

**Launch of the WHO report  
"Women and health: today's evidence tomorrow's agenda"  
9 November 2009, Geneva, Switzerland**

**Statement by Adrienne Germain, President  
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Dr Chan, Excellencies, ladies and gentlemen, good morning.

I want first to express appreciation to the Director-General who commissioned this report and who not only has said that the health of women is one of her two greatest concerns, but also has recognized improvement in women's health as a key indicator of the performance of WHO. We also all owe a vote of thanks to the many people who contributed to the report, and have long worked in WHO and with WHO to secure healthier lives for women and girls everywhere.

This report provides a significant compilation of available data—a baseline for action as the Director-General has said. By illuminating the multiple and cumulative threats to women's health over their lifetimes, it conveys just how severe—and how unnecessary—is our failure to protect women's right to health. The report can play a key role in generating the political will to act, simply by conveying WHO's concern and leadership. More than that, its content should shock and compel the world to act. How, in 2009, can we not act decisively in the face of such information about the health of over half the world's population—the half that also carries most responsibility for bearing and raising healthy children and that provides the bulk of formal and home-based health care?

We hope that this report will be used immediately by WHO and others to drive actions that are long overdue. However much we don't know—and the report indicates that we do need to learn more—we know enough to act on the major causes of morbidity and premature death in girls and women. The resources needed to secure women's health are attainable. We need only to mobilize sufficient political will.

Forty years ago, I began my work for women's health, human rights and gender equality in the mountains and plains of Perú. In the Amazon region, I watched as a family buried a young woman who had died giving birth to her sixth child. Everywhere I went, I talked to women who knew that they could easily die giving life, so they said goodbye to their families each time they went into labor. As most of us here know, deaths related to pregnancy still happen every minute of every day.

Over the last 25 years especially, international women's health and rights organizations and movements, and our hundreds of partners in Asia, Africa and Latin America, have helped to transform health policies, forge global agreements on gender equality and the human rights of women and girls, change national laws and influence development budgets. Together with national governments and the UN, we led the world to a new understanding that securing women's health, protecting their human rights and achieving gender equality are imperative in their own right—as well as crucial to the achievement of development and peace. Looking at the data presented in the WHO report, and considering what we and our uncounted thousands in the women's health movement have learned, we would emphasize three policy priorities that flow directly from the Director-General's emphasis on equality, social justice and giving people a voice. These are improving health services in low-income countries for girls and women, reducing the factors leading to women's ill-health and premature death and strengthening data in particular ways.

First, health services: all health system strengthening initiatives should prioritize services for women of all ages, particularly in the lowest income quintiles. In the majority of low-income countries, this will mean an essential services package, without user fees, centered on comprehensive sexual and reproductive health (contraception, access to safe abortion, maternity care, diagnosis and treatment of STI's including HIV, and services for women who have experienced sexual coercion and violence) along with neonatal interventions and the

standard communicable disease package. It will mean far stronger attention to nutrition, water and sanitation.

Second, changing the determinants of illness, death and underutilization of health services: The Director-General has emphasized the need for these factors to change and, indeed, the Commission on Social Determinants of Health, especially the Women and Gender Equality Knowledge Network, provides a solid data basis for this work. A necessary condition for achieving women's health at every point in the life-course is gender equality. This includes the empowerment of women and protection of their human rights. The health sector—including WHO itself—can and must play a leading role in promoting understanding of and actions on the linkages between violations of women's human rights and rates of morbidity and premature mortality. Nowhere is this more needed than in women's and girls' vulnerability to HIV/AIDS, in their high levels of depression and also in persistent patterns of unintended pregnancy and unsafe abortion. While various human rights violations play a role, one of the most severe, persistent and impactful is sexual coercion and violence, or the threat of it, including in marriage and the family.

The third priority area for action as the report notes is improved data: among the many needs for information, we would emphasize two. First, it is imperative to maintain and analyze data disaggregated not only by sex but also by five-year age cohorts—especially 15-24—at all levels of the health system, in countries and globally. Second, we need to assess and highlight regularly those aspects of women's health that are not yet well represented in DALYS and Burden of Disease estimates, such as violence against women and maternal morbidity among others.

How are we to generate effective movement for these actions? We see two necessary investments, recognized in rhetoric but too often overlooked in budgets and sustained institutional commitment: the first is investment in civil society, particularly women's and young people's organizations, and the second is in WHO itself.

Looking first at civil society, over and over again we have seen what people can do to mobilize their governments and other powerful actors. Two quite different examples should inspire all of us, one is women's involvement from the community up and the other is engaging women's organizations from the top down. Both are needed.

We all know that it is common for basic level services to be poorly managed, incomplete or not available at all. Consider Sangli, a rural district of about three million people in India about six hours by car from Mumbai. Primary health centers here are often closed because the doctor doesn't show up, or there are no medicines to dispense. When staff members are on duty their skills are poor and they treat people badly. The facilities are in chronically bad condition. Our partner organization, Sangram, works with the most disadvantaged women in Sangli district—widows, low-caste women, women living with HIV/AIDS, sex workers. Sangram informed its members about the health services the community is supposed to have and helped them learn how to mobilize to demand the services they are entitled to under state law and new national funding. The women then petitioned the doctors who manage the health centres—in some cases they had to stage sit-ins at the centers for weeks or months. As a result, six local health centers are well-managed, clean and freshly painted. They now have a regular supply of contraceptives, a nurse midwife on duty 24 hours, a community organized transport system to take women to the hospital if there are complications during labour and childbirth; HIV counseling and effective referral for testing and treatment—none of which were previously available.

In a very different approach in Bangladesh, in the 1990s, we helped the government, donors and a wide array of stakeholders expand the national family planning programme to include comprehensive reproductive health services using very limited financial and human resources. While the process was top down, it included nation-wide consultation, including with rural women and men about their health needs and experiences with the health system. We did this with many different NGOs—and, yes, it required a longer planning process, extra funds, and new people at the policy table. In five years, maternal mortality dropped by 26 percent, and this national programme has strong roots and staying power because it was designed

through a participatory, consultative process. Today, the UN's H4, including WHO, have designed a plan to help Bangladesh continue to move forward with comprehensive services focused on the poorest, and based on the strong foundation established in the 1990s in collaboration with civil society.

I will close with a reflection on what WHO can do, based on work with WHO since 1990, primarily in the areas that now fall within the Family and Community Health Cluster, Evidence for policy, HIV/AIDS and Health Systems. Over these 19 years, many of us inside and outside WHO have been asked to assist WHO in determining what the agency should do—and how—about the health of women. At this key juncture, two sets of actions are vital: the first is to fully implement WHO's gender mainstreaming strategy, which would help us all move forward much faster. Implementation requires backing the Director-General's commitment with full accountability of all senior staff, and sufficient budget allocations to implement the key elements and the strategy including increasing WHO's own technical competence in women's health and gender analysis in all levels, clusters and programmes of WHO; attention to sex differentials in all WHO-supported research; consultations with women who know the realities of women's lives and how to programme for them; and other actions to improve the technical support that WHO can provide to countries. We know from the sustained actions like those by RHR and HRP over nearly two decades that programmes can be transformed. The second vital action by WHO is sustained leadership. From our work at country level, we and our many local partners know that it will make a real difference if WHO officials from the Director-General down raise and pursue women's health, gender equality and women's empowerment regularly as a matter of health policy and programming.

Given the current interest of donors in health system strengthening, including the commitments of heads of donor governments, such as President Obama, to women-centred global health initiatives, as well as a number of other favorable factors, we all have a substantial opportunity—and an unquestionable obligation—to do far more and far better to ensure the right of every girl and woman to a just and healthy life.

Thank you.