WORLD HEALTH ORGANIZATION
Regional Office for the Eastern Mediterranean
ORGANISATION MONDIALE DE LA SANTE
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منظمة الصحة العالمية
المكتب الإقليمي لشرق المتوسط

In the Name of God, the Compassionate, the Merciful

Address by

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to the

REGIONAL CONSULTATION ON GENDER AND HEALTH IN THE SOCIOCULTURAL CONTEXT OF THE EASTERN MEDITERRANEAN REGION

Cairo, Egypt, 19–21 December 2004

Ladies and Gentlemen, Dear Colleagues,

I have great pleasure in welcoming you to Cairo to participate in a meeting which I feel is of unique character; and the expected outcome of which will hopefully accentuate programmes in public health in the Eastern Mediterranean Region.

I would like to welcome all participants and temporary advisers to this consultation, at which you will explore the social gaps between the sexes in public health outcomes. My special thanks go to all the participants from the Eastern Mediterranean Region, who have kindly agreed to collaborate with us in exploring equitable health care in all countries of the Region. I would also like to welcome our colleagues from WHO headquarters in Geneva; it is always useful to have the input of our friends from headquarters and other regional offices.

This Consultation will address very important issues, which will have far reaching impact on the populations that we serve. The world has been showing an increasing commitment to the value and spirit of health promotion in an endeavour to reduce inequities in health. The adoption of the Millennium Development Goals (MDGs) in 2000, especially those related to health, gender, poverty reduction and improving people's lives, has added to the challenges and opportunities. The World Health Organization's Regional Office for the Eastern Mediterranean and its Member States have been endeavouring to meet these challenges and to respond effectively. Although much has been achieved by Member States to promote better health, much more can still be done.

The curative field of medicine is but one aspect of public health; the preventive field of medicine plays a far greater role in reducing burden of disease and reducing health care costs. Curative medicine will usually treat the illness but it will not change the environment or the unhealthy lifestyles which produced that illness. Preventive medicine must investigate all the dimensions of unhealthy habits, and what measures must be taken to enlist communities to adopt healthy habits. Social factors play a crucial factor in determining healthy lifestyles.

WHO recently formed a Commission on Social Determinants of Health. The Commission is part of a broader process that the Director-General of WHO has initiated to bring WHO clearly in line with its constitutional mission and with the values affirmed at Alma-Ata, in other words the attainment of complete physical, mental, spiritual and social well-being for all mankind. The Commission continues the work of the Health for All movement and re-emphasizes some of HFA's most important insights – notably the commitment to equity and the importance of intersectoral action for health. The specific social roles of males and females will be an integral cross-sectoral consideration in this process.

There are distinct biological and social factors that differentiate health outcomes between males and females. For example, our society places a high value on protecting women. This protection, however, can lead in some countries to a situation where women are prevented from moving freely within society and can consequently lead to women having less access to health care. In situations where women face constricted freedom of movement, treatment is often delayed, and the disease is exacerbated. Some situations may result in a woman not seeking

treatment at all. WHO seeks to support Member States in addressing these issues to make sure that we are not only fully aware of all the constraints that affect the attainment of health, but that we find ways to work together in overcoming the obstacles that prevent the attainment of optimal health for all.

As many of you are aware, WHO issued an organization-wide gender policy in 2002. The gender policy enhances the WHO primary objective, which is the highest attainable standard of health without distinction of race, sex, religion, political belief, economic or social condition. Shaping health policy to account for the specificities of both males and females will help us reach that highest attainable standard. Not only are biological differences between the sexes responsible for different manifestations and vulnerabilities to disease, but also social role differences can be responsible for different manifestations and vulnerabilities. Society assigns different roles and functions for men and women and places different values upon those roles. The work of gender in health explores situations in which those roles and values contribute to vulnerabilities in illness.

Dear Colleagues,

We are blessed in this region with strong family units held together by religious values and community responsibility. This is a blessing which we cannot take for granted. Mechanisms must be in place to preserve our value system. At the same time, there must be flexibility in our societies to respond to existing conditions that do not favour positive health outcomes for all our populations. With religious values as our resource, we can together tackle societal structures that impede the positive health outcomes of our region.

Religion is relevant in discussions about gender and health because gender comprises the social roles that males and females hold to ensure the proper functioning of their society. In the populations of this Region, religion, both Muslim and Christian faiths, strongly influences the roles that males and females play. We will hear from distinguished speakers in the next three days about how roles are distributed in religion to males and females. In addition, discussions will be held to determine where traditions interrupt those roles to the detriment of public health. For instance, female genital mutilation is a tradition rather than a religious practice. Over time distinctions between tradition and religion can become blurred. In areas where those distinctions

prove harmful to the health of males and females, the distinctions must be re-established. One of the goals of this meeting will be to identify specific areas where the lines have been crossed and are impeding the positive health outcomes of our populations.

Ladies and Gentlemen,

We are gathered here for the next few days to learn from our colleagues some of the social obstacles faced in achieving public health and to share our thoughts and concerns about how we can accentuate the health of our Region. Together we can explore the meaning of gender and how it relates to both males and females, as well as how social roles can impact health outcomes. Most importantly the task lies before us to devise mechanisms to work together to close the gender gaps in public health and to ensure optimal health for all people of the Eastern Mediterranean Region, regardless of sex, race, religion, political belief, and economic or social condition.

I wish you great success in your deliberations and am confident, with the wide array of experience and wisdom sitting before me, that relevant and practical recommendations will be formulated for our Member States. May God help and guide you all.