan promoting a ‘work/life balance’ means balancing paid and unpaid work rather than leisure and work time. Evidence of the effects on health of full-time caring role of women has been documented by several studies in developed countries including Australia. The Commonwealth Financial Planning Women Carers in Financial Stress Report (2009) in Australia examined the lifetime financial consequences of caring on Australia’s predominantly female carer population and found that women carers face a lifetime of negative health and economic consequences including high stress levels, low sense of wellbeing and poor health, ‘lower workforce participation rates and reduced healthy lifespan, fuelling a reduction in household incomes and retirement savings’(National Centre for Social and Economic Modelling, 2009).

The Report concludes that ‘Australia’s 2.6 million unpaid carers provide services estimated at more than $30.5 billion annually, yet many remain economically and socially disadvantaged’ and because ‘primary carers are more likely to be women than men, women are more likely to ‘pay the price’ of being a carer’. The two groups, who represent the largest proportion of informal carers, most at risk of detrimental financial, social and health outcomes are ‘women caring for a child with a disability and women caring for a male partner with a disability.’ (National Centre for Social and Economic Modelling, 2009:1)

The Australian Unity Wellbeing Index Survey 17.1 (Cummins et al, 2007: vi) provides overwhelming evidence that ‘carers have the lowest collective wellbeing of any group’ in Australian society. ‘Female carers have lower wellbeing than male carers ‘ which goes against the trend of better wellbeing outcomes for women in the general population and carers have’ an average rating on the depression scale that is classified as moderate depression’.
There is no reason to believe that the health, social and economic impacts on women are any different in the other countries of WPR but the data are not yet available to make the comparison.

4.2.3. Older women as carers

When they retire, older women tend to play a key role in child care for their grandchildren and great grandchildren. Older women also make up the highest proportion of volunteer workers in hospitals, community organizations, NGOs and local support services. In Cambodia and PNG older women are playing a key role as carers for children who have lost their parents to HIV/AIDS. Older women also tend to be the source of information about home remedies for various ailments and although research on the amount of lay healing and treatment which occurs in the home and in informal healing networks is underdeveloped. In many traditional societies women take on key healing roles in old age as shaman and lay healers. For example, many of the TBAs in the Philippines, Lao, Cambodia and Vietnam are older women who are seen as the font of knowledge and experience on birthing, usually because they had a large number of children themselves. In the Philippines 'hilits' are older women whose healing knowledge is passed down through the maternal line and in Kadazan culture in Sabah, East Malaysia, high priestesses (‘bobohizan’) are responsible for the spiritual and physical well-being of the community. Their special knowledge and skills are also passed down through the generations on the maternal line (WHO, WPRO, 1995).

*Figure 30 Bobohizan High priestess in Sabah, Malaysia (photo courtesy of Sabah Tourism Promotion)*

4.3. Women as carers in crisis situations including effects of climate change

In times of crises, whether they be climatic upheavals and natural disasters like floods, tsunamis and earthquakes, or man-made crises like civil unrest, women are not only victims, but they play a role as carers, both as formal health care providers (doctors, nurses, midwives, social workers and counsellors), as well as helping in an informal way. This has often been observed in evacuation
camps where women volunteer to take care of fellow inmates and their families. A specific example of the role of women in serious crisis situations is afforded by the experience in Cambodia during, and after several decades of, political upheaval and civil war. The absence of a whole cohort of men, after the atrocities of the Pol Pot regime, catapulted women into public life under tragic circumstances but also accentuated their caring and nurturing role within the family to heal the invisible wounds of war and trauma.

In mobilizing responses to natural disasters and to the more incremental effects of climate change, the health workforce plays a crucial role. Given that the health workforces in all countries of the WPR are dominated by women, women are closely involved in frontline leadership, care, support, treatment and rehabilitation. Prevention activities such as public education campaigns, disease surveillance, food hygiene and inspection, nutritional supplementation, vaccines, primary and mental health care and training are mainly carried out by nurses and other feminized health occupations.

4.4. Summary – Issues and the way forward

Health systems are not always sensitive to the needs of women as users of health service, and women in all countries report negative experiences in the health system as both consumers and providers of health care. Women make important contributions to the health system, both formally and informally. There are substantial benefits, but also serious disadvantages, of women playing a central role as providers of health care while at the same time being the main consumers of such care. Health policy makers need to be cognizant of this dual role that women occupy in health care and design health care systems to maximize their multiple contributions as providers and their positive experiences as consumers. For example.

(1) Health care workers must be given competencies not only in their technical and professional roles, but also in the “softer” qualities of patient care to ensure a caring patient-centred and women-friendly service.

(2) Working women face difficulties in balancing work-home responsibilities. Solutions to this lie with institutional based childcare which is affordable and easily accessible, and which removes a major barrier to women continuing in prolonged training courses, and paid parental leave. Paid maternity, and paternity leave, ensures that women do not lose allowances when they have children. In most countries of the WPR, where parental leave is offered, it is often inadequate.

(3) The collection, processing, dissemination and use of sex-disaggregated data can help to plan, monitor and evaluate successful gender-sensitive interventions in the work place, bringing attention to the ways in which social and behavioural differences between women and men may lead to inequities in working conditions in the health sector and, ultimately, in inequities between women’s and men’s access to health care services and health outcomes. Access to reliable,
timely information on gender and the health workforce can inform the steps needed to achieve gender equity.

References

5.1 Social and environmental determinants and MDGs

All of the Millenium Development Goals are health related. Although MDGs 4, 5 and 6 directly refer to health outcomes, the other 5 MDGs point to some of the social, environmental and structural factors that impact on health outcomes. Poverty (MDG1), educational and literacy deficits (MDGs 2 and 3), gender inequality (MDG3), environmental degradation (MDG 7) and uncoordinated development and governance (MDG 8) are critical barriers to women achieving optimum health in all regions of the world.

The determinants that lead to the diversity of health outcomes for women in the WPR, outlined in Chapters 1-3, and disparities between men's and women's health experiences in the Region, include the factors highlighted by the MDGs as well as a raft of other social, economic, structural and cultural determinants such as ethnicity and gendered expectations. 'Gender influences the health of men and women through multiple pathways. Gender roles and norms , and the gender-based division of labour, interact with other social determinants - such as education, employment status, income, culture, household position, age, the physical and social environments- to shape the possibility of good health' (WHO, WPRO, 2008c:16). In this chapter, the economic, educational, employment and environmental dimensions of gendered inequality are used to illustrate the impact of social factors on health experiences and outcomes for women in the WPR.

5.2 WPR response to the Marmot Report

In 1999 Marmot and Wilkinson (1999) published key research on the impact of the social environment on the health of individuals and populations, including the effects of the labour market, poverty, unemployment, the organization of work, transportation, social support and social cohesion, food supply, and smoking on health outcomes. In 2006, a second edition of their book added chapters on the impact on health of other dimensions of structural and social inequality such as race and ethnicity, ageing, housing, and sexual behaviour (Marmot and Wilkinson, 2006). In 2005, WHO launched the Marmot Commission on Social Determinants of Health which reported its findings in 2008. Its key recommendations pointed to policy failures at all levels of governance and suggested action at international, regional, country and community levels to:

- improve daily living conditions;
- tackle the inequitable distribution of power, money and resources; and
- measure and understand the problem and assess the impact of action (WHO, 2010).

WHO is charged with responsibility in three key areas, namely:
strengthening global and national capacities to address social determinants...and assessing the impacts of global policies on health inequities;

- strengthening efforts to measure and evaluate health inequities, through national health-equity surveillance systems and appropriate tools; and

- building internal capacity to address social determinants and health inequities. (WHO, WPRO, 2010)

These recommendations are very broad but had already been anticipated, and operationalized, for the WPR through a series of sourcebooks addressing the nexus between poverty and gender in determining health outcomes in the Region. The series on *integrating poverty and gender into health programmes* (WPRO, 2005-2009) outlines activities and approaches for health professionals on a variety of topics including sexual and reproductive health, HIV/AIDS, non-communicable diseases, ageing, malaria, mental health, gender-based violence, water, sanitation and food. The series also includes foundational modules on gender and poverty, strategies for curricular integration and a regional report on surveys of health ministries and educational institutions (WHO, WPRO, 2005-9). The books aim to 'improve the awareness, knowledge and skills of health professionals' on social determinants such as poverty and gender as key factors in health outcomes and to break down the hegemony of the medical model of explaining disease (causation, prevention and treatment) for health providers, health consumers, and policy-makers, in all health settings in the WPR.

### 5.2.1 Poverty and health

Evidence that health outcomes are closely related to level of economic development and its consequences has been mounting since the UNDP started systematically reporting the nexus between health and economic development globally in 1990. Expenditure on education and health services, provision of social security, investment in communication, transport and roads and capacity to service populations with adequate nutrition, clean water, adequate sewerage and housing – all determinants of health including women's health – obviously are dependent on gross national income. The significant contribution of poverty to ill health especially health of girls and women is well known. The most stark outcome of poverty is in maternal mortality rates; of the more than half million maternal deaths a year 98% are in poor countries. On the household and individual levels, since many more women than men are poor, access to health care is compromised for women in many parts of the world.
However, the nexus between poverty and health must not be seen from a narrow lens. It is important for nations to aspire to total well-being and quality of life for their peoples as well as physical health. In this regard, wealth alone, as measured by GDP is increasingly being seen as an insufficient measure of progress in societies, especially in relation to women’s health and well-being.

‘For a good portion of the 20th century there was an implicit assumption that economic growth was synonymous with progress: an assumption that a growing Gross Domestic Product (GDP) meant life must be getting better. But now the world recognizes that it isn’t quite as simple as that. Despite high levels of economic growth in many countries many experts believe we are no more satisfied with our life (or happier) than we were 50 years ago; that people trust one another - and their governments - less than they used to; and that increased income has come at the expense of increased insecurity, longer working hours and greater complexity in our lives. Much of the world is (physically) healthier and people live longer than they did just a few years ago, but environmental problems like climate change cast a shadow over an uncertain future’ (OECD 2009).

There is therefore a need to evaluate the status of human development overall, beyond the GDP to look for answers to health inequities measures for women that capture the “physical, mental and social well-being” of women. These measures need to be developed and applied in evaluating the effect of interventions. These include measures of objective conditions of life as well as subjective quality of life.

5.2.1.1 Human development, gender development and gender empowerment

The attempt of the United Nations to overcome an over-simplistic measure of progress (GDP) led to the development two decades ago of a composite measure of progress, The Human Development Index (HDI) (United Nations, 1990). The HDI, and its later variants the Gender-related Development Index(GDI) and the Gender Empowerment Measure (GEM), have been used by the United Nations to report the level of progress of countries in improving the lot of all, but in particular women.

The HDI is a ranking that combines indices of GDP, education (using adult literacy and school-enrolment data), and health (based on life-expectancy at birth). The GDI uses the same education and health indicators, and replaces GDP with estimated earned income, and disaggregates them all by sex to build a composite score by which nations are ranked. The GEM combines measures of women’s participation in public life (percentage of total seats in parliament, ministers, legislators, senior officials and managers, professional and technical workers) with women’s earning power (female: male earned income) and enfranchisement (year women received the right to vote, stand for election and year a woman became a presiding officer of parliament for the first time). Although these measures have been described as the only measures which have succeeded in challenging the hegemony of growth-centric thinking they also have their detractors. In particular, the HDI’s three-part weightings are regularly criticized for being arbitrary, why choose school enrolment rather
than completion rates to represent education, and why choose life expectancy at birth to represent health? The main contentious issue is that minor variations in any of the indices, such as literacy rates of developed nations, can yield significant differences in how countries rank (N.Y. Times, 2010).

Despite these criticisms over the use of HDI, it is still being used by the United Nations to compare countries and their progress over time. Annex 1 shows the HDI in countries of WP Region, along with the other measures that contribute to the determination of the HDI, namely life expectancy in females and life expectancy index; adult literacy rate, gross enrolment into the three levels of education (primary, secondary and tertiary) and education index; the GDP and GDP index. Figure 11 shows the trend of HDI ranking across four points in time (1990, 1995, 2000, 2005) in countries of the Region, which reveal an encouraging trajectory overall, although this improvement is of varying magnitudes among countries. In most countries, the HDI lies between 0.6 and 0.8, with nine countries exceeding 0.8 in 2005, and three countries with HDI below 0.6. Countries can be classified according to HDI as follows: Very High (Australia, Japan, New Zealand, Singapore, Hong Kong, Korea, Brunei), High (Malaysia); Medium (China, Samoa, Philippines, Fiji, Mongolia, Vietnam, Vanuatu, Lao PDR, Solomon Is, Cambodia, PNG).

**Figure 30 Human Development Index Trend 1975-2005 in countries of WP Region**

![Graph showing HDI trend across countries](source: UNDP, World Development Report 2009)
However, when we compare the HDI with the gendered indicators, GEM in particular, we get a slightly different picture. Economic development does not necessarily lead to better outcomes for women, and women's situation can improve despite low economic indicators. For example Australia ranks impressively high on HDI and GDI but lower for the GEM. Japan and Korea are also ranked high on HDI and GDI (although not as high as Australia) but also relatively low for GEM. At the other end of the scale Vietnam and the Philippines are ranked low on the HDI but attain relatively high rank for GDI and impressive ranks for GEM. See Table 4.

Table 7 Comparing HDI with GDI and GEM in selected countries, 2009

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>HDI Rank</th>
<th>GDI Rank</th>
<th>GEM Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>2</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Japan</td>
<td>10</td>
<td>14</td>
<td>57</td>
</tr>
<tr>
<td>New Zealand</td>
<td>20</td>
<td>18</td>
<td>10</td>
</tr>
<tr>
<td>Singapore</td>
<td>23</td>
<td>-</td>
<td>16</td>
</tr>
<tr>
<td>Hong Kong</td>
<td>24</td>
<td>22</td>
<td>-</td>
</tr>
<tr>
<td>Korea</td>
<td>26</td>
<td>25</td>
<td>61</td>
</tr>
<tr>
<td>Republic of Brunei</td>
<td>30</td>
<td>29</td>
<td>21</td>
</tr>
<tr>
<td>Malaysia</td>
<td>66</td>
<td>58</td>
<td>68</td>
</tr>
<tr>
<td>China</td>
<td>92</td>
<td>75</td>
<td>72</td>
</tr>
<tr>
<td>Samoa</td>
<td>94</td>
<td>80</td>
<td>89</td>
</tr>
<tr>
<td>Tonga</td>
<td>99</td>
<td>78</td>
<td>102</td>
</tr>
<tr>
<td>Philippines</td>
<td>105</td>
<td>86</td>
<td>59</td>
</tr>
<tr>
<td>Fiji</td>
<td>108</td>
<td>90</td>
<td>-</td>
</tr>
<tr>
<td>Mongolia</td>
<td>115</td>
<td>92</td>
<td>94</td>
</tr>
<tr>
<td>Viet Nam</td>
<td>116</td>
<td>94</td>
<td>62</td>
</tr>
<tr>
<td>Vanuatu</td>
<td>126</td>
<td>104</td>
<td>-</td>
</tr>
<tr>
<td>Lao PDR</td>
<td>133</td>
<td>112</td>
<td>-</td>
</tr>
<tr>
<td>Solomon Islands</td>
<td>135</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Cambodia</td>
<td>137</td>
<td>116</td>
<td>91</td>
</tr>
<tr>
<td>Papua New Guinea</td>
<td>48</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Source: UNDP, World Development Report 2009

More recently the UNDP has revised these measures. To overcome the shortcomings of the HDI (and the Human Poverty Index - HPI), the Oxford Poverty and Human Development Initiative has developed a new international measure of poverty for use in the 2010 UNDP Human Development Report – The Multidimensional Poverty Index (MPI). The MPI uses microeconomic data to reflect
the percentage of households that experience overlapping deprivations in three dimensions—education, health and living conditions' (OPHI, 2010). The new measure allows countries to target households and pockets of poverty more effectively. For example, according to the new MPI measure 13% of Filipinos are poor (compared to an estimate of 23% using the old HPI) and the particular dimensions contributing to that poverty are clearly identified (Alkire & Santos, 2010).

5.2.2 Literacy and education

Female education is one of the strongest determinants for health of families and communities. MDG2 is devoted to primary school completion rates for all children, and MDG3 addresses equal opportunities for boys and girls for tertiary education. From Figure 12, the literacy rates for males and for females in selected countries of the Region show marked gender differentials for PNG, Lao PDR and Cambodia. These are the countries with the least favourable health outcomes for girls and women as detailed in Chapter 1. Figures 13A to 13C show the female to male ratio of enrolment in primary, secondary and tertiary education. For primary education there is little gender preference, but the situation is less positive for secondary education. For example in Lao PDR and Cambodia, for every 100 boys enrolled in secondary education, only 60 to 80 girls are enrolled.

For tertiary education, the gender differential increases. Even in high income countries such as Japan and Korea, the number of girls enrolled is far lower than that of boys. In Cambodia, Lao and Vanuatu, the number of boys in tertiary education is about twice that of girls. Completion rates at all three levels of education would provide a better picture of the sex differentials but sex disaggregated data for this indicator are not available in the WP Region.

Figure 31 Female-Male Literacy Rate (%) in selected countries of WP Region, 2007


UNDP, World Development Report 2009
Figure 32A: Female-Male ratio of enrolment in primary education, selected countries, 2007

![Graph showing female-male ratio of enrolment in primary education for various countries in 2007, 2004, and 2000.]


Figure 32B: Female-Male ratio of enrolment in secondary education, selected countries, 2007

![Graph showing female-male ratio of enrolment in secondary education for various countries in 2007, 2004, and 2000.]

5.2.3 Female employment

Another social measure that has influence on women’s health is the paid employment of women. Figure 14 shows that the overall labour force participation among 15-64 year olds in 12 selected countries is high in both men and women, and there is a small gender difference. This is most likely accounted for by the participation of women in the informal sector, which may have implications on the income earned. In fact in Lao PDR, women have higher workforce participation rates than men but largely in the informal sector where salary rates are very low. Mongolia too shows negligible male/female difference but the overall participation rate is lower than the other countries. There are significantly larger gender differences in Malaysia, Philippines and Rep of Korea, where the participation rate among men is higher than that among women.

Even where there is equality in percentage of men and women employed, women work less hours than men in paid employment and even in developed countries their pay rates are significantly lower than those of men with equivalent training and experience. For example, the pay differentials, per hour, between men and women in Australia remain at 18% in 2010. In New Zealand the differential is 17% across all age groups, and even in younger cohorts where one would expect parity, the gender wage gap remains high. In a New Zealand birth cohort of 30 year-olds, 'prior to adjustment for explanatory variables, male wages were 38.0 per cent higher than female wages. After adjustment for human capital endowments, job characteristics and family responsibilities,
there remained an unexplained gender wage gap of 11.5 per cent. Decomposition of the gender wage gap revealed that 66.4 per cent of the total gender wage gap could be explained by gender differences in human capital, job characteristics and family factors. These results suggest that, even after accounting for gender differences in a wide range of explanatory variables, males continue to earn significantly higher wages than females' (Gibb et al., 2009: 281). This differential results in gendered patterns of economic disadvantage which impact on health.

**Figure 33 Percentage of Labour Force Participation, Women and Men, selected countries, 2008**

![Percentage of Labour Force Participation, Women and Men, selected countries, 2008](image)


Paid maternity, and paternity, leave ensure that women do not lose allowances when they have children. They are encouraged to return to paid work after the birth as their partners are able to take leave without losing pay, and benefits, themselves. Paid parental leave gives children the best start in life by allowing parents more time to stay at home to care for their baby during the vital early months of their baby's life. Furthermore, such schemes support women to maintain their connection with the workforce and boosts workforce participation, give parents more options to balance work and family and help employers retain skilled and experienced staff. The health consequences for parents and their offspring of constant parent-infant contact in the first few months of the baby's life, without fear of economic hardship, has been well documented. The Australian Productivity Commission analysed the available evidence on parental leave and concluded that significant positive benefits include:

- 'Allowing most infants to be exclusively cared for by a parent for the first six months of life (without undue financial stress), which improves child development outcomes, enhances
support for breastfeeding with its health benefits for mothers and infants, and provides a reasonable period of leave for maternal recovery from childbirth;
- changing community attitudes by sending a strong signal that having a child and taking leave from work around the time of the birth or adoption is part of the normal course of work and family life'.

The Productivity Commission concluded that "there is compelling evidence of child and maternal health and welfare benefits from a period of absence from work for the primary caregiver of around six months and a reasonable prospect that longer periods (nine to twelve months) are beneficial" (Productivity Commission, 2009). Paid parental leave is not currently offered in 25 countries of the WPR, and where parental leave is available, it is often inadequate both in terms of pay and time (see Table 11). Only Cambodia and the Philippines currently have paid paternity leave and, even there, 7-10 days is not enough to support a partner/spouse returning to work. Australia currently relies on industry to provide parental benefits but will introduce a paid national parental leave scheme of 18 weeks in January 2011 (http://www.fahcsia.gov.au/sa/families/progserv/paid_parenal/parental_leave/Pages/AustraliasPaidParentalLeaveScheme.aspx, 2010).

In addition to paid parental leave high quality child care for young children while mothers are at work is essential for mothers', children's and families' wellbeing. Very few countries have work-based childcare provisions for their workforce where mothers have easy access to their infants for breastfeeding. In most countries in the Region, child care is expensive and of varying quality.

**Table 8 Countries with national parental leave (weeks) 2010**

<table>
<thead>
<tr>
<th>Country</th>
<th>Paid maternity leave (wks)</th>
<th>Unpaid maternity leave (wks)</th>
<th>Paid paternity leave (wks)</th>
<th>Unpaid paternity leave (wks)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>0</td>
<td>52</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cambodia</td>
<td>13</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>China</td>
<td>13</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Fiji</td>
<td>12</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Japan</td>
<td>14</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Lao PDR</td>
<td>13</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Malaysia</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>NZ</td>
<td>14</td>
<td>38 share</td>
<td>0</td>
<td>38 share</td>
</tr>
<tr>
<td>Philippines</td>
<td>8</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>
5.3. ‘Climate change puts at risk the basic determinants of health’ (WHO, 2009b)

‘There is now widespread agreement that the earth is warming, due to emissions of greenhouse gases caused by human activity. It is also clear that current trends in energy use, development and population growth will lead to continuing – and more severe- climate change’ (WHO, 2009b: 2). The extra burden of disease caused by climate change is already significant. Between 1970 and 2004 WHO estimates that ‘140, 000 excess deaths annually were attributable to climate change and global warming is contributing to a widening gap between health outcomes for the rich and poor, and men and women, in most countries.

Evidence from around the world suggests that gender is a major differentiating factor in the health consequences of climate change. ‘Climate changes are not gender blind’ (NIKK, 2009:2). Women and girls are not only the most vulnerable to the health effects of climate change but also women are the most proactive in trying to mitigate the effects of global warming (Ban Ki-moon, 2009). In many parts of the Pacific, for example Tuvalu, king tides, coastal erosion, severe tropical storms, flooding and rising sea levels have already caused salinization of formerly fresh water and agricultural land, claimed lives and undermined the livelihood of the inhabitants. These island’s public health infrastructures are severely compromised just when elevated rates of diarrhoeal diseases, malaria and nutritional deficiencies, as a result of flooding and the disappearance of arable land, require more health resources. ‘Women and children are particularly vulnerable to death and illness following natural disasters’. In the 1991 Bangladesh cyclone disaster death, injury and disease rates among women were ‘four times greater than for men’ and for children ‘six times greater than those of adult men (WHO, 2009b: 19; Oxfam, 2002). In Aceh during the 2004 tsunami more than 75% of those who died were women and girls (NIKK, 2009:15). Some of the reasons cited for this gender skew in deaths are Asian ‘norms for women’s dress which limit their opportunity to move away quickly’ and women and girls in many cultures ‘are not taught to run and swim to the same extent as men’ (NIKK, 2009:15). Furthermore, ‘when villages are flooded in Asia, you die if you are, as a women, not allowed to be seen alone and in wet clothes among unfamiliar men’ (NIKK, 2009:21).

Over the past decade there have been unprecedented floods in the northern mountainous parts of China causing massive loss of life as well as infrastructure and social disruption. The crises caused by flooding of the lakes at the bottom of the melting glaciers have been exacerbated by ‘higher temperatures intensifying the risk s of transmission of vector –borne diseases , such as malaria,

<table>
<thead>
<tr>
<th>Solomon is</th>
<th>12</th>
<th>0</th>
<th>0</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Singapore</td>
<td>12</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Vietnam</td>
<td>17-26</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Source: Labour statistics 2010.
among high altitude population that lack immunity against such disease’ (WHO, 2009b: 14). Pregnant women are particularly vulnerable to malaria and consequent anaemia which has devastating effects on unborn children.

The extra burden of disease and death that women carry as a result of the effects of natural disasters is not confined to the immediate aftermath of the disaster. ‘In many developing countries in the WPR ‘the women are the main actors in the home and in the production of food in agriculture. Therefore their work (including collecting uncontaminated water) will grow as the weather changes’. In addition, if they have to travel further to collect water or cultivate crops, ‘their safety is at risk’ (NIKK, 2009:22). In the home they are at greater risk too because ‘natural disasters can also result in increased suffering from domestic violence and post-traumatic stress disorders in women who are also often called upon to play a leading role in disaster recovery and in rebuilding shattered communities’ (WHO, 2009b: 19) and it is feared that the specific effects of climate change for women will have long-term consequences for gender equality.

There is a glaring gap in research on the gender implications of climate change and the gendered nature of the response to climate change. Research should respond to the needs of communities on the ground, and empower men and women to participate in decision-making and implementation. This implies people-centred and participatory methodologies. More research is also needed to enable the development of gender sensitive policies, programmes and measures in adaptation as well as in mitigation. A gender and climate change conference in June 2010 set up a gender and climate change research network. The network addresses the problems of mainstream research looking more into physical aspects of climate change than into social and political issues. In particular cross-cutting issues such as the linkages between Gender and Climate Change have widely been ignored. However, in a number of areas relevant to climate change, there is strong evidence for a gender dimension that needs to be considered, especially in regards to vulnerability and adaptation, as well as to attitudes and contributions towards solutions (IUCN, 2010).

5.4 Conclusion

Environmental, social, cultural and economic factors are as important as physiological factors in determining health outcomes for women. Every health event has physiological, psychological, economic and sociological determinants. For example the higher prevalence and incidence of malaria among young children and women in PNG (WHO, WPRO, 2008c) relates partly to physiological vulnerability but also to gendered and culturally and socially determined living conditions (such as differential nutrition).

The further upstream, and the earlier in the lifespan, interventions happen in the flow of health determinants, the greater the chance of successful health and wellbeing outcomes. Ultimately, the elimination of poverty, education of girls to their full potential, provision of meaningful and equally paid employment for women, support for families during early child-rearing, civil stability, and
gender equity in all spheres of life, in a sustainable physical environment will minimize the need for
downstream health interventions which are expensive, resource intensive and often ‘too late’.

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CHAPTER 6
POLICY IMPLICATIONS – A CALL FOR ACTION

While some responses have been suggested in the summary of each of the Chapters above, it is also useful for Member States and WPRO to have a broader perspective on policy options for women’s health beyond the MDG 2015 targets. A fruitful template is that adopted by the global report “Women and Health – Today’s Evidence, Tomorrow’s Agenda” which uses the options described in the World Health Report 2008 “Primary Health Care – Now More Than Ever” to provide a practical framework for translating evidence into policies and actions to improve women’s health. It also points to ways to enhance women’s experiences as both consumers and providers of health care.

The values and principles of Primary Health Care are particularly relevant to strategies for improving women’s health, namely;

- inter-sectoral collaboration is central to tackling the broad determinants of women’s health that reside in several sectors,

- community participation is facilitated by civil society and organizations, many of which have women as their special target,

- access to a package of minimum health services when provided by a strong health system has benefited women in many parts of the world,

- the use of appropriate technology is relevant; there have been technologies that may be “appropriate” in a specific context, but are detrimental to girls and women, such as sex-determination of the foetus,

- equity and solidarity, priority will be given to those with greatest need,

- self-reliance and determination are forms of empowerment, a process that has propelled progress in women’s affairs.

6.1. Building strong leadership

The benefits of human development do not always reach women, as seen from the GDI and GEM index values for countries of the WPR, and gender differentials in educational and employment
opportunities in many countries. To ameliorate these disparities, leadership and governance are crucial. In the presence of evidence, and known technologies and interventions that can improve the health of women, it is leadership that is sometimes lacking making it difficult for women to attain the best possible level of health and quality of life. Some options for countries are to:

(i) heighten the political will of governments, which is crucial in making laws, formulating policies, allocating resources and deploying trained staff for women's health. Strong leadership also ensures that women's needs are not compromised within several possible competing priorities;

(ii) involve women's organizations and NGOs in participatory leadership, in guiding the agenda for women's health in their communities; leadership must not be limited to only official authority or people in seats of government;

(iii) use leadership and good governance to facilitate gender mainstreaming in the developmental agenda of countries, because a separatist approach that risks neglect and marginalization of women can have hazardous impact on the well being of not only women themselves, but also of families and communities;

(iv) make the MDGs a guiding agenda for national development until 2015, and for this a strong national leadership is required, especially in ensuring that the MDG's influencing women's health and well being (in particular MDG's 1,2,3,4,5,6 and 7) are addressed adequately and MDG 8 is part of a concerted solution to uneven development;

(v) ensure accountability, which is an important component of leadership and governance, through appropriate mechanisms such as health observatories;

(vi) forge partnerships and build consensus with development partners and international organizations; this need for consensus and collaboration is reflected in MDG 8 for which the first target is especially pertinent to WP Region – to address the special needs of the least developed countries, landlocked countries and small island developing states;

(vii) ensure leadership is exercised in times of crisis and emergencies, both natural and man-made, so that health care for women is not disrupted significantly and well being of women is not jeopardized; and

(viii) monitor progress made towards international covenants that the government has ratified, such as Convention of Elimination of All Forms of Discrimination Against women (CEDAW), the Beijing Platform for Action, and the like, and ensure that remedial actions are taken for barriers and constraints which prevent the achievement of health for all.
6.2. Providing responsive health services in a strong health system

There is adequate evidence from life expectancy, disease burden (as expressed by DALY's) and mortality data that women have specific needs to which health systems must respond. While the diseases and conditions that need to be addressed to ensure women remain healthy require medical and technical interventions, there is also the need for addressing environmental, social, cultural and economic determinants of health and the "softer" aspect of quality of care. This aspect of responsiveness can sometimes be difficult to define and to measure, but health systems will need to be more women-friendly in order for women to be motivated to use services and quality measures are needed to monitor whether users are satisfied with such services. This report has also presented evidence that women have different experiences than men in health systems, and often health systems do not respond to women's needs. For women's health services, technical accuracy and quality is seldom an issue; what keeps women away from health care is often the quality of the health care environment. In formulating policies, countries should consider the following:

(i) ensuring that health system provides services that cover an adequate range depending on the situation, evidence and needs of the country/community, and this to a large extent is influenced by the level of socio-economic development, with low income countries having to face the challenge of achieving MDG5 to reduce maternal mortality and ensuring universal access to reproductive health; middle income countries facing the double burden of disease; and high income countries facing the epidemic of non-communicable and chronic diseases;

(ii) providing services that are not only accessible and affordable, and of good technical quality, but are also acceptable to women from all backgrounds;

(iii) ensuring that health staff are not only trained to be technically proficient, but also to have the people skills to work with women in a respectful way. Such "women-friendly" and "person-focused" care that has courtesy, compassion and caring at its core is more likely to be used by women;

(iv) ensuring that health staff are encouraged, motivated and trained to improve their professional standards to the highest possible level; and that they undergo continuing professional development that emphasizes values and medical ethics including non-maleficence, beneficence, respect and justice;

(v) introducing, encouraging and nurturing the paradigm of 'health as wellness' (as clearly stated in the WHO official definition of 'health') over the older paradigm of 'health as absence of disease and illness'. This report presents evidence that women across the Region are becoming increasingly aware of the need for prevention and health promotion, and require services such as breast and cervical cancer prevention, menopause management and health education alongside curative interventions;
facilitating service providers to provide accurate, up-to-date and accessible information; and for them to be aware that the client is an informed person, with access to a variety of sources of health information including the internet;

(vii) tailoring or customizing services to the needs of specific groups of women and girls, for example ethnic minority groups with particular cultural practices that can be health enhancing or health damaging; remote communities, migrants and refugees;

(viii) motivating staff at all times to respond to the changing needs of women clients, and encouraging them to undergo skill development such as change management;

(ix) reviewing the health policies and interventions that may not be suitable for women, recognizing that even though women suffer from several similar diseases as men, their experiences may differ and require special attention. This may cover areas such as diagnosis, prescription and participation and representation in clinical trials and other research projects; and

(x) addressing the needs of older, menopausal and post-menopausal women who constitute a significant proportion of the female population in several countries but whose health and well-being needs are often overlooked.

6.3. Improving access for universal coverage

There is ample evidence that many women do not use health services as optimally as they should, and there are many barriers that compromise access and use. Coverage rates for essential services such as family planning, ante natal care, cervical cancer and breast cancer screening, remain low in many countries. Access to available services does not necessarily lead to utilization of these services by women. The issue of responsiveness described above is only one barrier to use. Countries may need to select options to improve access and use, depending on the barriers that exist. Strategies may include:

(i) improving geographical access especially for countries with difficult terrain, remote areas, and poor roads and transport. The long term sustainable solutions in improving these have to be part of an inter-sectoral policy for women's health including departments of transport and communication. Other shorter term measures such as maternity waiting homes for pregnant mothers and outreach primary health care and immunization services may improve maternal and child outcomes immediately;

(ii) reducing financial barriers to use of service, which are a common feature of women's health services. For health services, especially those for achieving MDG5 to reduce maternal mortality (such as family planning, antenatal care, skilled birth attendance, emergency obstetrics care), countries need to have policies on free or subsidized services or social protection schemes and micro-credit and micro-insurance opportunities. Financial barriers must also be broken down for other
services such as screening for breast and cervical cancer, and for prevention and management of other diseases;

(iii) introducing appropriate interventions to address cultural barriers, according to the particular practice, beliefs and norms of a community (such as birthing positions and traditional herbs). It is important that in providing technically sophisticated interventions, women's identities are not unravelled;

(iv) using innovative strategies to improve access to quality care, and health monitoring and advice. Malaysia and Australia for example are making extensive use of Telemedicine, Tele-health and Tele-care services and other remote technologies to address the health needs in remote communities. Smart pill containers that can be monitored from a distance and personal emergency alarm pendants are also increasingly in use in the Region;

(v) introducing and implementing flexible clinic hours and outreach clinics at working sites (e.g. factories, offices), and shopping malls has made health services more accessible for both waged and unwaged women in several countries in the Region; and

(vi) paying attention to the needs of marginalized groups with interventions designed according to the situation in each country – such as ethnic minority groups, refugees and migrants, female sex workers, disabled women, poor women; and for the more vulnerable women such as older women living alone.

6.4. Women-friendly public policies

Besides enabling health policies, public policies and legislation in other (non-health) sectors also impact women's health either directly or indirectly. Reference has been made, and evidence presented, on the unequal benefits of human development on men and women in some countries as reflected by literacy rates, enrolment in tertiary education, and gainful employment rates. It was also seen that women are exposed to risks such as domestic smoke, passive cigarette smoking and domestic violence. In a few countries, son preference has led to sex selection and sex selective abortion. Hence there is a need for policies against gender discrimination, violence against women, and for appropriate family and marriage laws, inheritance laws, and equal employment legislation and opportunities. Countries, in their efforts to formulate women-friendly policies, can consider the following:

(i) ensuring that gender is mainstreamed in all appropriate policies and legislations, and creating a national mechanism that oversees and monitors this;

(ii) conducting extensive consultations with women's organizations and other community based stakeholders;

(iii) encouraging inter-sectoral collaboration and creating a mechanism for facilitating this while acknowledging the impact of social & economic determinants on health;
promoting micro-insurance, microcredit and other income generating activities for women such that they participate in poverty alleviation rather than relying on handouts to service their health needs; and

keeping the rights agenda at the forefront (ARROW, 2009); where necessary strengthening and adequately enforcing laws pertaining to women’s rights and protection such as inheritance laws, marriage and family laws and laws pertaining to violence against women.

6.5. Tracking progress

This report had highlighted the problem of inadequate sex-disaggregated data in almost all countries of the Region, which has made tracking of progress made for women’s health difficult. Similarly, disaggregation of data along other dimensions such as socioeconomic class, geographical location and ethnicity is vital to identify inequities within countries and to track progress in overcoming those inequities. Like all matters in health, the women and health agenda aims to make progress, and progress needs to be monitored or tracked, and as far as possible measured. Progress also depends on generating new information and evidence through research. Countries are recommended to:

(i) where applicable, urgently address the long-standing problem of inadequate, unreliable and incomplete data on maternal health. These data are required for tracking of progress on MDG5, especially for maternal mortality and skilled birth attendants for MDG5 target 5A, and for universal access to reproductive health for MDG5 target 5B;

(ii) sex-disaggregate where feasible, all indicators such that gender analysis can be undertaken and trend data collected;

(iii) disaggregate data also by age, socioeconomic class, ethnicity, indigeneity, rural/urban location to identify intra-country differentials in health outcomes for setting priorities in resource allocation;

(iv) develop as a priority, and resource adequately, strong registration systems, creative approaches to collecting data where traditional methods are failing e.g. using village stories to estimate MMR and maternal death surveillance systems. It is vital that these health registers include mortality data, as well as morbidity data, health services provision and usage data;

(v) develop (and refine) appropriate and adequate indicators with targets for the various aspects of women’s health which are not covered in the MDGs. Many conflicting monitoring frameworks, with multiple indicators, are already in existence which frustrate countries and make cross-country comparisons and trend analysis very difficult. This needs to be addressed with a regional convention of health information systems decision-makers from all countries in the Region;

(vi) introduce and use specific investigation systems that are pertinent to certain aspects of women’s health such as maternal death audit systems;
(vii) encourage research that includes women in clinical trials and research methodologies, so that research on men is not used as basis for public policy for all;

(viii) invest in research to generate baseline data sets.

In selecting and implementing the activities within these policy options, countries may require assistance from WHO and other development partners, especially in the spirit of MDG8, for technical expertise in several areas: data management; gender analysis and training in gender issues; consultation with women's groups, NGOs, community; inter-sectoral approaches; prioritization of issues; advocacy; and collaboration with other partners. WHO WPRO will:

(i) advocate to Member States for a higher commitment towards women's health;
(ii) provide Member States with the needed technical assistance, guidelines, standards and tools to strengthen health system and improve women's health;
(iii) assist Member States to better track progress in their efforts to improve women's health, using appropriate indicators and measures; and
(iv) study the situation of women's health in the Region, and consult Member States on the findings and appropriate recommendations.

6.6 Conclusions: Summary, remaining challenges to meet the MDGs and beyond 2015

The evidence presented in this Report shows that there have been some significant gains in the health of girls and women in most countries of the WPR in the past two decades. This is reflected in longer life expectancy, reduced deaths from infectious diseases, lower levels of morbidity for a variety of disease categories, and better DALY scores. There is also improvement in some of the measures of social determinants of women's health as shown in the composite Gender Development and Gender Empowerment Indices. These improvements can be attributed to a variety of upstream and downstream interventions and initiatives, especially in the context of the wide ranging social determinants of women's health. Thus, some of these interventions are clinical, interventions, others are public health initiatives such as improved nutrition and clean water, better sanitation, and campaigns to improve contraceptive prevalence rate; yet others are social, economic and political initiatives such as enactment of laws against gendered violence, incentives for universal school attendance, and income generating initiatives to enable women to have more control over their lives.

However, these gains have been uneven across countries, and across groups within countries. In a few cases, countries have moved backwards in health outcomes for girls and women. This is partly a consequence of new health threats and emerging risk factors, and partly because of lack of funding because other priorities have replaced women's health, especially during the latest global financial crisis. New health problems are emerging for women and girls such as HIV/AIDS, traffic
accidents, drownings, addiction, obesity and other eating disorders, mental health problems and other NCDs, and health problems emerging from climate change. At the same time the perennial problems of high maternal mortality ratios, TB and malaria persist in the low income countries in the Region, producing a double burden of disease.

The Report identifies gaps in the data that need to be filled to provide a comprehensive and thorough overview of the health of women and girls. In spite of the paucity of disaggregated data, we now know something about health of women's and girls in terms of morbidity, disability, risk taking and mortality but very little about the more subjective aspect of their quality of life. This has a bearing on whether or not women use health services and find them acceptable, whether they are motivated to protect their own health and the health of others and what sources of health information, advice and intervention they trust.

The United Nations Summit on the MDGs held in New York in September 2010 addressed the remaining challenges for countries in meeting the MDGs and how progress on a variety of dimensions of life should be monitored after 2015 (United Nations, 2010). Under the heading of Keeping the promise: united to achieve the Millennium Development Goals, the draft resolution revealed unanimous support for prioritising women's health and empowerment as a centrepiece for achieving all of the MDGs over the next five years.

Item 12. We recognize that gender equality, the empowerment of women, women's full enjoyment of all human rights and the eradication of poverty are essential to economic and social development, including the achievement of all the Millennium Development Goals. We reaffirm the need for the full and effective implementation of the Beijing Declaration and Platform for Action. Achieving gender equality and empowerment of women is both a key development goal and an important means for achieving all of the Millennium Development Goals. We welcome the establishment of the United Nations Entity for Gender Equality and the Empowerment of Women (UN Women), and pledge our full support for its operationalization (United Nations, 2010).

The remaining challenges for meeting the MDGs identified in the draft resolution from the UN Summit on the MDGs (New York, September 2010) resonate with those that this Report has identified for the WPR namely acknowledgement that:

- much more needs to be done in achieving the Millennium Development Goals as progress has been uneven among regions and between and within countries.

In particular, grave concern was expressed:

- over the slow progress being made on reducing maternal mortality and improving maternal and reproductive health.

In suggesting the way forward, the Summit participants proposed an action agenda for achieving the Millennium Development Goals by 2015 acknowledging that improvements to health underpin all the other MDGs (Item 44), that women are key agents of development and thus investing in women and girls has a multiplier effect on all aspects on productivity (Item 54) and that disaggregated data is essential for adequate monitoring of MDG progress (Item 68). Addressing these basic principles, the Summit participants pointed to actions such as strengthening national health systems, equal access of women and girls to education, basic services, health care,
economic opportunities and decision-making at all levels, gender mainstreaming in the formulation and implementation of development policies, and disaggregating data (UN, 2010: Items 44, 54, 68) as key initiatives to meet the MDGs. However, the question remains of what happens after 2015. Will the United Nations just extend the MDG targets, negotiate new targets or adopt a totally new approach to equity and development?

In the lead up to the September 2010 Summit, The Lancet and London International Development Centre Commission (LIDCC) (2010) recommended a more holistic approach to health development after 2015, using a life course framework which is identical to that which was adopted in this Report. The authors ‘envisage future health development goals that are focused on sustainable health systems, built around delivering healthy objectives across the life course (involving) close linkage with learning, economic, social and environmental elements’ (The Lancet and LIDCC, 2010:31). They suggest that post-2015 ‘reasonable health expectations over a lifetime’ would guide international and national agencies in filling the gaps and accommodating ‘differences in health challenges in different countries’. These expectations and health objectives ‘would be agreed by international consensus’ but how they were ‘then developed into goals would be a process led at national level, building through dialogue to a set of ‘regional and global goals’. The authors of The Lancet and LIDCC article (2010: 31) emphasize the need to ‘generate well-being for all while taking a proactive, pro-poor approach’ which avoids the problems that the MDGs faced by having ‘threshold-based targets and indicators’ that could ‘increase inequity’ particularly gender inequity (The Lancet and LIDCC, 2010:27). This proposed approach would identify specific concerns at specific stages of life and realistic and reasonable expectations for:

- **Pregnancy**: access to antenatal care; adequate maternal nutrition; protection from exposure to dangerous infections and toxins.

- **Infancy**: a reasonable probability of survival coupled with access to a loving parental relationship; protection from death or disability attributable to malnutrition, vaccine-preventable and other infections, trauma, or other causes.

- **Childhood**: quality primary school education; safe space for play at home and school; protection from abuse in the home environment; cognitive and social development; adequate nutrition and protection from both hunger and obesity.

- **Adolescence**: reproductive and sexual health; increasing autonomy; self-respect; access to social security for those with learning difficulties; fulfilling potential.

- **Adulthood**: access to care, diagnosis, and treatment for major causes of death and disability (childbirth, non-communicable diseases, mental health, major infectious diseases); employment opportunities and a social welfare net.

- **Elderly**: social inclusion; dignity in dying; dementia and disability services (The Lancet and LIDCC, 201:26).

These ‘reasonable expectations’ summarize many of the key issues addressed in this Report on *Women and Health in the WPR: Remaining Challenges and New Opportunities*. They provide a holistic framework which countries in the Region can use as a basis from which to discuss how they will monitor women’s health and its synergies with other dimensions of wellbeing (environmental, economic, political and social) even before the MDG end-date of 2015. The framework proposed by
The Lancet and LIDCC also emphasizes that ‘actions in one generation promote the health of subsequent generations’ thus encouraging countries to take urgent measures now, beyond the limits of the MDG targets, to ensure intergenerational health and wellbeing equity (The Lancet and LIDCC, 2010:31).

Ultimately, whatever post-2015 framework for monitoring development is negotiated between the United Nations and member states, optimizing women’s health, and their role in health as providers and decision-makers, will be a central plank given the unanimous endorsement at the MDG Summit for the establishment of the United Nations Entity for Gender Equality and the Empowerment of Women. If women’s and girls’ health needs and their contribution to the health of others are resourced and supported adequately by international organizations, governments of Member States, NGOs, donors, business interests and other stakeholders we can look forward to a future of healthier and happier women in the WP Region.

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