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GENDER MAINSTREAMING IN DEVELOPMENT STRATEGIES

CONTENTS

1. INTRODUCTION

The last two decades have created an active interest with regard to the gender dimensions of the human, economic, social and environmental development processes. One of the major approaches to development identified by the eight world conferences convened during the 1990s, in which WHO participated, was that the "improvement of the status of women, including their empowerment, is central to all efforts to reach sustainable development in all of its economic, social and environmental dimensions" [*1*].

The links between health and the socioeconomic status of women are well documented. Historical evidence suggests that government policies and societal practices, coupled with low investment of resources in women's potential, have created a serious imbalance between the opportunities afforded to women to develop themselves and thereby contribute to the socioeconomic development of the country and those afforded to men. Globally, low levels of literacy among women, their lack of economic power and their low rates of participation in development and in the political decision-making processes are among the key factors that have led to continued poor health status for women, including high levels of maternal mortality, in almost all societies, but especially in poor and developing countries.

A gender perspective in health leads to a better understanding of the factors that influence the health of women and of men and is vital if equitable and effective health policies and strategies are to be developed and implemented. It is not only concerned with biological differences between women and men, or with women's reproductive role, but acknowledges the effects of the socially, culturally and behaviourally determined relationships, roles and responsibilities of men and women, especially on individual, family and community health. A gender perspective, linked to the advancement of equity, must be incorporated into health policies and programmes. Specific aspects include:

- performing gender analysis and encouraging gender awareness;
- attending to the special needs of girls and boys, women and men, throughout life;
- supporting the human rights, dignity, self-worth and abilities of girls and women; and
- creating opportunities for full participation of women with men in decision-making at all levels.

Gender mainstreaming is a strategy for achieving equity between women and men in access to and control over the available resources. It evolved from the Women in Development approach (WID) promoted by development theory in the 1970s and 1980s. This approach itself arose out of the concern that women were being excluded from the development process and its benefits and, therefore, focused on women-specific programmes and projects as a way of "integrating women into development". The approach, while important, tended to isolate women as a separate and homogeneous category and did not bring about sufficient long-term changes in the social and economic conditions experienced by women. The Gender and Development (GAD) approach aims at redressing the inequalities between women and men, and emphasizes that women's disadvantaged position needs to be analysed and addressed, not in isolation but in relation to that of men.

The Fourth World Conference on Women, held in Beijing in 1995, noted that "it is essential to design, implement and monitor, with the full participation of women, effective,

efficient and mutually reinforcing gender-sensitive policies and programmes" [2]. Following the Beijing Conference, most countries of the Eastern Mediterranean Region established National Committees for Women, developed national plans of action to implement their commitments, and set up monitoring systems to regularly map the progress made towards mainstreaming gender in the national development process. Following the Beijing Conference and its resolutions and commitments, the United Nations system, including WHO, formally endorsed the conclusion of the United Nations Economic and Social Council (ECOSOC), stated in July 1997, that "gender mainstreaming in all activities of the United Nations system is a high priority" [3]. Subsequently, at the Fifty-first World Health Assembly, WHO adopted the World Health Declaration, endorsing the health-for-all policy for the 21st century which underscores gender mainstreaming as a key value, along with equity, ethics and the right to health, for achieving Health for All.

WHO, as the specialized agency responsible for health in the United Nations system, and the leading international health organization, is committed to improving the low health status experienced by women by addressing the existing gender gaps and disparities between women and men. To this end, WHO has initiated, at global, regional and country level, the process of developing a policy framework to mainstream gender in health and health-related development.

The basic principles of most cultures of the countries of the Eastern Mediterranean Region of WHO support, protect and promote women's rights, including their right to a high standard of health and quality of life. This principle of gender equity is enshrined in the religions of the Region, which all emphasize that men and women have equal responsibility for building and maintaining human life on earth; have the same rights to undertake any profession; have the same rights to education; and have equal responsibilities in the home.

In February 1999, the Regional Office for the Eastern Mediterranean organized a three-day intercountry consultation on the role of women in health and sustainable development in Amman, Jordan. The main aim and outcome of the consultation was to develop a regional strategy and plan of action for WHO and countries of the Region to promote gender mainstreaming in health development. These are presented in this paper.

2. REGIONAL SITUATION ANALYSIS

2.1 General

The level of socioeconomic development, lifestyle, extent of coverage and quality of the health care system, the environment, and a health-for-all policy that incorporates principles of social equity and a gender perspective, are among the determinants of the health of both men and women in the societies they live in. As the concept of development centres around development of the human being, both men and women should each be given equal opportunity to participate in the process of development.

A number of indicators on health and development enable us to identify gender gaps in health and development. Women's participation in the development process is governed by traditions, values and religious beliefs. Tables 1–7 compare available data for 1985 with available data for 1995 on education, literacy, health, family planning, contribution to economic activity, employment, political participation and decision-taking.

Table 1. Adult literacy rate (%) by sex in the Eastern Mediterranean Region, 1985–1995

Country	1985			1995		
	M	F	D	M	F	D
Afghanistan	39.00	8.00	31.00	45.20	13.50	31.70
Bahrain	79.00	64.00	15.00	89.70	80.30	9.40
Cyprus	98.00	94.00	4.00	98.00	90.30	7.70
Djibouti	34.00	14.00	20.00	73.80	40.00	33.80
Egypt	59.00	30.00	29.00	63.00	37.00	26.00
Iran, Islamic Republic of	62.00	39.00	23.00	84.70	74.20	10.50
Iraq	95.00	85.00	10.00	63.00	51.00	12.00
Jordan	83.00	63.00	20.00	91.20	80.90	10.30
Kuwait	84.00	80.00	4.00	90.00	86.00	4.00
Lebanon	86.00	69.00	17.00	92.80	84.00	8.80
Libyan Arab Jamahiriya	81.00	50.00	31.00	91.00	74.00	17.00
Morocco	45.00	22.00	23.00	55.10	30.50	24.60
Oman	47.00	12.00	35.00	84.00	75.50	8.50
Pakistan	44.00	22.00	22.00	51.00	28.00	23.00
Palestine	...	...	...	91.50	77.00	14.50
Qatar	51.00	49.00	2.00	79.00	80.00	–1.00
Saudi Arabia	74.00	37.00	37.00	85.10	64.50	20.60
Somalia	18.00	7.00	11.00	36.00	14.00	22.00
Sudan	44.00	17.00	27.00	66.00	40.80	25.20
Syrian Arab Republic	76.00	53.00	23.00	89.40	68.70	20.70
Tunisia	68.00	41.00	27.00	79.00	55.00	24.00
United Arab Emirates	61.00	36.00	25.00	83.00	89.00	–6.00
Yemen, Republic of	32.00	7.00	25.00	68.40	23.00	45.40

D = Difference = Male rate – Female rate
... Data not available

Source: EMRO HST Database

2.2 Education

Although the education gap between men and women is narrowing in many countries of the Region, still more men than women are literate. In 1985, the percentage of adult literacy was higher in males than females in all countries of the Region. The difference ranged between 2% and 37%. Good progress in female adult literacy had been achieved in most of the countries by 1995, although in Djibouti, Somalia and the Republic of Yemen the gap between the percentage educated among males and females increased (Table 1). Adult literacy rates for females in 1995 were above 74% in Bahrain, Cyprus, Islamic Republic of Iran, Jordan, Kuwait, Lebanon, Libyan Arab Jamahiriya, Oman, Palestine, Qatar and United Arab Emirates; 50% and above for Iraq, Saudi Arabia, Syrian Arab Republic and Tunisia; and below 50% for Afghanistan, Djibouti, Egypt, Morocco, Pakistan, Somalia, Sudan and Republic of Yemen.

In 1995, the gap between male and female secondary school enrolment ratios showed wide variations between the countries. From 1985 to 1995, it decreased in Egypt, Islamic Republic of Iran, Iraq, Oman, Saudi Arabia, Sudan, Syrian Arab Republic and Tunisia. The gap also decreased, but at the same time was accompanied by an increase in

Table 2. Secondary school enrolment ratio (%) in the Eastern Mediterranean Region, 1985–1995

Country	1985			1995		
	M	F	D	M	F	D
Afghanistan	11.00	5.00	6.00	20.00	10.00	10.00
Bahrain	83.00	70.00	13.00	89.00	94.00	–5.00
Cyprus	94.00	95.00	–1.00	95.00	99.00	–4.00
Djibouti	...	...	...	13.00	10.00	3.00
Egypt	68.00	45.00	23.00	81.00	69.00	12.00
Iran, Islamic Republic of	47.00	32.00	15.00	82.00	77.00	5.00
Iraq	70.00	39.00	31.00	53.00	34.00	19.00
Jordan	80.00	78.00	2.00	67.00	72.00	–5.00
Kuwait	...	...	...	100.00	100.00	0.00
Lebanon	57.00	56.00	1.00	61.00	68.00	–7.00
Libyan Arab Jamahiriya	...	...	...	95.00	95.00	0.00
Morocco	33.00	22.00	11.00	40.00	29.00	11.00
Oman	30.00	12.00	18.00	96.00	84.00	12.00
Pakistan	31.00	12.00	19.00	62.00	36.00	26.00
Palestine	...	...	...	...	100.00	...
Qatar	71.00	67.00	4.00	82.00	86.00	–4.00
Saudi Arabia	39.00	27.00	12.00	81.00	70.00	11.00
Somalia	15.00	8.00	7.00	...	...	...
Sudan	23.00	17.00	6.00	24.00	19.00	5.00
Syrian Arab Republic	63.00	40.00	23.00	54.00	43.00	11.00
Tunisia	38.00	24.00	14.00	55.00	49.00	6.00
United Arab Emirates	48.00	59.00	–11.00	85.00	83.00	2.00
Yemen, Republic of	12.00	3.00	9.00	32.00	11.00	21.00

D = Difference = Male ratio – Female ratio
... Data not available

Source: EMRO HST Database

the female enrolment ratio over the male ratio in Bahrain, Cyprus, Jordan, Lebanon and Qatar. The male/female secondary school enrolment gap increased in Afghanistan, Pakistan and the Republic of Yemen. Morocco was the only country that retained the same gap in 1985 and 1995, while Kuwait and the Libyan Arab Jamahiriya showed no gap (no difference) between males and females (Table 2).

Lower enrolment levels of girls in secondary school are still mostly due to social, cultural and economic factors. Such factors include early marriage and child bearing, household duties, son preference and limited work opportunities.

Table 3. Total fertility rate and percentage change in countries of the Eastern Mediterranean Region, 1985–1995

Country	1985	1995	% change
Afghanistan	6.90	6.20	–10.10
Bahrain	5.90	3.40	–42.40
Cyprus	2.30	2.10	–8.70
Djibouti	6.60	5.80	–12.10
Egypt	5.30	3.60	–32.10
Iran, Islamic Republic of	...	2.60	...
Iraq	6.70	4.70	–29.90
Jordan	6.80	4.40	–35.30
Kuwait	4.90	3.20	–34.70
Lebanon	3.80	2.50	–34.20
Libyan Arab Jamahiriya	7.20	4.10	–43.10
Morocco	5.40	3.00	–44.40
Oman	7.20	4.80	–33.30
Pakistan	7.00	5.30	–24.30
Palestine	...	4.60	...
Qatar	5.90	2.80	–52.50
Saudi Arabia	7.30	5.90	–19.20
Somalia	6.60	6.80	3.00
Sudan	6.60	5.70	–13.60
Syrian Arab Republic	7.20	4.20	–41.70
Tunisia	4.90	3.20	–34.70
United Arab Emirates	5.20	4.90	–5.80
Yemen, Republic of	7.80	5.90	–24.40

Total fertility rate = the average number of births by women of reproductive age (15–49)

$$\% \text{ change} = \frac{1995 \text{ rate} - 1985 \text{ rate} \times 100}{1985 \text{ rates}}$$

... Data not available

Source: EMRO HST Database

2.3 Fertility

Considerable reduction of the total fertility rate was observed between 1985 and 1995, except in Somalia (Table 3).

2.4 Socioeconomic and public life

The gender gap exists not only in education but in income and ownership of resources. Women's participation in the regional labour force is still low (Table 4), ranging between 13% and 38% in 1995. A recent study in Egypt [*4*] on technology and training and its effect on women's employment confirmed the phenomenon of the feminization of poverty. The study noted that the feminization of poverty represents a vicious circle of illiteracy, lack of training opportunities and lack of ownership of resources. The technology accessible to women is usually of a traditional kind and generates very modest income, while, because of their multiple roles inside and outside the home, women have very little time for training and acquiring new skills in non-traditional areas.

Table 4. Women in socioeconomic and public life in countries of the Eastern Mediterranean Region, 1995

Country	Participation of women in adult labour force 1995 (%) age 15+	% of national labour force in agriculture 1990	Seats in Parliament held by women 1997 (%)	Women at ministerial and sub-ministerial level 1995 (%)
Afghanistan	...	...	...	...
Bahrain	19.00	2.00	0	0.00
Cyprus	38.00	14.00	5.40	5.00
Djibouti	...	...	...	1.00
Egypt	29.00	40.00	2.00	2.00
Iran, Islamic Republic of	24.00	32.00	4.90	0.00
Iraq	18.00	16.00	...	0.00
Jordan	21.00	15.00	1.70	2.00
Kuwait	31.00	1.00	0.00	6.00
Lebanon	28.00	7.00	...	0.00
Libyan Arab Jamahiriya	21.00	11.00	...	0.00
Morocco	34.00	45.00	0.70	1.00
Oman	14.00	45.00	0	4.00
Pakistan	26.00	52.00	2.60	2.00
Palestine	...	...	...	...
Qatar	13.00	3.00	0	2.00
Saudi Arabia	13.00	...	0	0.00
Somalia	...	...	...	...
Sudan	28.00	69.00	5.30	1.00
Syrian Arab Republic	25.00	33.00	9.60	4.00
Tunisia	30.00	28.00	6.70	5.00
United Arab Emirates	13.00	8.00	0.00	0.00
Yemen, Republic of	27.00	61.00	...	0.00

... Data not available

Source: [6]

According to a recent study by UNDP [5] on the relationship between women's education on the one hand and fertility and income on the other, for every additional year of education, a woman's fertility rate decreases by 10.5% and her income increases by 15%.

The lack of opportunities for women to participate equally in economic and political life is reflected in the indicators relating to women's participation in decision-making in economic and political activities (Table 4). Despite the trend towards democracy, nowhere do women enjoy the same opportunities for participating in public life as men. They occupy only between 0% and 9.6% of parliamentary seats and between 0% and 6% of ministerial and sub-ministerial positions. However, it is known that many women play a large part in civil society organizations (nongovernmental organizations) and in pressure groups. This grass roots progress towards greater participation deserves further study in the Region.

Table 5. Women's access to health care in countries of the Eastern Mediterranean Region

Country	Women delivered by trained personnel (%)			Maternal mortality rate (per 10 000 live births)
	1985	1995	Difference	1995
Afghanistan	10.00	15.00	5.00	170.00
Bahrain	98.00	98.00	0.00	3.90
Cyprus	100.00	100.00	0.00	1.50
Djibouti	73.00	60.00	−13.00	...
Egypt	24.00	62.00	38.00	17.40
Iran, Islamic Republic of	...	86.00	...	3.70
Iraq	60.00	83.00	23.00	13.00
Jordan	75.00	92.00	17.00	4.10
Kuwait	99.00	100.00	1.00	1.60
Lebanon	45.00	96.00	51.00	10.40
Libyan Arab Jamahiriya	76.00	99.00	23.00	4.00
Morocco	24.00	47.00	95.80	22.80
Oman	60.00	92.00	32.00	2.10
Pakistan	24.00	35.00	11.00	30.00
Palestine	...	97.00	...	2.90
Qatar	96.00	100.00	4.00	1.00
Saudi Arabia	79.00	92.00	13.00	1.80
Somalia	2.00	20.00	18.00	160.00
Sudan	20.00	86.00	66.00	36.50
Syrian Arab Republic	35.00	83.00	48.00	9.50
Tunisia	60.00	81.00	21.00	6.90
United Arab Emirates	96.00	99.00	3.00	0.20
Yemen, Republic of	...	35.00	...	100.00

Source: EMRO HST Database

2.5 Access to health care

From 1985 to 1995, the percentage of women delivered by trained personnel increased in all countries except Djibouti (Table 5); 100% of Cypriot, Kuwaiti and Qatari women were delivered by trained personnel. The increase in the rate varied considerably between countries, especially among those with originally low rates. No change occurred in Bahrain and Cyprus as they had already attained higher rates (98% and 100% respectively).

The maternal mortality rate showed a variable pattern. Comparison with 1985 data is not possible due to the unreliability of the 1985 data on maternal mortality. There is an obvious inverse correlation between the percentage of pregnant women delivered by trained personnel and maternal mortality rate.

Table 6. Life expectancy at birth in the Eastern Mediterranean Region, 1985–1995

Country	1985			1995		
	F	M	D	F	M	D
Afghanistan	40.00	41.00	−1.00	44.00	43.00	1.00
Bahrain	68.00	64.00	4.00	75.30	70.40	4.90
Cyprus	77.00	72.00	5.00	79.80	75.30	4.50
Djibouti	44.00	56.00	−12.00	...	...	...
Egypt	61.00	58.00	3.00	66.40	62.90	3.50
Iran, Islamic Republic of	69.00	66.00	3.00	70.00	68.00	2.00
Iraq	65.00	63.00	2.00	59.00	57.00	2.00
Jordan	71.00	67.00	4.00	69.50	66.00	3.50
Kuwait	74.00	70.00	4.00	76.40	73.80	2.60
Lebanon	67.00	63.00	4.00	72.00	69.00	3.00
Libyan Arab Jamahiriya	60.00	57.00	3.00	67.00	65.00	2.00
Morocco	62.00	58.00	4.00	70.70	67.10	3.60
Oman	55.00	53.00	2.00	74.20	71.80	2.40
Pakistan	56.00	57.00	−1.00	62.10	62.90	−0.80
Palestine	...	...	...	73.50	69.00	4.50
Qatar	74.00	71.00	3.00	74.50	74.20	0.30
Saudi Arabia	67.00	65.00	2.00	73.40	69.90	3.50
Somalia	50.00	49.20	0.80	47.90	44.70	3.20
Sudan	50.00	48.00	2.00	55.50	52.50	3.00
Syrian Arab Republic	64.70	63.00	1.70	69.00	67.00	2.00
Tunisia	63.00	62.00	1.00	73.30	69.50	3.80
United Arab Emirates	72.00	67.00	5.00	74.00	72.00	2.00
Yemen, Republic of	45.00	43.00	2.00	59.00	56.00	3.00

D = Difference = Female life expectancy (in years) – Male life expectancy (in years)

Source: EMRO HST Database

2.6 Life expectancy

During 1985–1995, life expectancy at birth increased for both men and women in most countries of the Region (Table 6). Regionwide, one of the fastest levels of progress in raising life expectancy since the1980s was in Oman and the Republic of Yemen. In 1985, in most countries females had a longer life expectancy at birth than males except in Afghanistan, Djibouti and Pakistan.

The same pattern continued in 1995 with some variation in gap (the difference between life expectancy of females and males). Some countries showed a reduction in the life expectancy gap, to the benefit of males (Cyprus, Islamic Republic of Iran, Jordan, Kuwait, Lebanon, Libyan Arab Jamahiriya, Morocco, Qatar and United Arab Emirates). In one country (Iraq) there was no change. Most other countries showed an increase during the decade in the difference between life expectancy of females and male, to the benefit of females (Afghanistan, Bahrain, Egypt, Oman, Saudi Arabia, Somalia, Sudan, Syrian Arab Republic, Tunisia and Republic of Yemen). One country (Pakistan) has a longer life expectancy for males than females.

2.7 Other indicators

Additional indicators that are valuable for assessing women's status in society but for which no data exist are:

- % of women below poverty line
- % of women-headed households
- % of elderly living alone
- % of violence against women.

2.8 Summary

It was assumed for a long time that development was gender neutral and had a positive impact on all groups in society. In reality, that has proved not always to be the case. However, countries of the Region have made good progress over the past decade in achieving more equitable distribution between women and men of the fruits of development. Gender gaps in education and health have narrowed rapidly. In the more affluent countries of the Region almost all boys and girls are enrolled in both primary and secondary schools and there has been a noticeable advancement regarding female education in schools and universities.

3. IMPEDIMENTS TO PARTICIPATION OF WOMEN IN DEVELOPMENT

Impediments to the participation of women in development identified at the consultation on the role of women in health and sustainable development in February 1999 are:

- use of the women in development approach rather than the gender and development approach;
- absence or lack of institutionalization of multisectoral national committees for women;
- lack of resources, e.g. allocation of budgets; weak coordination between government and nongovernmental organizations and within government ministries; and absence of research into the gender perspective in health;
- lack of capacity, skills and gender-sensitized approaches and tools (e.g. gender-specific indicators, and communication methods to reach out to women and to listen to their voices) for generation of gender- and age-specific data; lack of check-lists and guidelines to undertake situation analysis; and lack of appropriate and informed policies and programmes;
- lack of policy support to integrate gender as an intersectoral issue.

4. MAINSTREAMING GENDER IN WHO REGIONAL PROGRAMMES

WHO's role in promoting women's participation in health and development in the countries is to advocate for and support the development of policies, strategies and programmes that incorporate a gender perspective. WHO approaches to women in health and development emphasize that gender is a cross-cutting (intersectoral) theme, and

therefore the women in health and development programme works in collaboration with all divisions and programmes. It has three main targets:

- establishment in each country of a multisectoral National Committee on the Role of Women in Health and Sustainable Development, including also membership from nongovernmental organizations;
- development of national information systems on the status of the role of women in health and development;
- formulation of national plans of action to promote the role of women in health and development.

To achieve these targets the following priority actions have been taken.

- Women in health and development focal points have been identified in 21 countries of the Region so far.
- In some countries WHO provided technical expertise to develop gender-sensitive indicators for the health information systems.
- The role of women in development has been promoted in other regional programmes, such as the healthy cities programme. For example, the Healthy Cities and Women's Development Project to encourage local level initiatives in Alexandria, Egypt, has demonstrated that empowerment of women is among the approaches basic to the success of WHO's collaboration with countries. The methodologies developed in this initiative are now being applied to a variety of projects dealing with other priority health issues in other countries of the Region, such as the role of women in traditional medicine, health promotion and protection and basic development needs.
- WHO has raised awareness regarding the need for national health agendas to take account of and address obstacles to women's development (e.g. violence and female genital mutilation).
- WHO has also started discussions in some of the countries to prepare hardship profiles in order to document the impact of poverty, armed conflict, displacement and other traumatic events on the health and quality of life of women, and on women's role in the health and development of their families, communities and nation. The aim is to develop appropriate strategies to meet the special health-related needs of women from these groups and to promote women's role in health and development processes in their communities.

5. PROPOSED STRATEGY FOR GENDER MAINSTREAMING IN THE REGION

It must be said at the outset that while gender and development (GAD) remain the conceptual and methodological framework within which this strategy is developed, given the existing gender disparities between women and men, special emphasis must be placed on women, so that the gender gap can be bridged. The regional strategy developed by the

participants in the consultation on the role of women in health and sustainable development is as follows.

a) Establish/support/strengthen gender focal point(s)/gender unit(s) for health to be represented in national committee(s) for women with clear terms of reference in order to:

- ensure the required promotion and advocacy for promotion of gender mainstreaming in health and health-related development processes;
- provide technical advice to formulate health and development plans and programmes with a gender focus;
- assist and facilitate identification and mobilization of resources;
- coordinate and liase with all other ministries and agencies concerned with gender issues, such as ministries of planning, education, labour, justice, rural development, social affairs and agriculture, development banks, etc.

b) Create opportunities for capacity building and leadership for women in order to promote their active participation in health and health-related development sectors, such as primary health care, environmental health, traditional medicine, health care reform, and in the strategic health-focused development initiatives such as basic development needs, healthy villages and healthy cities.

c) Integrate health concerns and issues into economic development processes.

d) Address harmful traditional health-related practices and misinterpretations about religion through dialogue, education and awareness-raising, in order to introduce appropriate sociolegal changes for protection of women's health and their quality of life.

e) Conduct gender-sensitive research studies to map the factors affecting women's role in health and sustainable development processes, and to identify women's health needs and other related development issues.

f) Develop gender-disaggregated health information systems.

g) Sensitize the media to create gender awareness among the public, especially by presenting positive images of women that enhance and promote the importance of women's role in health and health-related sustainable development.

h) Give special attention, including provision of policy support and allocation of resources, to meeting the special health-related needs of women living under difficult circumstances, such as armed conflict or civil strife, or as refugees and in displaced communities.

i) Recognize and strengthen positive cultural, traditional and religious values, and related practices, that promote and protect women's interests and benefits concerning their quality of life and health.

6. RECOMMENDATIONS

The following recommendations to countries are the outcome of the consultation on the role of women in health and sustainable development.

1. Establish/strengthen multisectoral gender focal point(s)/gender unit(s) for health and multisectoral national committee(s) for women; and develop linkages and mechanisms for gender focal point(s)/gender unit(s) to liase and collaborate closely with national committee(s) for women.
2. Develop a clear policy framework, including legislative support, and mobilize greater investment to promote women's role in health and development processes, including equal opportunities for women and men for employment and training and other sources of professional growth.
3. Guided by the regional strategy, prepare a national strategy and plan of action, based on the country's priorities and needs.
4. Using gender-sensitive indicators and information categories, prepare a country profile on gender in health and development.
5. Start/support programmes to develop gender-sensitive leaders, both women and men.
6. Build and strengthen capacities and partnerships, and foster linkages, with national and international nongovernmental organizations and civil society institutions, in order to mainstream gender in national health and development planning processes.
7. Develop information exchange and networking activities/programmes, including establishment of a clearing house(s) to collect and disseminate health and health-related research and information on gender to all health and health-related stakeholders in the country.
8. Undertake specific studies/assessment and develop a specific strategy to reduce the hardship of women in low-income groups, facing armed conflict and civil strife as well as refugee and displaced women.

7. REGIONAL PLAN OF ACTION FOR 2000–2001

Based on the strategy proposed and the recommendations suggested by the consultation, and guided by the three programme targets, the following is the tentative plan of action for WHO for the next two years.

1. Set up a Regional Advisory Committee to facilitate the process of gender mainstreaming at all levels of health development.
2. Constitute a small Regional Working Group to prepare gender-sensitive indicators, guidelines and checklists for health information systems, situation analyses, country profiles and qualitative research on issues relating to the role of women in health and development.
3. Develop proposals and ensure implementation of two priority issues—hardship and violence against women.

4. Initiate demonstration projects to mainstream gender progressively in WHO programmes, to promote the role of women in health development, especially in traditional medicine, environmental health, health protection and promotion, basic development needs, healthy cities and healthy villages.
5. Provide technical support in the above initiatives to a number of countries in the Region.
6. Organize an intercountry meeting to follow up on the progress made with regard to the strategy and the recommendations proposed in the first intercountry consultation on the role of women in health and sustainable development.
7. Produce a regional publication documenting case studies of best practice/success stories with regard to the role of women in health and development in the Eastern Mediterranean Region, some of which were presented at the consultation.
8. Start a newsletter or a web page to share policies, strategies, lessons learned and case studies of best practice regarding gender mainstreaming in health and health-related sustainable development in the Region.
9. Identify and designate a WHO collaborating centre(s) for gender mainstreaming.

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