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003. report	re: U.S. Government Report (2 pages)	03/14/1995	P1/b(1)
004. report	re: U.S. Government Report (1 page)	04/05/1995	P1/b(1)
005. report	re: U.S. Government Report (1 page)	04/05/1995	P1/b(1)
006. report	re: U.S. Government Report (1 page)	06/05/1995	P1/b(1)
007. report	re: U.S. Government Report (1 page)	05/13/1993	P1/b(1)
008. report	re: U.S. Government Report (1 page)	05/13/1993	P1/b(1)
009. report	re: U.S. Government Report (1 page)	08/31/1995	P1/b(1)
010. report	re: U.S. Government Report (1 page)	03/29/1989	P1/b(1)
011. report	re: U.S. Government Report (1 page)	09/19/1990	P1/b(1)
012. cable	re: Minister Resigns (2 pages)	08/31/1995	P1/b(1)
013. report	re: U.S. Government Report (1 page)	04/11/1990	P1/b(1)

COLLECTION:
Clinton Presidential Records
First Lady's Office
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2012-0094-F
jp3675

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015. bio	re: Stephen Lewis [Personally Identifiable Information] [Partial] (1 page)	00/00/0000	b(6)
016. report	re: U.S. Government Report (1 page)	09/23/1994	P1/b(1)
017. report	re: U.S. Government Report (1 page)	09/23/1994	P1/b(1)
018. report	re: U.S. Government Report (2 pages)	01/06/1995	P1/b(1)
019. report	re: U.S. Government Report (2 pages)	08/29/1995	P1/b(1)

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WHO Colloquium
"Women & Health Security"

Divider Title: _____

WHO COLLOQUIUM - "WOMEN & HEALTH SECURITY"

DATE:	**Tuesday, September 5**
TIME:	**11:15 am**
LOCATION:	**Beijing Commodities Center**
FROM:	**Brenda Costello**

I. PURPOSE

To underscore your interest in promoting women's economic security by participating in a colloquium on women's health sponsored by the World Health Organization.

II. BACKGROUND

In conjunction with the Fourth World Conference on Women, the World Health Organization (WHO) is planning a Women's Health Day on September 5 with four panel discussions on various topics and a colloquium entitled "Women & Health Security" (see schedule attached). The WHO has asked you to give the keynote address in the colloquium, which is a joint WHO/ UN Population Fund activity.

The goal of the colloquium is to promote health security for all women, ensure that women have access to quality health care throughout their lifespan, and to reduce the impact of poverty on women's health. In the WHO position paper on the Conference, Dr. Hiroshi Nakajima states, "Sustainable progress will be achieved when women are finally empowered to make free, informed and responsible choices, and assert themselves as leaders in their own right within their societies. Women's health is the surest road to health for all." (Note: The U.S. took the lead in the prepatory meetings of the conference to highlight the comprehensive approach to women's health, not just reproductive health.)

The "Women and Health Security" colloquium will be a three-part session, consisting of opening addresses, your remarks, and panel discussion. Both Dr. Hiroshi Nakajima, Director General of the WHO and Dr. Natis Sadik, UN Population Fund (UNFPA) will give opening remarks before you arrive (bios attached).

You will arrive to hear remarks by Mrs. Gertrude Mongella, Secretary Genneral of the FWCW, who will discuss violence. Following Mrs. Mongella's remarks, Dr. Nakajima will introduce you. Your address will be followed by remarks and discussion from three panelists: Princess Basma of Jordon and Lady Chalker, the Baroness of Wallasey, who will both discuss poverty and health care (bios attached); and Cindy Robins, an AIDS patient from Canada, who will discuss AIDS as a women's health issue. Ms.Vivian Creegor of the UK is moderating. (Bios to be forwarded.)

Note: There is an 18-minute video being shown at the beginning of the colloquium before you arrive. This video, which will focus on threats to women's health, including reproductive health, is apparently somewhat sensationalistic and violent.

The audience will be comprised of approximately 450 people, including approximately 200 official Conference delegates, 100-150 NGO members, 20 Chinese government officials, and members of the Press.

Topics for the four panel discussions to be held later in the day include: Women, health and education; Women, health and work; Women, health and violence; and Women and AIDS. Secretary Shalala will deliver the keynote address at the panel discussion on "Women and AIDS" that evening.

WHO

The World Health Organization is an intergovernmental organization with 166 Member States within the United Nations System, whose mission is the attainment by all people of the best possible level of health. The WHO has two main constitutional functions: (1) to act as the directing and coordinating authority on international health work; (2) to encourage technical cooperation for health with member states. Headquartered in Geneva, Switzerland, WHO has six regional offices and committees.

In 1981 the World Health Assembly, the annual meeting of delegates from all Member States, unanimously adopted a Global Strategy for Health for All by the Year 2000. The focus of the Strategy is to develop a health system infrastructure to ensure resources for health will be evenly distributed, and that essential health care will be accessible to everyone with full community involvement.

The WHO's position paper for the Fourth World Conference on Women outlines the challenges the health community still faces in securing the health of millions of women around the world, and points to both progress and setbacks in women's health since the Nairobi conference on women in 1985.
(executive summary attached).

III. PARTICIPANTS

Dr. Hiroshi Nakajima, M.D., Ph.D., Director-General, WHO
Mrs. Gertrude Mongella, Secretary General, FWCW
Dr. Nafis Sadik, Executive Director, UNFPA

Panelists and Guests
Dr. Aleya El Bindari Hammad, Exec. Administrator for Health Policy in Development, WHO
Princess Basma Bint Talal, Jordan
Ms. Cindy Robins, Canada

The Baroness Chalker of Wallasey, UK
Ms. Vivian Creegor, UK
Dr. Nafsiah Mboi, Member of Parliament, Indonesia
Mrs. Nana Konadu Agyeman-Rawlings, First Lady of Ghana-TBA
Ms. Amparo Claro, Chile
Mrs. Maria Pia Fanfani, Italy -TBA

IV. SEQUENCE OF EVENTS

SEE TRIP BOOK

V. PRESS

Open press.

VI. REMARKS

Prepared by Lissa Muscatine.

ORGANISATION MONDIALE DE LA SANTE

DR HIROSHI NAKAJIMA
DIRECTOR-GENERAL OF THE WORLD HEALTH ORGANIZATION

Biographical Note

Dr Hiroshi Nakajima, Director-General of the World Health Organization, was born in Chiba City, Japan, on 16 May 1928. He obtained his medical degree at the Tokyo Medical College in 1955 and he holds a postgraduate degree in medical science. In 1984 he was awarded the Kojima Prize, the highest award given in Japan for achievements in public health.

Shortly after graduation Dr Nakajima began his training in neuropsychiatry, first as a junior physician in the Department of Neuropsychiatry, Tokyo Medical College, and later, as a postgraduate fellow supported by the Government of France, in the Department of Neuropsychiatry, Faculty of Medicine, Paris University, and in the Institute of Pharmacology of the same university where he received practical training in pharmacology. From 1958 to 1967 he worked as a scientist at the National Institute of Health and Medical Research, Paris, carrying out research in basic and clinical neuropsychopharmacology and finally, as principal scientist, supervising research activities in the neuropsychopharmacological unit of the Institute. In 1967 he returned to his home country as Director, Research and Administration, Nippon Roche Research Centre, Tokyo. Between 1967 and 1973 he became internationally known in the field of pharmacology and neuropsychiatry and contributed, as an expert nominated by his government, to a number of WHO activities.

Dr Nakajima joined the World Health Organization in January 1974 in the position of Scientist, Drug Evaluation and Monitoring. He became Chief, Drug Policies and Management unit in 1976. It was in this position that he played a key role in developing the concept of essential drugs, as Secretary of the first Expert Committee on the subject. In 1978 the WHO Regional Committee for the Western Pacific, at its twenty-ninth session, nominated Dr Nakajima as Regional Director; he was appointed to that office by the WHO Executive Board at its sixty-third session in January 1979, and he took up his duties as the Region's third Director on 1 July 1979. On the nomination of the Regional Committee he was reappointed by the Executive Board for a further five-year term from 1 July 1984. In May 1988, while still in office as Regional Director, he was appointed Director-General of the World Health Organization by the Forty-first World Health Assembly. He took up his duties as the Organization's fourth Director-General in July 1988. In May 1993 the Forty-sixth World Health Assembly elected Dr Nakajima to a second term of office as Director-General for five years from July 1993.

Dr Nakajima is the author of scientific articles and reviews relating to the medical and pharmaceutical sciences, published in the English, French and Japanese languages.

He is married to Martha DeWitt Nakajima and has two sons.

BIOGRAPHY OF DR A. EL BINDARI HAMMAD

Dr Aleya El Bindari Hammad currently holds the position of Executive Administrator for Health Policy in Development (HPD) in the World Health Organization. In this capacity she is responsible for health policy analysis, particularly relating to the effects of development policies and economic strategies on the health status of populations. From this analysis, health policy advocacy is carried out to provide input to the UN system and to ensure the promotion of WHO's health policies in the work of relevant agencies, organizations and bodies. A seminal part of this work is carried out under the auspices of the WHO Task Force on Health in Development, of which Dr Hammad is the secretary.

Dr Hammad is responsible for work on women's issues at a policy level, both within and outside the Organization. In this capacity, Dr Hammad is Secretary to the WHO Global Commission on Women's Health. Her functions also encompass work on human rights and health where WHO provides support to Member States and the UN system in the review, design and monitoring of instruments and practices in the field of health to protect and promote health-related human rights. As focal point for human rights, she represented the Organization at the World Conference on Human Rights (Vienna, June 1993).

Dr Hammad has a wide range of experience in public health and education. Her qualifications include a Masters degree in public health administration and a Ph.D. in education (health and social anthropology) from Boston University, and post doctoral studies at Harvard University, working with culturally deprived children in the USA.

Her pioneering work in the infancy of primary health care led to her appointment to the WHO programme responsible for primary health care, in Geneva. She participated in the preparation of, and attended the International Conference on Primary Health Care held in Alma-Ata in 1978.

Dr Hammad's extensive knowledge and experience of the linkages between health status and the development process led to her being responsible for intersectoral action for health. During that time she was Secretary of the Technical Discussions held during the Thirty-Ninth World Health Assembly in 1986, which were co-sponsored by the United Nations, FAO, UNESCO, and the United Nations Environment Programme (UNEP) and Habitat. She has also been designated as the Secretary for the Technical Discussions, in May 1992 on the theme of Women, Health and Development, a responsibility she has retained in her present position. She is also the focal point for human rights and represented the Organization in the International Conference.

Dr Hammad is married and has two children.

WORLD HEALTH ORGANIZATION

INFORMATION CIRCULAR No. 64

IC/95/64
20 July 1995

Distribution: HQ + RO

ORIGINAL: ENGLISH

HEALTH POLICY IN DEVELOPMENT (HPD)

The Director-General is pleased to announce the appointment of Dr Aleya El Bindari-Hammad, formerly Adviser on Health and Development Policies, as Executive Administrator for Health Policy in Development (HPD), with effect from 21 July 1995.

The responsibilities of Health Policy in Development, which will report direct to the Director-General, include the following:

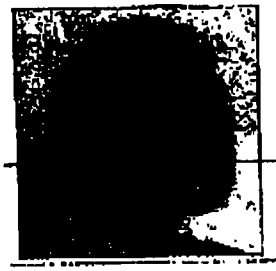
- Health in socio-economic development policies
  Secretary of Task Force on Health in Development and Global Commission on Women's Health; Promoting leadership for health: health policy analysis including intersectoral development policies; health aspects of socio-economic development.

- Health policy advocacy
  Input to the UN system; ensuring the promotion of WHO's health policies in the work of relevant agencies, organizations and bodies.

- Human rights and health
  Support to Member States and the UN system in the review, design and monitoring of instruments and practices in the field of health to protect and promote health-related human rights.

****

~~Nafis Sadik, M.D.~~
~~Under-Secretary General~~
United Nations Population Fund
220 East 42nd Street
New York, NY 10017
Tele: 212-297-5111
Fax: 212-297-4911



Dr. Nafis Sadik, born in Pakistan, is the recipient of numerous prestigious awards for her numerous contributions to advancing the cause of women and to alleviating problems associated with population growth. She was the first woman Director-General of Pakistan's National Family Planning Program, and as Executive Director of the United Nations Population Fund with the rank of Under-Secretary-General, is the first women in the history of the United Nations to head one of its major voluntary programs. Dr. Sadik, as Secretary-General of the International Conference on Population and Development (ICPD) successfully concluded in Cairo in September 1994, was most instrumental in focusing world attention on the urgent need to collectively address the critical challenges and interrelationships between population and development.

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4:45 pm - 6.15 pm

PANEL DISCUSSION

Women, health and violence

(A World Health Organization activity in collaboration with the Centre for Human Rights)

Keynote address: HE Mrs Specioza Wandera Kazibwe, Uganda*

Special guests:
Mrs Maria Pia Fanfani, Italy*
Dr Radhika Coomaraswamy, Sri Lanka
Mrs Esoleda Alvear, Chile*
Mrs Joyce Kadandara, Zimbabwe
Ms Joan Dunlop, USA
Mrs Patricia Giles, Australia

Challenges

- To recognise the impact of all forms of violence on women's health
- To adopt strong measures for reducing violence against women
- To promote health and support services for women who are subjected to violence
- To ensure that penal or criminal justice systems provide comprehensive legal protection against all forms of violence, including those perpetrated against women during periods of war and conflict

Outcome

- A call for a stop to violence against women

* to be confirmed

6:30 pm - 8.30 pm

PANEL DISCUSSION

Women and AIDS

(A World Health Organization activity in collaboration with UNAIDS and the NGO Coalition)

Keynote address: Dr Donna Shalala, USA*

Special guests:
Dr Hilary Homans, UK
Ms Yolanda Simons, Trinidad
Ms Cindy Robins, Canada
Professor Hakima Himmich, Morocco
Mrs Nicerine Kateeba, Uganda
Dr Adepeju Olukoya, Nigeria
Dr Mabel Bianco, Argentina

Moderators: Dr Nafsiah Mboi Indonesia
Dr E. Maxine Ankrah, USA

Challenges

- To reduce women's vulnerability to HIV/AIDS and increase their ability to protect themselves against HIV infection
- To recognize gender disparity as a root cause of women's disproportionate vulnerability to HIV infection
- To recognize and build on the strength generated through partnerships, in particular with men, in combatting the AIDS pandemic
- To generate self-empowerment of women through collective action and solidarity in order to develop networks and services for women by women

Outcomes

- A call for unity of action to achieve greater effectiveness, revitalisation of current efforts in the fight against HIV/AIDS
- A commitment from delegations, NGOs and other agencies to address the pressing issues of HIV/AIDS through specific initiatives

Refreshments will be served

* to be confirmed

FOURTH WORLD CONFERENCE ON WOMEN

World Health Organization

Invitation to **Women's Health Day**

Tuesday 5 September 1995

Securities Exchange Building – opposite BICC

Addresses and presentations will be delivered by distinguished personalities

ALL DELEGATES TO THE CONFERENCE AND NGO FORUM ARE WELCOME

10:00 am - 1:00 pm

COLLOQUIUM

Women and health security

(A joint World Health Organization/ United Nations Population Fund activity)

Opening addresses: Dr Hiroshi Nakajima, WHO
Mrs Gertruce Mongella, FWCW
Dr Nafis Sadik, UNFPA

Keynote address: HE Mrs Hillary Rodham Clinton, USA*

Special guests: HRH Princess Basma Bint Talal, Jordan
Dr Nafsiah Mboi, Indonesia
The Rt Hon The Baroness Chalker of Wallasey, UK*
HE Nana Konadu Agyeman-Rawlings, Ghana*
Ms Amparo Claro, Chile
Mrs Maria Pia Fanfani, Italy*
Ms Cindy Robins, Canada

Moderator: Ms Vivian Creegor, UK

Challenges

- To promote health security for all women
- To ensure that women have access to quality health care throughout their life span, including reproductive health services during their reproductive years
- To reduce the impact of poverty on women's health

Outcome

- Commitment to equity, development and peace as basic requirements for women's health security

* To be confirmed

1:15 pm - 2:45 pm

PANEL DISCUSSION

Women, health and education

(A World Health Organization activity in collaboration with the United Nations Educational, Scientific and Cultural Organization)

Opening address: Mr Federico Mayor*, UNESCO

Keynote address: HE Mr Julius Nyerere, Tanzania

Special guests: HE Mrs Suzanne Mubarak, Egypt
Ms Jane Fonda, USA*
Mr Shankar Chowdhury, India
Dr Ann Kerwin, USA

Challenges

- To improve health by ensuring access to education/ information for girls and women
- To develop a culture for health which states that health education is an integral part of primary and secondary education

Outcome

- Commitment by the international community to educating girls and women, and to including health in the education core curriculum, as one of the most powerful means for achieving the objectives of development

* to be confirmed

3:00 pm - 4:30 pm

PANEL DISCUSSION

Women, health and work

(A World Health Organization activity in collaboration with the International Labour Office)

Keynote address: HE Mr Assane Diop, Senegal

Special guests: Dr Kaisa Kauppinen-Toropainen, Finland
Ms Cecilia Lopez, Colombia
Mrs Ela Bhatt, India
Dr Florence Mangoyu, Kenya
Mrs Noel Irwin-Hentschel*, USA

Challenges

- To maximise the opportunities for women to safeguard their health in the work environment
- To build on positive experiences of delegates in their own work environment from which lessons can be drawn for wider application
- To reduce the inequities in employment conditions for women especially during periods of crisis

Outcome

- Recommendations for the protection and promotion of women's health in all work environments, formal and non-formal

* to be confirmed

WHO/FHE/95.9
Original: English
Distr.: General

(3)

WOMEN'S HEALTH

Fourth World
Conference on Women
Beijing, China
4 – 15 September 1995

EXECUTIVE SUMMARY

World Health Organization
Geneva, 1995

Acknowledgements

This document is based on contributions from WHO Regional Offices, WHO Headquarters, and experts in the field of women's health and development around the world. WHO would like to thank the numerous colleagues who contributed to, and critically reviewed, the document at different stages.

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Page 10: WHO/E. Rice
Page 15: anon

Table of contents

Preface

We are not asking for privileges for women. All we are saying is that equitable care is not identical care, particularly where physiological differences obviously call for specialized health services.

Sustainable progress will be achieved when women are finally empowered to make free, informed and responsible choices, and assert themselves as leaders in their own right within their societies.

Women's health is the surest road to health for all.

Dr Hiroshi Nakajima
Director-General of the World Health Organization

The 1995 *Fourth World Conference on Women* provides us with an opportunity to draw attention to the challenges now facing the health community as it strives towards promoting – and ensuring – the health of women everywhere. In many ways we have come a long way since the beginning of the United Nations Decade for Women (1976–85). And yet we find ourselves faced with the same obstacles to progress recognized then. Poverty, inequitable relationships between women and men, women's unequal access to health care and education, and social and cultural factors that discriminate against girls and women still prevent the attaining – and maintaining – of health for millions of women around the world.

Introduction

People generally accept the level of health and well-being that their society defines as appropriate for them. This has implications for women, who often consider themselves "healthy" as long as they can fulfil the roles expected of them. Millions of women around the globe, suffering from malnutrition, anaemia, extreme fatigue, chronic pelvic inflammations, and much more, will describe themselves as being "in good health" as long as they can get up in the morning, do a day's work, and cope with household chores and family obligations.

Historically, women's health has been largely defined by family and community interpretations of culture and tradition, and by a medical profession in which men are the main decision-makers. In addition, the resources required to achieve and maintain health have for too long been denied to individual women. The definition of health applied to a woman – and the resources allocated for this – have been influenced by social perceptions of women's status and role, which in turn interact with class, caste, race and ethnicity.

Many women accept ill-health as their lot in life, often ignoring painful and debilitating symptoms because in their culture a women is expected to endure without complaint; or because taboos and myths have led them to believe that their health problems stem from some sort of reproachable behaviour on their part; or simply because they have no alternative.

Such views are by no means universal, however. Women and women's groups in all parts of the world, increasingly supported by men, are formulating their own interpretations of what health means in the context of their own lives. For many women it means not only physical well-being, but also exercising more control over their lives and relationships, and having the information and resources to take responsibility for their own health and that of their family – in short, it means having choices. When women themselves are asked about health what they have to say comes as a challenge to health system planners. The needs women express at first may seem only indirectly related to health – see Box 1. But if they say they want resources of their own to use as they wish, or if they want a better work environment then they are in fact defining health in their own terms, and explaining what is important to their physical, mental and social well-being.

Box 1. Women speak out on health

"What we need most for our health," said a group of women in a village not far from Bangalore, "is a rabbit-raising project. We could sell the meat and pelts and have a few rupees to spend the way we want: for food, or a daughter's school fees." In a Nepalese village, the women had another idea: "What we really need for our health is a bridge across that gorge. It would cut two hours off the trip for firewood."

With a nudge from women themselves, many societies are getting better at listening to women and *looking at the world through women's eyes*, to paraphrase the theme of the 1995 NGO Forum on Women. This is a healthy addition to the long-prevailing predominantly male viewpoint which has often been accepted as applying to all. To look at the world through the eyes of women is to bring hidden issues into the open. It suggests different priorities and alternative solutions.

When WHO adopted the goal of Health for All by the year 2000, it again underscored its commitment to working for the health and well-being of all people, especially those most in need and in danger of being marginalized. We need to reaffirm that human rights and the goal of Health for All apply equally to women.

For many years it was assumed that the differences between men's and women's health must flow from the biological differences between women and men. Consequently, attention was focused on this aspect of women's health, namely pregnancy, childbirth and women's role as mothers. Other major differences in the lives of men and women received little attention from the health sector.

In fact, women have health needs above and beyond those related to pregnancy and motherhood. Their health problems take different forms at different stages of their lives, and in different parts of the world. In some areas, women may die because they do not have access to services, or because services cannot provide the basic skills, technology and equipment they need, while in other areas they may suffer from over-medicalization and inappropriate use of sophisticated technologies. In both cases the needs and well-being of the women concerned are not being given adequate consideration.

Although the problems are different, many of the dynamics that lead to inequities in health for women are much the same everywhere. These are derived from the generally low status of women legally, economically and socially; from the imbalance of power in relationships which limits women's choices and ability to protect their own health; and from the world's indifference to the abuse and neglect of women.

Progress in some areas of women's health has been mixed with setbacks in others. There have been three very positive developments with regard to women's health since the Nairobi conference on women in 1985:

- a return to the emphasis on health as a human right, and renewed interest in the broad definition of health
- increasing use of gender analysis in health issues
- intensified activism on women's health, to the point that one now finds groups of people everywhere, men and women, advocating and working for the fundamental changes in society that will lead to better health for women.

Two overall developments in the past decade have however had a significant and adverse impact on women's health:

- First, the late 1980s and early 1990s brought severe economic difficulties and painful economic transitions in several areas of the world. In many countries, the already meagre health and social service budgets, including those allocated for women's needs, were slashed. As a consequence, the quality and accessibility of services deteriorated even further.
- Secondly, in many places, ethnic conflict, civil wars and uprisings have further disrupted health and social service systems, with much of the violence having been directed at civilians, especially women. The extent of this large-scale public violence – and the domestic violence that many women experience in their daily lives – is only now becoming apparent. Violence is one of the major health concerns for women today.

The primary health care approach (PHC) – with its emphasis on community participation – enabled many women to take part in discussions of local health issues for the first time. The United Nations Decade for Women (1976–85) spurred an increase in local women's groups, including those addressing health issues. These groups have grown in number and size, become more organized, and are now in touch with one another through various national and international networks. Today the women's health movement, in all its diversity from the grassroots level to international gatherings, has a significant influence on policies and programmes affecting health and development.

In any review of women's health, the spread of the HIV/AIDS pandemic must also be taken into account. The pandemic has had a truly disastrous effect on the lives of both men and women. However, it has made possible a far more public discussion of topics that have previously been difficult to address in a frank and open manner: for example, sexuality, human rights issues related to sexual and reproductive health, and the inequality between women and men in relationships. The rapid spread of HIV infection has forced the world to look more carefully at the differences in men's and women's experience with health and illness, and to look at the many different factors limiting women's ability to protect themselves from ill-health. HIV/AIDS provides many insights into the ways in which gender issues can interact with biological factors to the detriment of women's health.

Women's health is a fundamental human right and must clearly be promoted as such. The health of women is moreover a crucial determinant of social and economic development – a point that the World Health Organization continuously emphasizes.

Women are the cornerstones of the family and assume responsibility for many of its most vital functions, not only in regard to health and education, but also in food production and income generation. Therefore, the health of women is a prerequisite for the health of the whole family and, by extension, of communities and societies.

Human development, indeed human survival, would be impossible without the contributions that women make, often at the expense of their own health. Women and men both could make additional contributions to human development if they were to enjoy full health. **Health for All is not an achievable goal until millions more women are empowered to promote and safeguard their own health, and consequently their own development**

Investing in programmes that benefit women is one of the most cost-effective development strategies, whether it be investing in women's health, or their education, or supporting them in income-generating activities. There is a synergy in these investments – they not only enhance a woman's personal health and well-being but also contribute to the development of a nation's human resources.[2] Investing in women's health leads directly to women making personal choices they could not make otherwise, and helps them to be more effective, whatever the roles they choose to play, whatever the tasks they undertake.

Women – when provided with a supportive and enabling environment – can improve their own health and that of their families and communities, often in the face of many hardships and constraints. The time is long overdue for an acceleration of action on policies and programmes that are truly supportive of women in this endeavour.

[1] *Health, Population and Development – WHO Position Paper.* World Health Organization, Geneva, 1994. Prepared for the International Conference on Population and Development, 1994, Cairo.

[2] *Investing in health: world development report 1993.* The World Bank.

PART I Why women's health?

Women's health matters – to women themselves, to their children and families, to their communities, and to society as a whole. The pervasive neglect of women, their inferior social, economic and cultural status, their exclusion from so many aspects of human development – education, access to resources, political power – and their specific biological needs and functions, have historically meant that women could not take good health as a given. For many women in large parts of the world, life is conditioned by poor health and inadequate access to the benefits health care can bring.

In addition to the adverse effects on women themselves, women's ill-health has a broader societal impact:

on children and families – malnutrition and ill-health in mothers can initiate a cycle of ill-health in the next generation, as many of these women will bear low-birthweight babies whose future growth, development and nutrition will be jeopardized from the start.

on household income and national productivity – women are an increasing proportion of the formal labour market, apart from their participation in food production for household consumption – calculated at 80% in Africa – and the informal markets. Malnutrition and lack of health among women undermines their income-earning capacity, which is even more serious when one notes the growing proportion of female-headed households.

Collecting information on women's health permits a better understanding of their needs and concerns. It is not enough however to simply collect data – women's health problems need to be analysed from the perspective of women because they suffer from diseases and conditions that:

- affect women and men differently
- are unique or more prevalent in women
- are more serious in women or among some groups of women
- have different risk factors or different exposure to risk for women and men
- require different interventions for women and men.

During the last few decades there has been an evolution in programmes addressing women and health, due in large part to a significant shift which is occurring in the way women are viewed:

Women as childbearers – initially, women were viewed primarily as beneficiaries in need of specific services for themselves and their babies during pregnancy and childbirth. Another area of attention was family planning primarily as a means of reducing fertility and thereby slowing population growth. In both cases, women's health tended to be seen as a means to an end rather than an objective in itself.

Women as mothers and care givers – women have been seen as guardians of family health and health care givers, with the emphasis on primary

health care. This perspective puts the emphasis on women as people in need of information, training and support so that they can contribute to the health of others.

Women as individuals with multiple roles, needs and potential – this more holistic, gender-oriented approach looks at women in all their roles and relationships, across the life span, in all the contexts that may affect their health. It helps identify the social and cultural determinants of health, notably relations between the sexes. This type of analysis has already provided new insights as to why good health eludes so many women. However, there is much still to be done, both to learn more and to translate the knowledge into programmes and action that will make a difference in the lives of women.

Due largely to action on the part of women themselves, the decade since the previous world conference on women held in Nairobi in 1985 has brought an increased public awareness of women's health issues. Perhaps even more important is the widening of perspective from looking at women and health in isolation to a wider appreciation of "gender issues" – see Box 2. In the health sector such widening of perspective has contributed to an improved understanding of the many interactions between women's health and socioeconomic development. It has also helped to reveal the diversity of needs amongst women, and the constraints that they face in addressing them.

The word "gender" is used to describe those characteristics of men and women which are socially constructed, in contrast to those which are biologically determined.

People are born female or male, but learn to be girls and boys who grow into women and men. They are taught what the appropriate behaviour and attitudes, roles and activities are for them, and how they should relate to other people. This learned behaviour is what makes up gender identity and determines gender roles.[1]

Gender is a dynamic concept which looks at the system formed by the interrelations between men and women. These vary from one culture to another, and from one social group to another within a culture. But in practically all cultures the role of women is subordinate to that of men. The gender approach highlights the need for more equal relationships between men and women in all matters, in order to fully address women's health problems.

The empowerment of women is a fundamental prerequisite for their health. This means promoting increased access for women to resources, education and employment and the protection and promotion of their human rights and fundamental freedoms so that they are enabled to make choices free from coercion or discrimination. Women will necessarily remain at the focus of health activities, but efforts should be increased to facilitate their involvement in programme development so that they become participants in, rather than objects of, health interventions. Women's contribution to human development must be reflected in their ability to share equally in the benefits development can bring. Women's health is an issue that concerns everyone – women and men and the generations of tomorrow.

Box 2. Spotlight on gender

WHO, in applying a gender approach to health, moves beyond describing women and women's health in isolation, but rather brings into the analysis differences between women and men. It examines how these differences determine differential exposure to risk, access to the benefits of technology and health care, rights and responsibilities, and control over their lives. In practice, a gender approach leads to:

- **More consideration of all the factors that affect women's health, not only biological factors, but social and economic status, cultural, environmental, familial, occupational and political factors.**
- **More attention to all of women's roles, not only as wives and mothers.**
- **More attention to the roles and responsibilities of men, and the inequalities between men and women, with an examination of men's roles, perspectives and beliefs in relation to women's health concerns.**
- **More involvement of men in bringing about change.**
- **Listening to what women have to say about health and what they would like to know about it, rather than simply transmitting information to women.**
- **Strengthened research which shows that the voices of women are heard in identifying health issues and in researching, planning, carrying out, and monitoring the responses to them.**
- **More attention to the entire duration of a women's life, from birth to death – health for everyone is a cumulative matter.**
- **Greater recognition and support of women as active participants in the development of health care for themselves, their families and communities.**

[1] *The Oxfam Gender Training Manual*. S. Williams, with J. Seed and A. Mwau. Oxfam UK and Ireland, 1994.

PART II What factors affect women's health?

Poverty and other economic factors

The statistics about women and poverty are all too familiar by now – the majority of the 1.3 billion people living in extreme poverty are women; women are more likely to be poor than men; in all areas of the world, households headed by women (between 10% and 27% in developing countries) are more likely to be poor than those headed by men.

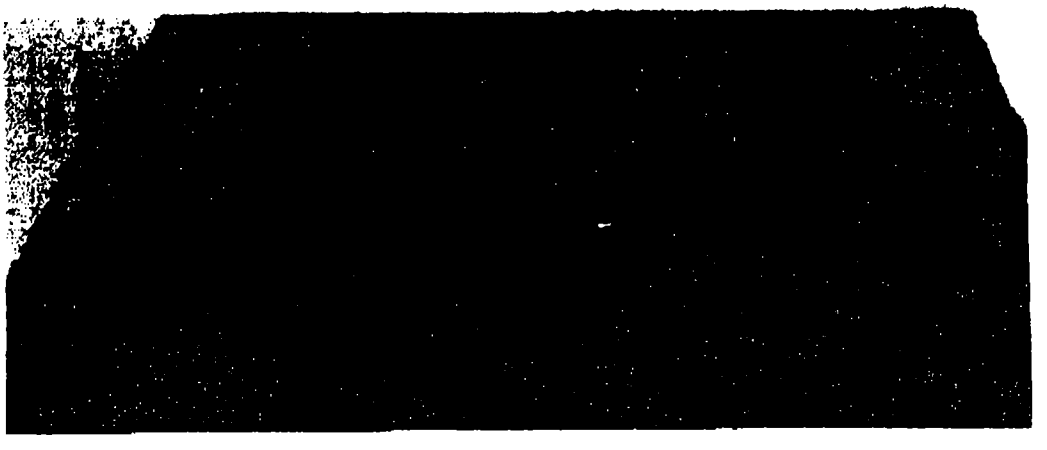
The relationship between women and poverty tends to be the same, whether one looks at urban or rural women, or whether the data come from developed or developing nations. People living in countries with a low ranking on the scale of human development invariably suffer from several combined forms of vulnerability in relation to health, knowledge and education, purchasing power and income-earning capacity.

Poverty often means that people exist on insufficient food or the wrong kinds of food. For women, when this is combined with childbearing and a staggering workload, it often leads to serious malnutrition. Poor women are more likely to live in crowded, unsanitary housing with an inadequate water supply. Poverty and gender-defined roles limit access to education, especially for girls, narrowing their possibilities for future employment and denying them the opportunity to break out of the cycle of poverty and ill-health. Poverty limits access even to free health care if a family cannot afford the costs of medication or transport, or if a woman cannot afford to take time off from paid work to visit a health facility.

Still, the correlation between poverty and poor health for women is not a direct one. Economic growth does not necessarily guarantee better health or higher status for all women because the benefits are not equitably distributed. Indeed, in general the health gap between rich and poor appears to be widening. A deteriorating economic situation can create severe health risks for women even when they do not live in extreme poverty. As the world has learned in recent years, women remain more vulnerable to adverse economic trends than men, especially in times of rapid social, economic and political change.

Lack of personal and social status and opportunities

The status of girls and women in society, and how they are treated or mistreated, is a crucial determinant of their health. Educational opportunities for girls and women affect their status and the control they have over their own lives, their health and their fertility in a powerful way. Equal opportunities for women in other areas of their lives – for example in the judicial, legislative, educational and employment sectors – would also directly promote and protect their health and well-being.



The generally subordinate status of women has an impact on their health in many ways:

Legal status – laws and customs about land ownership, inheritance, marriage or divorce that discriminate against women need to be revisited. Women should not be economically dependent upon men or left entirely without resources of their own since this would have a very negative effect on their health and nutrition, and that of their children, and other family members for whom they are responsible. Even when laws have been made more equitable, millions of women continue to be disadvantaged because custom prevails over law, laws are not enforced, or women are unaware of their rights.

Son preference – the high value placed on sons in some regions leads to discrimination with serious health consequences for girls and women. In extreme cases it may lead to prenatal sex selection in favour of boys, or infanticide. In areas with a strong preference for sons, patterns of food distribution within a household may contribute to malnutrition in girls. Young girls are more likely to be malnourished but less likely to receive treatment for malnutrition or any other health problem. The woman who has many daughters may be under pressure to keep on having more children until she produces sons.

Lack of decision-making power and participation – there is often a hierarchy within households based on age and gender. The older women in some families are quite influential, but younger women may have little autonomy and little weight in family decisions. This becomes important to women's health if they cannot, for example, take part with their husbands in decisions on family planning, or make decisions on their own about the emergency referral of children to a health facility.

Status through childbearing – many of the roles traditionally assigned to women are those of lesser value in a society, which tends to keep women's social status low. On the other hand, the bearing of children, is a role that is symbolically highly valued and respected almost universally. It may also be the only way for women to gain status or to survive in a given society. However, women receive little support in this role in terms of policies or resource allocation.

Lack of education – when illiteracy rates are considered, the gap between women and men becomes even wider. Globally, more than 960 million adults are illiterate, two-thirds of whom are women. In many parts of the developing world, girls are simply not expected to attend school. Sixty million of the 100 million children who have no access to primary schooling are girls. Findings prepared for the World Conference on Education for All suggest that the more education girls and women receive, the greater the likelihood that they will seek prenatal care during pregnancy and that they will be attended by trained health personnel during the births of their children. Although the relationship is not uniform, fertility rates generally decrease as the proportion of women who attend school increases. Improving the health and well-being of children and mothers cannot be sustained and cannot be advanced further without primary education, literacy and basic knowledge for better living for girls and women.

Demographic factors

Population dynamics reflect the life events of people – birth, growth, maturation, migration, family formation, aging, illness and death. Such events are the driving forces of changing demographic and health profiles, and are inextricably linked to the health status of a population. Therefore, the health of individual men, women and children remains of paramount importance at each level of population change.

But demographic, epidemiological and socioeconomic factors in developing and developed countries alike are combining to create new patterns of mortality and morbidity for both women and men, and to force a redefinition of the determinants of women's health. Such factors include marriage and childbearing in adolescence in some parts of the world, contrasted with falling fertility rates in others as women are tending to have fewer children and to have them later in life, increased exposure of women to occupational hazards both within and outside the formal work economy; the particular problems faced by women as they grow older often without any personal or societal support networks; and the stark realities faced by women in refugee or other displaced populations.

All of these – and other – demographic factors bring inevitable sociocultural and epidemiological changes, and challenge health and social service systems. One such challenge is to prepare for changing health-care needs as the proportion of older women increases. Another challenge is to reach young women now with information that will help them avoid the preventable disabilities and illnesses of old age. To meet these and other challenges, it will be necessary to study the physical, economic and social situation of women in their locality, and to

be prepared to respond. Attention must be given to listening to what women of all ages in the community are saying about themselves, and their health concerns.

Harmful practices – female genital mutilation

There are a significant number of practices that have a distinctly negative impact on women's health and well-being. Some examples are dowry and bride price that may in some circumstances lead to physical abuse, intimidation, or even death; and the practice of marriage and childbearing before girls have reached physical and psychosocial maturity, which creates many health risks for young women. Most of the young women in these situations are powerless to resist. The social sanctions for doing so would be severe, and they have few alternatives.

Another traditional practice with serious health risks for women is female genital mutilation (FGM) – a tradition deeply embedded in patriarchal power structures and the desire to control women's lives. Over time, however, both men and women in societies where it is practised have come to believe that FGM is necessary and in the best interests of the girl concerned.

An estimated 2 million young girls are subjected to FGM each year. Most of these girls live in Africa, some in the Middle East, a few in Asia, and an increasing number among immigrant communities in Australia, Canada, Europe and the United States of America.

Women's groups, health professionals, human rights activists, governments and international agencies have all taken firm stands against FGM, considering it a violation of children's – and women's – human rights. At the international level, the Convention on the Rights of the Child explicitly requires States to take all appropriate measures to abolish traditional practices prejudicial to the health of children. In 1994, the World Health Assembly again called the attention of the world to the detrimental health consequences of FGM, and has called for the elimination of FGM. In addition, the World Health Assembly has declared that medicalization of the procedure should not be allowed under any circumstances.

Female genital mutilation (FGM)

FGM is a deeply rooted traditional practice that adversely affects the health of girls and women. It is a form of violence against them that has serious physical and psychosocial consequences, and is a reflection of discrimination against girls and women.

Definition of FGM

All procedures which involve partial or total removal of the external female genitalia and/or other injury to the female genital organs whether for cultural or any other non-therapeutic reasons.

Lack of access to health care

It has been found that women are grossly under-represented in statistics relating to the use of health services. Although they suffer from levels of disease comparable to those of men – and even higher in the area of reproductive health – many do not get the care they need. They wait longer than men before seeking treatment and have difficulty leaving their families and household duties behind if long hospitalization is required. Such delays add to the risk of treatment failure.

In order to address – and redress – these imbalances, health systems are taking action in several pressing areas – see Box 4 in Part IV. Nevertheless, the long-term, more effective solution has to be to reduce the social, economic and cultural inequities that are at the origin of women's unequal and inadequate access to health care.

PART III What are the major issues in women's health today?

Nutrition

Malnutrition is undoubtedly the most widespread and disabling health problem among women in developing countries. It is often the result of two inequities: poverty and the status of women. These inequities lead, among other outcomes, to the unfair distribution of food within the family, and to the lack of money to buy good food. All of this is exacerbated by factors such as ignorance of nutritional requirements, illnesses and parasites (such as hookworm) that interfere with the body's utilization of food, improper food storage or preparation, and taboos against eating certain foods. Malnutrition is, moreover, a contributing factor in many other health problems that prevent women enjoying physical, mental and social well-being.

Although both men and women are affected by nutritional factors, women, for biological reasons, have a higher risk of suffering from health-impairing nutritional deficiencies. Women and girls need more iron than men because of menstruation, pregnancy, lactation and other demands on their body's iron supply. Insufficient iron in the diet leads to anaemia, a condition that causes extreme fatigue and lower resistance to disease, and in women to difficulties in pregnancy and childbirth. In developing countries, about 55% of pregnant women and 44% of all women suffer from anaemia. Significant disparities exist not only between developed and developing countries but also between different areas of the world. In some settings there is a dangerous interaction between anaemia and malaria that greatly increases the risks for both mother and child in pregnancy.

Breast-feeding

Breast-feeding, besides promoting child growth by providing the best possible nutrition for both physical and mental development, also benefits maternal health in several important ways. In addition to strengthening maternal-infant bonding, breast-feeding immediately after delivery may reduce the mother's risk of postpartum haemorrhage and anaemia. Breast-feeding also lowers the risk of ovarian and breast cancer, promotes child spacing, and reduces fertility rates. Longer intervals between births allow women time to regain their strength and nutritional well-being before having another baby. Although these benefits of breast-feeding for baby and mother have been recognized for a long time, there has been a lag in ensuring the practical support that breast-feeding mothers need in their daily lives, such as adequate nutrition and reduced workload. With more women going to work outside the home, supportive policies are also needed to ensure that working mothers who want to breast-feed can continue to do so.

Reproductive health

WHO is committed to implementing the Programme of Action – especially in the area of reproductive health – agreed upon at the International Conference on Population and Development (ICPD) held in Cairo in September 1994. The definition of reproductive health agreed upon in Cairo represents an important widening of perspective, and contains many concepts that are of vital importance to the general health of women and men:

> **Reproductive health ... implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. ... [It implies] the right of access to appropriate information and services that will enable women to go safely through pregnancy and childbirth. ... It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.**

Reproductive health is a crucial part of general health – not only is it a key element of health during adolescence and adulthood, it also sets the stage for health beyond the reproductive years for both women and men, and has pronounced intergenerational effects. The reproductive health component of general health increases during adolescence and, particularly for

women, during the reproductive years. In old age, although general health continues to reflect earlier reproductive life events, other health issues become more important. Even though at each stage of life an individual's needs differ, there is a cumulative effect across the life span – events at each phase having important implications for future well-being.

Women bear by far the greatest burden of reproductive health problems. Women are at risk of complications from pregnancy and childbirth; they must deal with unwanted pregnancy, suffer the complications of unsafe abortion, bear most of the burden of contraception, and are more exposed to contracting, and suffering the complications of, reproductive tract infections, particularly sexually transmitted diseases (STDs).

Biological factors alone do not explain women's disparate burden. Their social, economic and political disadvantages have a hugely detrimental impact on their reproductive health. Young people of both sexes are also particularly vulnerable to reproductive health problems because of a lack of information and access to services.

This concept of reproductive health, as promoted by WHO and its partners, is based upon principles of gender equity and human rights. Human sexuality and relationships between the sexes directly affect the ability of young people and adults – both women and men – to maintain good reproductive health. Putting these principles into effect will require the involvement of those most directly concerned – women themselves and young people. It will also involve a multisectoral effort to increase access to care and to improve quality so that no opportunity is missed to offer people a full range of reproductive health information and services.

Maternal mortality and morbidity

In the mid-1980s it was estimated that half a million women died each year from pregnancy-related causes – 99% of them in developing countries. Unfortunately, little has changed since then. Inadequate reporting in the past (and today) makes it difficult to discern trends, but it appears that there has been very little reduction in global maternal mortality, in spite of the fact that almost all of these deaths could be prevented with existing knowledge and technology.

Sexuality and reproductive health in adolescence

Whether they live in developing or developed countries, adolescent girls and boys are subject to many health risks in a rapidly changing world, but for adolescent girls, some of the biggest risks they face are related to reproductive health. Female children and adolescents (as well as young males) are highly vulnerable to pressure from older people to have sex – such pressures can be experienced both inside and outside their own family.

Unless young people who are sexually active have appropriate information, skills and services, they risk very serious health problems, including sexually transmitted diseases (STDs) and HIV infection leading to AIDS. For girls, unprotected sex can also result in an unwanted pregnancy and childbirth. In addition to the physical dangers of early childbearing (inside or outside marriage) it can mean the end of their education, greatly reduced employment prospects, and having to assume the responsibilities of parenthood before they are ready for them. If they resort to unsafe abortion they run many more health risks.

Family planning

Family planning services should provide information, education and universal access to the full range of safe and reliable methods, and be closely linked to, or integrated with, other reproductive health services. Family planning programmes must focus on enabling people to make informed choices about the timing, number and spacing of their children, and on empowering women to manage their own fertility, while emphasizing men's joint role and responsibilities in healthy sexuality and reproductive health.

Unsafe abortion

Each year there are about 20 million unsafe abortions performed worldwide. It is estimated that at least 70 000 women die as a result of these abortions, while millions more become infertile or are left with other lasting damage to their health. Unsafe abortions account for a sizable proportion of all maternal mortality and morbidity, and in some countries may be the cause of more than half the total number of all maternal deaths.

Unsafe abortion is a major public health issue and a clear indication of unmet needs for contraception. The health consequences of unsafe abortion should be recognized and managed, and counselling and care provided for all complications. Where abortion is legal it should be safe. All women should have access to high-quality and affordable counselling and services, including post-abortion family planning.

Sexually transmitted diseases (STDs) including HIV/AIDS

Biologically women are more susceptible to most sexually transmitted diseases than men, at least in part because of the greater mucosal surface exposed to a greater quantity of pathogens during sexual intercourse. In addition, the risk of transmission of STDs, including HIV infection, is greater whenever the vaginal mucosa is damaged. As a result of such factors most STDs, including HIV infection, are transmitted more readily from men to women than from women to men. Women with STDs are more likely than men to be asymptomatic, and therefore are less likely to seek treatment for STDs, resulting in chronic infections with more long term complications. Untreated STDs increase the likelihood of HIV infection occurring during unprotected sex with an HIV infected partner.

These biological factors are compounded by sociocultural ones. In many parts of the world women have little or no control over decisions relating to sexuality, nor do they have control over the sexual behaviour of their male partners or the use of condoms for the prevention of STD/HIV infection or pregnancy. The symptoms of STDs may not be recognized as needing treatment. Stigmatization, which is particularly acute for women with STDs, keeps women from seeking treatment, or services and facilities suitable for women may not be available. In most cultures, women tend to have sexual partners who are older, who are usually sexually more experienced, and who have had more partners and thus are more likely to have become infected. This plays a particularly important role when adolescent women have sex with older men. The HIV/AIDS pandemic provides some dramatic illustrations of these issues, and of the need for sex- and age-specific analysis of data. In many places, young women are becoming infected with HIV and progressing to AIDS at much earlier ages than men

Women and sexually transmitted diseases

It is estimated that 365 million cases of curable STD occur globally each year among women aged 15–49 years. Case numbers are distributed as follows with many women having more than one disease:

- syphilis — 6.5 million
- gonorrhoea — 31.3 million
- chlamydia — 47.0 million
- trichomoniasis — 80.0 million.

STDs in women are not easily identified and cured for a number of reasons:

- over 50% of STDs in women are asymptomatic
- diagnosis is difficult
- women's access to services is frequently poor, because STD management is rarely provided as part of an integrated approach to women's health needs.

This leads to complications which seriously impair the health of women causing considerable mortality and morbidity:

- STDs cause pregnancy-related complications, sepsis, spontaneous abortion, premature birth, stillbirth and congenital infections.
- 1–5% of all maternal mortality is due to ectopic pregnancy
- 35% of postpartum morbidity is attributed to STDs
- almost two-thirds of cases of infertility among women are attributed to STDs
- 17–40% of all gynaecological admissions are due to PID
- almost half a million new cases of cervical cancer occur each year in the world; cervical cancer is the second most common cancer in the world.

Worldwide, the disease burden of STD in women is more than 5 times that in men.

It is essential to address the power relationships between men and women and provide women, especially young women, with the personal skills and confidence to refuse sexual relations when they so wish. This will be possible, however, only when women have sufficient status and economic opportunities to reduce their dependence on men for survival and relative well-being.

The rise of the HIV/AIDS pandemic has confirmed what women's health advocates have long been saying: women's poor health is linked to their relative powerlessness in relations with men, stemming in part from an inferior social status and economic dependence, and in part from society's tolerance of human rights violations against women.

Women bear much of the burden of the HIV/AIDS pandemic in other ways. In HIV-infected women, the virus can pass on to their children during delivery or through breast-feeding. Women are also likely to be the care providers when their husband or someone in the family or community is sick with AIDS. When sick themselves, they may not get support or care. Many older women in the areas hardest hit by the pandemic find themselves taking care of a number of children orphaned by AIDS. It is to be hoped that the growing understanding of how HIV/AIDS affects women will lead to more effective interventions to help them protect themselves against it, and to more support for those who are affected.

Women and the HIV/AIDS pandemic

From almost being absent from the HIV/AIDS pandemic in 1980, women infected with HIV now number 7 to 8 million. Some one million new infections occur in women each year, mainly through unprotected sexual intercourse. Every minute 2 women are infected with HIV, every 2 minutes one woman dies of AIDS. By the year 2000 over 14 million women will have been infected and about 4 million will have died. In some regions where heterosexual transmission is predominant, women infected with HIV outnumber men 6 to 5.

The transmission of HIV from men to women is 2–4 times more efficient than from women to men. Data suggest that STDs, especially those which cause ulcerative genital diseases, and syphilis facilitate the acquisition and transmission of HIV.

Studies in some countries show that up to 30% of HIV infections occur during the first year of sexual intercourse in young women who have had sexual intercourse with a single male partner who in turn has had – or is continuing to have – unprotected sex with other partners.

Women's vulnerability is in fact linked to their low status in society and their economic, cultural and social dependence on their male partners.

Work-related and environmental health hazards

WHO promotes a definition of occupation which includes all women's paid and unpaid tasks, performed inside or outside the home. Women are more likely than men to work in situations where they are not protected against exposure to potential health hazards. Outside the home, women tend to work in the informal sector or in smaller, less-regulated enterprises. In rural areas women and men are frequently exposed to pesticides and other toxins. Whether in the formal or informal sector, the health hazards relating to women's work have been inadequately studied, and as a result are poorly addressed.

Women's work is not confined to the formal and informal sectors. In most cultures, women continue to carry the main responsibility for maintaining the household, including caring for the children, the sick and the elderly. In many developing countries, the time, work and sheer physical burden involved in satisfying basic requirements for food, water and fuel can be enormous. When women's increased participation in wage-labour is added to their household responsibilities, the resulting "double or triple burden" means that women work far longer hours than men.

Communicable diseases

Tropical diseases

In recent years, the use of gender analysis in the study of tropical diseases has led to a better appreciation of how such diseases in women differ from those in men.

Women have a different risk of exposure to certain tropical diseases than men. This is as a consequence of their traditional roles related to water (schistosomiasis), cultivation (malaria, filariasis), domestic roles (dengue, Chagas

disease, and leishmaniasis) and certain biological characteristics (for example, during pregnancy when malaria is an important cause of maternal death, abortion, miscarriage, stillbirth and neonatal death)

Women's social and economic activities are particularly affected by diseases which lead to disfigurement or stigmatization. Women frequently do not seek care for themselves or for their children following infection with tropical diseases.

Tuberculosis

Tuberculosis – seldom a prominent item on the agenda of women's health advocates – is reponsible for the deaths of around one million women each year. For reasons not fully understood, women seem to be most vulnerable to tuberculosis in their early and reproductive years. The biological changes that occur in those years may make women more likely to progress to tuberculosis once infected. Tuberculosis is an indirect or contributory cause of many maternal deaths.

Noncommunicable diseases

As infectious and parasitic diseases are brought under control, and as populations age, noncommunicable diseases become more prominent. Women now spend a much greater proportion of their lives in the post-reproductive, post-menopausal years. Even if the problems are similar – for instance, breast cancer or cervical cancer – the strategies for dealing with them differ for younger and for older women. Older women are more vulnerable to cardiovascular disease, diabetes and cancers – noncommunicable diseases will therefore play a larger role in women's health in coming years. In addition, the problems of older women often differ from those of older men, for example in the higher morbidity rates associated with incapacitating osteomuscular diseases such as osteoporosis and arthritis, and the higher levels of depressive illness among women. Not enough is known about how noncommunicable diseases and conditions are manifested in women.

Substance abuse

Gender-sensitive research has uncovered many differences between men and women in their experiences with substance abuse. For example, the rates of tobacco smoking among men have levelled off or declined in many developed countries, while the rates among women are still climbing and climbing fastest among young women. An estimated 21% of women in the developed world are smokers – in the developing world the corresponding female smoking prevalence is estimated at 6%. In some developed countries the numbers of male and female smokers are currently converging. In many of these countries fewer men than women are taking up smoking and, in addition, the prevalence of female smoking is not declining as rapidly as it is among men.

Socially, women drinkers are more likely to become isolated. They are less likely than men to seek treatment. A study in one Latin America country found that nine out of ten husbands leave their alcohol-addicted wives, whereas one out of ten wives leaves her alcohol-addicted husband.

The rehabilitation and treatment needs of women drug abusers differ from those of men. However, very few rehabilitation facilities specifically address women's needs, and there is a general lack of information on how to deal with drug abuse among women.

Mental health

A gender perspective when applied to mental health, takes into account men's and women's status, roles and positions in society. A recent WHO publication on women's mental health concludes:

> **When women's position in society is examined, it is clear that there are sufficient causes in current social arrangements to account for the surfeit of depression and anxiety experienced by women.**

In developing countries, community surveys usually find more women than men suffering from some form of mental illness, but more men getting treatment. In developed countries, depression is the most common mental disorder among women. Although adequate data are lacking in developing countries, it appears that the same is true there.

The gender perspective has been a useful addition to the work on women's mental health. But there is still much to be done in order to understand the origins of mental illness in women; to help women find ways to protect their mental health and avoid illness; and to develop and disseminate more effective treatment strategies for women.

Violence against women

In a world where violence seems endemic, both men and women experience it in many forms and both suffer considerable damage to their health and well-being because of it. But the nature of the violence they are exposed to is almost always different, the causes of it are usually different, and the impact on their lives is different.

Women are exposed to a continuum of violence – from domestic violence taking place in the home, where the woman or girl usually knows the assailant; to settings outside the home where women are subject to random violence by people unknown to them; to the large-scale, systematic violence against women found in situations of conflict and mass movements of people.

Some women make repeated trips to emergency rooms and clinics, each time with more serious injuries. Their injuries are often not recognized or reported as deliberate violence until they end in homicide.

Most health systems and health planners at all levels have been slow to respond to this "hidden epidemic". Women in many countries are demanding that the health sector:

- regard domestic violence as a serious public health issue
- undertake more specific research on its causes, consequences and ways to prevent it
- disseminate information about domestic violence to health workers or conduct training to strengthen their ability to recognize the signs of domestic violence

Women are especially vulnerable in situations of armed conflict or mass population movements. Women forced to leave their homes as refugees or displaced persons are often separated from the men in their families and have few means to protect themselves from violence. A refugee woman who has children or other dependents with her is vulnerable to sexual exploitation. Her only means of assuring their food and safety may be to accede to the demands for sexual favours made by soldiers, border guards or camp administrators.

In recent hostilities, there have been many examples of violence against women being used as a punitive measure against the enemy. This systematic rape and brutal sexual abuse destroys the dignity of women and violates many of their human rights, including their right to physical integrity, to survive, and to lead full and fulfilled lives.

Violence against women

The selected examples shown here indicate the [illegible] domestic violence and its impact on women.

- Worldwide estimates indicate that from [illegible] of women have been beaten by an intimate male partner.
- In Sydney, Australia, one study found that [illegible] of women reported to the police [illegible] had been beaten by their husbands.
- In the USA, up to one-third of women patients in hospital emergency [illegible] are there because of injuries sustained in domestic violence.
- In Papua New Guinea a survey found that over half of married women in cities had been battered, and almost one in five of these women had gone to a hospital after being beaten.
- A study in Alexandria, Egypt, showed domestic violence as the leading cause of injury to women, accounting for 25% of all visits by women to trauma units.
- In a survey in the Kisii District of Kenya, 42% of women reported being "beaten regularly" by their partners.
- In Jamaica, a study among girls aged 11–15 years found that 40% reported the reasons for their first sexual intercourse as forced.
- In a nationally representative sample of Canadian women, 29% of those ever married reported being physically assaulted by their current or former partners.

Source: From Heise et al. (1994) *Violence against women: The hidden health burden*. World Bank Discussion Papers 255, Washington D.C. USA.

PART IV The role of WHO in women's health

Towards better health for women

Almost 50 years ago the International Health Conference defined health as:

> **a state of complete physical, mental and social well-being, and not merely the absence of disease.**

This definition is embodied in the WHO Constitution which also affirms that:

> **everyone has the right to the highest attainable standard of health.**

WHO's activities in women's health are guided by the following operational principles, which are fundamental in promoting the centrality of human health and well-being to the process of development.

- health is a fundamental **human right**
- the highest **ethical standards** must be maintained
- **equitable relationships** between women and men and **equality of opportunities** must be achieved
- services must be **accessible**
- **quality of care** must be assured
- **individuals, families and communities must be fully involved** in the promotion and protection of their own health
- a **life-span** approach to health must be taken
- **partnerships** must be established between health care providers and clients and with sectors other than health
- **health services should be integrated** to promote a holistic approach to health care provision
- to invest in human resources is to invest in social and economic development
- optimal use should be made of human and material resources
- interventions must be **sustainable**.

Women do not perceive their bodies as separate groups of organs each requiring a different set of interventions. Nor do they see their lives as a series of discrete periods with the ages around pregnancy and childbearing as being the only ones of significance. And women are concerned not only with their own health needs but also with those of their children and other family members.

Yet the way health systems have been set up around the world is such that it is almost impossible to find a single facility that can address simultaneously the needs of young and older women, their children, or different concerns such as reproductive tract infections and tropical diseases. Research will be needed to develop alternative models providing such integrated services in different socioeconomic and cultural settings.

Improving women's health and eliminating inequalities requires partnerships of many kinds: women and men; old and young; international agencies, governments and NGOs; researchers in many disciplines; health professionals, women's health advocates, programme planners; and users of health services. In its own activities WHO will continue to:

- Advocate for greater allocation of resources to programmes that effectively address the health needs of women.
- Promote preventive strategies and programmes.
- Promote and expand the use of gender-sensitive approaches in all health programmes, through staff orientation, expansion of training activities in the regions and support for national training activities.
- Ensure that the voices of women are heard in identifying health issues, planning and carrying out interventions, and evaluating the results.
- Advocate for a greater proportion of women in decision-making and leadership positions in the health sector at all levels, from local and district health offices, to national ministries, to the highest levels of international organizations.
- Work for improved sex- and age-disaggregated data collection and analysis to sensitize policy-makers and lead to more effective action in the health sector.

For WHO, one of its most valued partnerships is with women health care providers – those millions of women who work day in and day out in health systems around the globe – see Box 3. In looking at women and health, there is a tendency to concentrate on women in need of health care or women as users of health services. However, WHO is mindful, too, of the inestimable contribution made to health by the women who provide health care to others – this despite the often poor salaries and limited career opportunities available to women in largely male-dominated health-system hierarchies.

At the end of the 20th century, global economic, social and political shifts make it imperative for the perspectives and contributions of women to be brought more forcefully into the health and development arena. WHO has an opportunity and a responsibility to address women's health and quality of life issues in all of its activities. Women's health must now assume its rightful place high on all social, economic and development agendas.

Box 3. Women in the health system

Women form the backbone of the health system in almost every country. They give long years of dedicated service as community health workers, nurses, midwives, doctors, pharmacists, [illegible] and in many other capacities. They contribute to the community and nation [illegible] professional functions and office hours. They are health advocates, health providers in the community, health care providers and carers for their children, the elderly and the ill [illegible].

In some countries women have served with distinction at the highest levels of national health systems; in general, however, women have been underrepresented at the top decision-making levels of health systems, a situation that WHO is working to correct.

[illegible] health care providers at all levels. Gender discrimination, combined [illegible] that young female health workers face increased [illegible] and harassment [illegible] health services unless they can be seen by women health workers. [illegible] to recruit and train more women. However, the same cultural factors that [illegible] health care activities may make it difficult to recruit women health workers unless their special needs are met. It is important that women in the health professions receive good training, are not discriminated against in pay or career opportunities, and have the support of more experienced workers in their first years at work. They should also have access to housing and transport, and working arrangements should be safe and culturally appropriate.

The work of WHO

Part of WHO's commitment to improving women's health is to make sure that the voices of women are heard wherever decisions are made about health. Particular attention is being paid to incorporating a gender perspective and addressing women's concerns in the work of WHO at both Headquarters and Regional levels.

Many programmes across the range of WHO's activities have made efforts to increase the emphasis placed upon women's health as an issue in its own right, and have attempted to ensure that this is reflected in programme activities.

WHO has strengthened the emphasis given to women's health issues by creating the unit of Women, Health and Development (WHD) within the Division of Family Health (FHE). The objective is to accelerate activities in women's health, and develop and consolidate a coherent and comprehensive strategy. At the regional level, focal points on women, health and development work to strengthen and coordinate activities for women in all WHO programmes, and to liaise with other organizations of the United Nations system concerned with women's health and development.

All of WHO's work in women's health is guided by the *Ninth General Programme of Work*, which draws attention to the risks of marginalization of vulnerable groups, particularly women, in overall development. It also emphasizes the human-rights basis for the protection of women's health at all stages of life, noting their increased vulnerability in situations of economic hardship, violence, warfare and environmental degradation. Among the major intended results of the Ninth General Programme of Work are the removal of inequities and the meeting of the special needs of women.

Regional achievements

WHO Regional Offices actively promote women's leadership and participation in health through consultations, through national and regional networks involving governmental and nongovernmental representatives, and through workshops and leadership training programmes. Although each Region has a different focus for its activities, a number of commonalities emerge, such as the need for improved data collection and analysis; for more research on women's health; and a universal concern for reproductive health issues.

WHO – closing the gap

WHO's future activities to improve women's health will continue to include setting norms and developing guidelines, policy development, the provision of technical support, and research. Increased efforts will be directed towards:

- Advocacy for women's health and gender-sensitive approaches
- Promotion of women's health and prevention of ill-health
- Making health systems more responsive to women's needs.

Advocacy for the importance of women's health, and for the need to develop effective policies and programmes to address it will continue to be needed. It was with such issues in mind that the Global Commission on Women's Health was established in 1993 in response to resolution WHA45.25 on Women, health and development emanating from the 1992 Technical Discussions at the World Health Assembly. The purpose of the Global Commission on Women's Health is to promote the adoption and implementation of effective measures at all levels for improving women's health, and to carry out international and national advocacy in the area of women's health concerns.

Promotion of women's health and prevention of ill-health involves addressing the underlying socioeconomic and other factors that determine women's health status and affect their access to information and services. It requires legal, regulatory and other mechanisms to promote and support improvements in women's health. WHO has a role to play in the following key areas:

- **Legislation and health policies** – to ensure that discrimination against women is identified and that efforts are made to introduce required changes. Education, legislation, information and other measures can, for example, improve communication and shared responsibility between men and women on responsible parenthood, sexual and reproductive behaviours and prevention of STDs (including HIV/AIDS).
- **Investment in female education** – including taking affirmative steps to keep girls and adolescents in school, developing more gender-sensitive curricula, and sensitizing parents to the value of educating girls.
- **Improvement in women's economic status** – especially focusing on poor or vulnerable women.

Making health systems more responsive to women's needs is another major focus in which WHO has particular responsibilities, both because of its technical expertise and also because it can bring women's health to the attention of those in a position to make changes. On the basis of its past experiences in the area of women's health and in the light of newly emerging trends, WHO has identified a number of areas for immediate action. Change in these areas could bring about rapid yet lasting improvements in women's health:

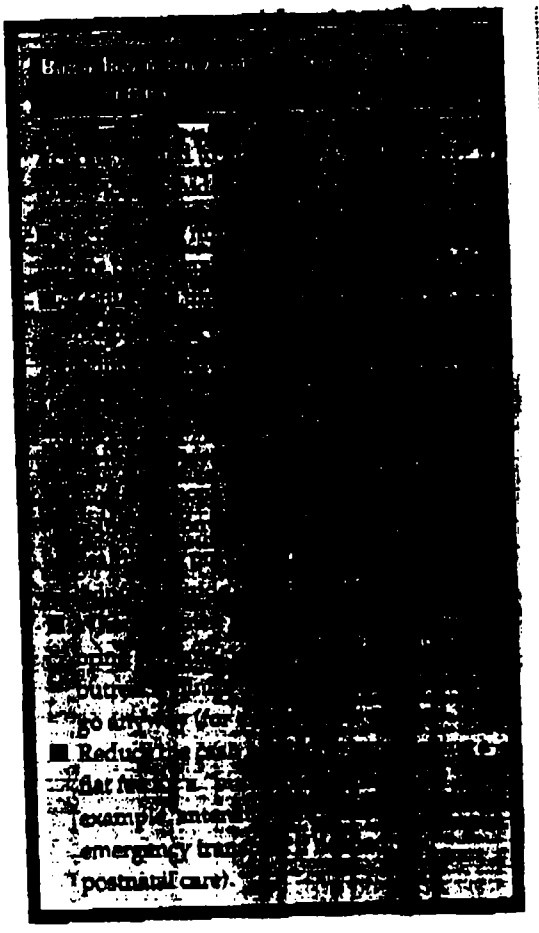
- Improving access to health care
- Improving quality of care
- Involving women in the planning and implementation of interventions
- Responding to the needs of women health care providers
- Encouraging discussion of ethical issues in health
- Providing information to women
- Gathering and analysing information about women and their health.

Improving access to health care

Women in developing countries, and poor women everywhere, tend to have less access to health inputs and services than do men. Underlying these inequitable patterns of access are social, cultural and economic factors which include practices that discriminate against women and girls; and a lack of women's control over household resources. As a result, barriers to the use of health services – for example time and travel costs, and health system deficiencies – may pose greater obstacles for women than for men. More women can be reached by health services if better use is made of peripheral services. It is less costly, in terms of both time and money, if people living in rural areas can get adequate care in facilities that are close by. But very often, the bulk of a country's limited resources for health is directed to the tertiary facility in the urban area or capital city. Bringing health care closer to where people live, through known and trusted providers – along with a range of other measures (Box 4) – could do much to reduce the gap between women and health care services.

Improving quality of care

Improving quality of care is critical to improving women's health, to increasing access to and use of health services, and to using limited resources effectively. Much of the difficulty of achieving the best balance can be resolved through a more



gender-sensitive approach to the needs of women on the part of health-care providers, and a rethinking of the relationships between providers and clients, one that removes the aura of infallibility and power of the provider, and recognizes the skills and knowledge of the client in her own health care. Addressing quality of care also means addressing the fragmented way in which women's health needs are currently addressed. Research will be needed to develop alternative models providing such integrated services in different socioeconomic and cultural settings.

Involving women in the planning and implementation of interventions

One important mechanism to improve quality of care is to involve women in decision-making so that they become active participants in their own health care. This means that women participate as equals in planning, implementing and evaluating policies and programmes, and that interventions are developed in a holistic and integrated manner. WHO's primary health care approach has underscored the necessity of involving women.

Responding to the needs of women health care providers

Much of the discussion on women's health uses language that defines women as needing care. However, to a large extent, women are also the main providers of health care – see **Box 3** above – particularly in the traditional health care systems and at the most peripheral levels of modern health-care structures. Yet little attention has been given to the constraints within which they work, to the difficulties faced by women in this role or to ways of improving their status and standing in the community. Efforts need to be made to improve their working conditions and promotion prospects, and to increase their access to the skills, supplies and equipment needed to fulfil their functions effectively.

Encouraging discussion of ethical issues in health

Ethical issues have concerned health practitioners since ancient times. In recent decades a new range of ethical concerns have arisen as a result of technological advances. Many of these concerns centre on "women's issues" – infertility, fertility regulation, pregnancy and childbearing. This has led to considerable debate in both developed and developing countries, in part reflecting conflicts between religious and secular approaches. Ethical guidance, and associated programmes in ethics education, with input from professionally qualified people, is needed to ensure that policies at the national level embody the recognized precepts of contemporary bioethics. National, regional and institutional ethics committees, with representation of all concerned sectors and professional groupings, especially women, can play a role in fostering adherence to ethical norms in this area, as well as other areas in health. WHO and other international organizations are promoting the development of ethical guidelines that can help to create a template for national efforts. WHO believes it is imperative for women – whether as health care providers or users of services – to have a major part in all discussions related to health care.

Providing information to women

A major constraint that women face is lack of information. Women need to know about danger signs and symptoms, and when to seek health care, whether for themselves, their children or for other members of their families. They also need information to make decisions about when to seek health care and from whom.

The idea of a Healthy Women Counselling Guide (HWCG) was conceived by several programmes of the World Health Organization as a tool to be used by rural women. The guide is intended to provide information to women about their health, in a way that can be understood readily by both literate and illiterate women. The information given to women in the HWCG will be strengthened by more positive feedback and interaction with health workers.

Gathering and analysing information about women and their health

A significant constraint in dealing effectively with women's health needs is the continuing lack of sex-differentiated data. Whereas WHO has long collected and analysed data on cause of death for males and females separately, the same has not been true in relation to the incidence and prevalence of specific diseases such as tuberculosis, and malaria and other tropical diseases. There is very little information on their differential impact on men and women. It is not enough simply to collect data – it has to be analysed from a gender perspective. Do the data indicate differentials in incidence or prevalence? What are the possible sources of such differentials? Do they lie in biological factors such as different responses to disease or differences in reactions to treatment; or are they a reflection of social factors such as differences in exposure, in health-seeking behaviour, or coping mechanisms?

In order for Member States to be able to use relevant information for policy development and management, and to include such information in their regular reporting on women's health and health care, it will be necessary to ensure that health information systems collect and analyse sex- and age-specific data as a matter of routine. Analysis and reporting of women's health need to go beyond looking only at reproductive health issues in order to assess the effect of sex differences and attitudes on women's health as a whole.

In the coming years WHO, its partners, and health systems globally must face up to the challenge of "closing the gap" between rhetoric and reality, and to give far greater attention to women's health issues.

other members of their families. They also need women's health issues.

26

Conclusion

All individuals have the right to "the highest attainable standard of health". But when it comes to women, double standards, poverty, social discrimination and inequality, amongst other factors, militate against this. Many of the facts have been known for years. Yet health and well-being continue to elude millions of the world's women.

The themes of the United Nations Decade for Women (1976–85) – **equality, development** and **peace** – will be reiterated at the Fourth World Conference on Women in Beijing in September 1995. These are all crucial elements in women's health, and in their personal and social development.

Quite simply, women will never enjoy the highest attainable level of health until they have equal access to resources and to the fruits of development – **equality** in access to education, to political power, and to the process of decision-making. This in turn means addressing inequitable gender relationships, and the underlying inequalities that currently stand in the way of women's access to health. Such inequalities – enshrined in traditional, cultural and legal frameworks – perpetuate women's lower social and economic status. All of this continues to limit the ability of women to make free and informed choices about their lives. In addition, to attain full health, women must have access to high-quality services, and the information and skills to use such services appropriately. Women – the primary care givers in the home and in the health system – must receive appropriate and acceptable care for themselves, and for their families.

To promote equality for women is not to favour health and human development has been recognized and awareness is now growing of the extent of that contribution and of the enormous toll it takes on women in terms of their own health. Human energy and creativity are the driving forces of development, yet for millions of women worldwide that vital energy is drained in the daily struggle to survive, and to protect the health and well-being of themselves and their families.

The achievement of **peace** at all levels – international, national, local and domestic – is a crucial step for the attainment of health for all. For women, it has a very special significance. Women and their children are most often on the receiving end of violence and aggression. Among the first to be affected by war and civil strife they are often the last to receive support and assistance.

Whether in the form of killing and maiming, ethnic cleansing, mass rape or forced prostitution, violence is all too often borne by women. Moreover, violence is not confined to the sphere of politics. Very often it is from within their own homes and families that girls and women have most to fear. Female genital mutilation, incest, sexual abuse, domestic assault and battery – these are the hidden faces of violence against women. For women, peace is a domestic as well as a societal issue.

For far too long women have been portrayed as powerless victims and have been seen as objects of health interventions. Undoubtedly women all over the world face enormous adversities that impact on their health and well-being. Yet women have power, are creative, can take and already have taken action. Women must be

identical approaches to health for women and men. Women and men are innately different and have differing needs. Promoting equitable access to health care implies recognizing these differences, and developing responses that address the varied needs of men and women throughout their lives. It also involves addressing the socioeconomic and cultural factors which discriminate against women and girls.

Ever since the start of the United Nations Decade for Women, the contribution that women make to recognized as protagonists in their own health, and in the provision of health care.

The time has come when women all over the world are beginning to ask questions, take actions and demand resources, results and accountability. The time has come for health-care systems to listen to what women are saying, and to take every possible opportunity to improve women's health and – by extension – the health of the world.

World Health Organization

UNITED NATIONS
Fourth World Conference on Women

Facts and figures on women's health

Health is not a commodity to be acquired, bought or sold, it is a right. Worldwide, however, the health security of women, that is, all that guarantees women's right to health, is at risk. Women's health security embraces all aspects of women's lives, including the right to freedom of choice and personal security, the right to adequate and sufficient food, the right to work in safe environments, and the right of access to education, information and decent housing. After all, what hope does a woman have who has been mutilated against her will or pulled out of school without any say? What prospects for a brighter tomorrow does the 15 year-old face when she discovers that she is unintentionally pregnant? What are the chances for a healthy survival for the children who are left behind after their mother has died in childbirth? Equity and equality are at the heart of health security for women. Equal opportunities and the ability to benefit from the fruits of development, work in an enabling environment, and live in a peaceful society free from the threat of aggression at home or in the street, are vital factors in shaping women's health today.

Equality

■ Gender bias is reflected in the use of health services, the quality of care provided and the success or failure of disease control programmes. In one developing country, only 16% of people attending malaria clinics were women, yet surveys revealed no significant gender differential in susceptibility to infection.

■ Over half a million women are estimated to die each year due to lack of access to adequate reproductive health care. In developing countries maternal mortality is a leading cause of death for women of reproductive age, the most common cause being haemorrhage (25%). Despite the availability of technology to prevent maternal mortality, at least half a million women die giving birth each year in developing countries. 23 million women undergo serious complications with child birth, such as postpartum haemorrhage, hypertensive disorders, eclampsia, and puerperal sepsis each year. 15 million suffer long-term morbidity.

■ Many women give birth without trained assistance. Only about one-third of all births are assisted by trained attendants in Southern Asia and 42% in Africa, as opposed to 76% in Latin America, 94% in Eastern Asia, and virtually 100% in North America.

2

■ Because women need more iron than men, and because they tend to receive a lower share in the distribution of food, globally, over half of pregnant women and a third of women of reproductive age who are not pregnant have anaemia.

■ The adolescent girl requires, but rarely gets, 18% more iron per kg body weight than male adolescents. Virtually all adolescent girls in developing countries suffer from iron-deficiency.

■ Each year unwanted pregnancy forces 20 million women to hazard unsafe abortions as a result of lack of access to family planning services, costly contraceptive methods, the unavailability of information and restrictive practices. Of these women, 60,000 to 100,000 die and countless more endure long-term disabilities. 25% of all maternal deaths occur in the teenage group, with unsafe abortion as the leading cause of these deaths.

■ Almost 30% of maternal deaths could be prevented by contraception. About 120 million women in the developing world say that they are not using family planning even though they want to avoid becoming pregnant.

■ Prevalence rates of sexually transmitted diseases are generally higher among sexually active women than among sexually active men, due to greater biological, social and economic vulnerability, their greater proportion of asymptomatic infections and inferior access to care than men. Over 20 million women are chronically infected with either genital herpes or human papilloma virus infections.

■ Globally, women account for an ever-increasing share of HIV infections. The proportion of women in the overall figure of those infected rose from 20% in 1980 to 40% in 1992. By the year 2000, half of those infected with HIV will be women. In many countries 60 % of all new HIV infections are among 15 to 24 year olds, with a female to male ratio of 2 to 1.

■ Due to different proportions of muscles, fat and water in the body, women develop alcohol-related liver diseases more rapidly than men. Studies show that the chronic use of alcohol, cannabis, cocaine and heroin affect menstrual dysfunction and contribute to obstetric complications and damage the foetus.

■ In some countries women are barred from drug and substance abuse treatment facilities as a matter of policy, because resources are limited and men are given priority. Most facilities refuse to treat pregnant women.

■ Many elderly women experience poor nutrition, reproductive ill-health, dangerous working conditions, violence and lifestyle-related diseases, all of which exacerbate the post-menopausal phenomena of increased likelihood of breast and cervical cancers and osteoporosis.

3 **Development**

■ 10% of women in developed countries and 40% in developing countries give birth before the age of 20. Early childbearing poses considerable obstacles to women's education and economic well-being.

■ In countries where participation rates of women in the labour market were as high as 50% prior to economic restructuring, over 60% of the currently unemployed are women.

■ Many women engaged in occupations heavily related to repetitive tasks (assembly lines), jobs requiring precise work for long periods (electronics assembly), or processing of agricultural products (fruit and flower packing), have been shown to have health problems which affect the musculo-skeletal and nervous systems, the reproductive tract, and skin. In the industrial working environment, exposure to toxic chemicals can cause cancer, dermatitis, miscarriage, and birth defects. Women may be particularly susceptible to some toxic chemicals for biological reasons.

■ For agricultural workers, a significant and positive correlation exists between heavy use of pesticides and prevalence rates of deformity of limbs, dysfunctions of joints, amputations and visual deformities.

■ Certain health conditions, such as chronic bronchitis and back pain, are particularly linked with women's traditional roles. These include the burning of biomass fuels in cooking and heating homes, the carrying of heavy loads of fuel wood and water, and the use of household chemicals. Toxicological effects on the foetus have also been shown. In addition, women and children are at greatest risk of burns within the home.

■ For poor women prostitution is often the only way of securing income. In one country, 50 000 to 75 000 street children survive through prostitution.

■ Depressive disorders are responsible for 5.8% of all deaths and disabilities among women of reproductive age - twice the rate among men.

■ While men have higher mortality rates from suicide, women predominate for suicide attempts. The typical suicide attempter is a single women under the age of 25.

■ Smoking amongst young women has increased rapidly, and now equals or exceed that of young men in a number of developed countries. Over the next thirty years tobacco-related deaths will more than double, so that by the year 2020, well over a million adult women will die every year from tobacco-related illnesses. Women are smoking in increasing numbers in developing countries. Women are a special target of cigarette and alcohol advertising world wide, further predisposing them to the immediate and long-term health consequences of addiction.

4 Peace

■ Numerous studies from many countries conclude that between 20 to 60% of all women report having been beaten by their partners.

■ Women are most at risk from men they know. Data from around the world suggests that girls and women are more at risk of violence in the home than anywhere else.

■ On a per capita basis the health burden of domestic violence and rape is roughly the same for reproductive-age women in industrial and developing countries, but because the overall health burden is greater in developing countries, the percentage attributable to gender-based victimization is smaller, at roughly 5%. In industrialized countries, rape and domestic violence account for almost one in every 5 healthy years of life lost to women aged 15 to 44.

■ Approximately 85 to 115 million females have been subjected to female genital mutilation. Each year, a further 2 million girls suffer this harmful practice, representing 6 000 new cases a day, and 5 girls every minute.

■ It is estimated that 75% of the world's 18 million refugees are women and girls. Most of them are exposed to poor nutrition and illness, and many of them to violence, including rape.

■ Migrant women have increased vulnerability to sexually transmitted diseases and HIV/AIDS due to high unemployment, and lack of community and family support, which force many to engage in sexual barter.

27

GLOBAL COMMISSION ON WOMEN'S HEALTH

The Global Commission on Women's Health was established as a high-level advocacy body by virtue of resolution WHA45.25 on "Women, health and development" emanating from the Technical Discussions at the Forty-fifth World Health Assembly in 1992. The objective of the Commission is to accelerate action at the national and international level to improve women's health as their fundamental human right. In recognition of the fact that health conditions affect subsequent phases of a woman's life, as well as the well-being of future generations, the Commission insists that attention be given to a holistic and life span approach to women's health.

In carrying out its objective, the Global Commission on Women's Health assumes a critical fourfold mission. First, it has produced an agenda for action on women's health focusing on a few select areas capable of yielding the most significant progress: nutrition, reproductive health, the health consequences of violence, aging, lifestyle-related health conditions, and the work environment. These issues represent the predominant factors leading to morbidity and mortality in women of all ages around the world, and are amenable to feasible and low-cost interventions. Second, the Global Commission raises awareness of women's concerns among policy-makers through the use of sex-disaggregated data on women's health and their socioeconomic situation. Third, the Global Commission advocates the inclusion of women's health issues as a priority within development plans by using all forms of mass media. It ensures that these issues are articulated at all major national, regional and international fora on women and development and the events leading up to them, notably the United Nations Fourth World Conference on Women. Finally, the Global Commission provides a forum for consultation and dialogue with women's health advocacy groups and others who mobilize women from the grassroots to the highest political levels.

Members of the Global Commission on Women's Health, listed below, work closely with numerous key individuals and institutions across the world, notably the following: Dr Hoda Badran, President, Alliance of Arab Women, Egypt; Dr Jo Ivey Boufford, Principal Deputy Assistant Secretary for Health, United States of America; Dr Lorraine Dennerstein, Associate Director, The Key Centre for Women's Health, Australia; Ms Marianne Haslegrave, Director, Commonwealth Medical Association, United Kingdom; Mrs Julia Hausermann, Executive Chair, Rights and Humanity, United Kingdom; Ms Elaine Wolfson, President, Global Alliance for Women's Health, United States of America; the World Bank and UNICEF.

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Conference Address

Divider Title: _____

THE SECRETARY-GENERAL

H/R Jones

C/C with Clinton

19 May 1995

Dear Mrs. Clinton,

I am honoured to invite you to attend the Fourth World Conference on Women, as my special guest. As you are aware, the Conference, which will be held in Beijing from 4 to 15 September 1995, will be a major milestone in the efforts of the United Nations to promote and protect women's rights and to define practical strategies to remove the remaining obstacles to the advancement of women.

Building on the series of landmark conferences and summits convened by the United Nations in the first half of this decade - on children's rights, the environment, human rights, population and social development - the Conference offers the international community an opportunity to achieve a concrete programme of action for progress into the next century. I believe that the Conference would benefit greatly not only from your experience, knowledge and commitment, but also from the prestige and respect which you command.

The Secretariat for the Conference is in the process of preparing a programme of Special Events in which I hope you will find it possible to participate. The Secretary-General of the Conference will convey the programme to you shortly.

I look forward to hearing from you and hope very much that you will be able to attend this important gathering during the United Nations fiftieth anniversary year.

Yours sincerely,

Boutros Boutros-Ghali

Mrs. Hillary Rodham Clinton
The White House
Washington, D.C.

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Boutros Boutros-Ghali
Discussion

Divider Title: _____

BOUTROS BOUTROS-GHALI DISCUSSION

DATE:	**Tuesday, September 5**
TIME:	**4:30 pm**
LOCATION:	**TBA**
FROM:	**Brenda Costello**

I. PURPOSE

To attend a discussion and reception hosted by UN Secretary General Boutros Boutros-Ghali entitled "Women in Decision Making Roles and Sharing Power".

II. BACKGROUND

This discussion is an opportunity for Secretary General Boutros Boutros-Ghali to meet with all the female heads of countries and distinguished VIPs whom he has personally invited to the Conference. The group includes members of the Secretary General's Advisory Group as well as special guests of the Secretary General.

There is no formal program, just a free-flowing discussion on women in decision making roles with a reception to follow. Approximately 25-40 people are expected to attend. Small conference style set-up (See bios and invitation attached.)

III. PARTICIPANTS

Queen Noor AL-Hussein, Jordan
Dr. Souad M. Al-Sabah, Kuwait
Mrs. Ruth Cardoso, Brazil
Madame Bernadette Chirac, France
Ms. Takako Doi, Japan
Mrs. Janet Museveni, Uganda

Advisory Group
Princess Basma Bint Talal, Jordan
Ms. Margarita Penon de Arias, Costa Rica
Queen Fabiola, Belgium
Honorable Victoria F. Chitepo, M.P., Zimbabwe
Mr. Idriss Jazairy, Agency for Co-operation and Research in Development (ACORD)
Ms. Roberta Lajous, Mexico
Mr. Jack Lang, Mayor of Blois, France
Mr. Stephen Lewis, Canada
Ms. Deng Nan, China
Ms Barbara Simons, Member, European Parliament, Germany
Baroness Shirley Williams, United Kingdom
Professor Muhammad Yunus, Bangladesh

Past Secretaries-General UN Conferences on Women
H.E. Dr. Lucille Mathurin Main, Jamaica
Senator Leticia R. Shahani, Philippines
Hon. Ms. Helvi Sipila, Finland

IV. SEQUENCE OF EVENTS

SEE TRIP BOOK

V. PRESS

Pool spray and live feed.

VI. REMARKS

No formal remarks necessary.

PREC: PRIORITY CLASS: UNCLASSIFIED SSN: 3257 MSGID: M1827270

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INFO: RHEHNSC/NSC WASHDC
RHEHAAA/WHITEHOUSE WASHDC
RUEHBJ/AMEMBASSY BEIJING 2376

UNCLAS USUN NEW YORK 003257

NSC FOR ERIC SCHWARTZ
WHITE HOUSE FOR M.VERVEER
G/CS FOR TERESA LOAR

E.0.12356: N/A
TAGS: KWMN, UN, CI
SUBJECT: REQUEST FOR MEETING WITH MRS. CLINTON

MISSION HAS RECEIVED THE FOLLOWING REQUEST FROM THE UN SECRETARY GENERAL FOR A MEETING WITH MRS. CLINTON AND OTHER SPECIAL GUESTS DURING THE FOURTH WORLD CONFERENCE ON WOMEN IN BEIJING. ORIGINAL POUCHED TO G/CS T. LOAR.

BEGIN TEXT:

21 AUGUST 1995

DEAR MRS. CLINTON,

I WAS MOST GRATIFIED TO LEARN THAT YOU HAVE ACCEPTED MY INVITATION TO ATTEND THE FOURTH WORLD CONFERENCE ON WOMEN AS MY SPECIAL GUEST.

IN THIS CONTEXT, IT GIVES ME GREAT PLEASURE TO INVITE YOU, ALONG WITH OTHER SPECIAL GUESTS AND MEMBERS OF THE SECRETARY-GENERAL'S ADVISORY GROUP FOR THE CONFERENCE, TO MEET WITH ME FOR AN EXCHANGE OF VIEWS ON 5 SEPTEMBER FROM 4.30 PM TO 6.00 PM AT THE BEIJING CONFERENCE CENTRE. I PROPOSE TO FOCUS OUR DISCUSSION ON THE TOPIC

CENTRE. I PROPOSE TO FOCUS OUR DISCUSSION ON THE TOPIC "PROMOTING THE ROLE OF WOMEN IN DECISION-MAKING AND THE SHARING OF POWER", A THEME WHICH REFLECTS ONE OF THE CENTRAL PREOCCUPATIONS UNDERPINNING THE AGENDA OF THE CONFERENCE. FOLLOWING THE MEETING, I HOPE YOU CAN JOIN ME AT A SMALL RECEPTION.

I LOOK FORWARD TO OUR MEETING AGAIN IN BEIJING AND TO HEARING YOUR VIEWS ON THE THEME OF OUR DISCUSSION.

BOUTROS **BOUTROS-GHALI**

MRS. HILLARY RODHAM **CLINTON**
THE WHITE HOUSE
WASHINGTON, D.C.. END TEXT. ALBRIGHT
BT
#3257

NNNN

DIST:

DIST>
PRT: VERVEER
SIT: NSC SCHWARTZ

List of the "Special Guests" of the Secretary-General to the Fourth World Conference on Women 4 - 15 September 1995, Beijing

Queen Noor Al-Hussein
Jordan

Dr. Souad M. Al-Sabah
Kuwait

Mrs. Ruth Cardoso
Brazil

Madame Bernadette Chirac
France

Mrs. Hillary Rodham Clinton
United States

Ms. Takako Doi
Japan

Mrs. Janet Museveni
Uganda

Members of the Secretary-General's Advisory Group for the Fourth World Conference on Women

Her Highness
Princess Basma Bint Talal
Jordan

Ms. Margarita Penón de Arias
Honorary President
The Arias Foundation for Peace and Human Progress
Costa Rica

Her Majesty
Queen Fabiola
Belgium

The Honourable Victoria F. Chitepo, M.P.
Member of Parliament
Zimbabwe

Mr. Idriss Jazairy
Executive Director
Agency for Co-operation and Research in Development (ACORD)

Ms. Roberta Lajous
Advisor, Partido Revolucionario Institucional (PRI)
Mexico

Mr. Jack Lang
Mayor of Blois
France

Mr. Stephen Lewis
Former Canadian Ambassador to the United Nations
Canada

Ms. Deng Nan
Deputy Director, Commission of Science
China

Ms. Barbara Simons
Member, European Parliament
Germany

Baroness Shirley Williams
Member of House of Lords
United Kingdom

Professor Muhammad Yunus
Managing Director, Grameen Bank
Bangladesh

Past Secretaries-General UN Conferences on Women

H.E. Dr. Lucille Mathurin Mair
Ambassador
Jamaica

Senator Leticia R. Shahani
Member of Parliament
Philippines

The Honourable Ms. Helvi Sipila
Finland

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003. report	re: U.S. Government Report (2 pages)	03/14/1995	P1/b(1)

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Briefing Book of the First Lady - U.N. Fourth World Conference on Women, September 5-6,1995 [binder] [4]

2012-0094-F
jp3675

RESTRICTION CODES

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PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

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007. report	re: U.S. Government Report (1 page)	05/13/1993	P1/b(1)

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010. report	re: U.S. Government Report (1 page)	03/29/1989	P1/b(1)

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PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
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b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
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b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
011. report	re: U.S. Government Report (1 page)	09/19/1990	P1/b(1)

COLLECTION:
Clinton Presidential Records
First Lady's Office
First Lady's Press Office - Lisa Caputo
OA/Box Number: 6059

FOLDER TITLE:
Briefing Book of the First Lady - U.N. Fourth World Conference on Women, September 5-6,1995 [binder] [4]

2012-0094-F
jp3675

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
012. cable	re: Minister Resigns (2 pages)	08/31/1995	P1/b(1)

COLLECTION:
Clinton Presidential Records
First Lady's Office
First Lady's Press Office - Lisa Caputo
OA/Box Number: 6059

FOLDER TITLE:
Briefing Book of the First Lady - U.N. Fourth World Conference on Women, September 5-6,1995 [binder] [4]

2012-0094-F
jp3675

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
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Freedom of Information Act - [5 U.S.C. 552(b)]

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
013. report	re: U.S. Government Report (1 page)	04/11/1990	P1/b(1)

COLLECTION:
Clinton Presidential Records
First Lady's Office
First Lady's Press Office - Lisa Caputo
OA/Box Number: 6059

FOLDER TITLE:
Briefing Book of the First Lady - U.N. Fourth World Conference on Women, September 5-6,1995 [binder] [4]

2012-0094-F
jp3675

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
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PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
014. report	re: U.S. Government Report (1 page)	05/08/1987	P1/b(1)

COLLECTION:
Clinton Presidential Records
First Lady's Office
First Lady's Press Office - Lisa Caputo
OA/Box Number: 6059

FOLDER TITLE:
Briefing Book of the First Lady - U.N. Fourth World Conference on Women, September 5-6,1995 [binder] [4]

2012-0094-F
jp3675

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
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RR. Document will be reviewed upon request.

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
015. bio	re: Stephen Lewis [Personally Identifiable Information] [Partial] (1 page)	00/00/0000	b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
First Lady's Press Office - Lisa Caputo
OA/Box Number: 6059

FOLDER TITLE:
Briefing Book of the First Lady - U.N. Fourth World Conference on Women, September 5-6,1995 [binder] [4]

2012-0094-F
jp3675

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

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P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
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PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

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[015]

LEWIS, Stephen, (b)(6) s. the late David, Q.C. (former Fed. Leader of New Democratic Party) and Sophie (Carson) L.; m. Michele Landsberg 30 May 1963; children: Ilana, Avram, Jenny; Candn. Ambassador to United Nations 1984–88; apptd. Special Advisor to UN Secretary-General on African Economic Recovery 1986–91; apptd. Barker Fairley Distinguished Visitor in Candn. Culture, University Coll., Univ. of Toronto 1988–90; apptd. Special Representative of UNICEF 1990; 1st el. to Ont. Leg., 25 Sept. 1963; Leader of Ont. N.D.P. 1970–78; became Leader of the official opposition in the Leg. 18 Sept. 1975; resigned seat 10 Nov. 1978; Address: 6 Montclair Ave., Toronto, Ont. M4V 1W1.

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
016. report	re: U.S. Government Report (1 page)	09/23/1994	P1/b(1)

COLLECTION:
Clinton Presidential Records
First Lady's Office
First Lady's Press Office - Lisa Caputo
OA/Box Number: 6059

FOLDER TITLE:
Briefing Book of the First Lady - U.N. Fourth World Conference on Women, September 5-6,1995 [binder] [4]

2012-0094-F
jp3675

RESTRICTION CODES

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68; ISM, 1978–79; Old Cliftonian Soc., 1979–81; Nat. Fedn of Assoc. of British Choral Dirs, 1993–. Mem. Council, Winston ... Freeman, City of London ... [illegible] ... Bristol, 1981; St Olaf Coll., Minnesota, ... Hon. Dr of Sacred Letters, Trinity Coll., Toronto, 1985. ...oral and instrumental works. *Address:* 13 Grange Road, Cambridge (0223) 359559. *Clubs:* Athenæum, Arts.

...**Michael Alan**; Chief of Staff Allied Command Europe Rapid ...994; *b* 27 July 1944; *s* of Henry Willcocks and late Georgina ...; *m* 1966, Jean Paton Weir; one *s* two *d*. *Educ:* St John's Coll.; ...Univ. (BSc Hons). Commnd RA, 1964; served Malaya, Borneo, ...; Instructor, RMA Sandhurst, 1972–74; MoD, 1977–79; Comd ...80; Directing Staff, Staff Coll., 1981–83; CO, 1st Regt, RHA, ...Q UKLF, 1985–87; ACOS, Intelligence/Ops, HQ UKLF, 1988; ...89–90; rcds 1991; ACOS, Land Ops, Joint War HQ, Gulf War, ...and Programme, 1991–93; Dir Gen. Land Warfare, 1993–94. ...and the Armoured Experience, 1989. *Recreations:* books, music, ...*ub:* National Liberal.

...y, CB 1988; Clerk of Public Bills, House of Commons, 1982–88, ...; *s* of George Henry and Annie Elizabeth Willcox; *m* 1st, 1950, ...le Dallas Ross (*d* 1984); one *s* one *d*; 2nd, 1985, Pamela, *widow* ...ett. *Educ:* St George's Coll., Weybridge; St John's Coll., Oxford ...IVR, 1942–45. Assistant Clerk, House of Commons, 1947; Sen. ...ding Committees, 1975–76; Clerk of Overseas Office, 1976–77; ...miner of Petitions for Private Bills and Taxing Officer, 1977–82. ...lening. *Address:* Ibthorpe Farm House, Ibthorpe, near Andover, ...stbourne Tarrant (0264) 736575. *Club:* Garrick.

...**minence Cardinal Johannes Gerardus Maria**; President, ...romoting Christian Unity, 1969–89, now President Emeritus; ...ad Primate of Holland, 1975–83; *b* Netherlands, 4 Sept. 1909. ...y, Holland; Angelicum, Rome (Dr Phil.). Priest, 1934; Chaplain, ...rdam, 1937–40; Prof. of Philosophy, Warmond, 1940; Director, ...rd Assoc., 1946; organised Catholic Conf. on Ecumenical ...tican Secretariat for Promoting Christian Unity, 1960; Titular ...64; Cardinal, 1969; Cardinal with the Title of St Sebastian, ...f Letters: Notre Dame Univ.; St Louis Univ.; St Olaf Coll., ...Paul's, Minn, 1979; Assumption Coll., Worcester, Mass, 1980; ...atholic Univ. of Louvain, 1971; Leningrad Theological Acad, ...ublin, Poland, 1985; Hon. DD Oxon, 1987; Hon. DTheol ..., 1987; Hon. DH Hellenic Coll./Holy Cross Orthodox Sch. of ...1989; Hon. DTheol St Michael's Univ. Coll., Toronto, 1990. ...e et Problèmes Actuels, 1969; Mandatum Unitatis: Beiträge ...hurch and Jewish People, 1992; reports on the ecumenical ...er-church relationships. *Address:* Via dell'Erba 1, I-00193–Rome,

...e 1992; Rt. Rev. Geoffrey Graham Dow; *b* 4 July ...l Dorothy May Dow (*née* Christie); *m* 1966, Molly ...*l. Educ:* St Alban's Sch.; Queen's Coll., Oxford (BA ...uston Theol Coll.; Birmingham Univ. (Dip. Pastoral ...n Univ. (MPhil 1982). Ordained: deacon, 1967; priest, 1968; Parish Church, 1967–72; Chaplain-Student, St John's Coll., ...n Christian Doctrine, St John's Coll., Nottingham, 1975–81; ...try, 1981–92. Canon Theologian, Coventry Cathedral, 1989–. Mills? Shaftesbury Project, 1979; The Local Church's Political ...hn's College Extension Studies B1—God and the World, 1980; ...ller?, 1983; Those Tiresome Intruders, 1990; Explaining ...ian Renewal in Europe, 1992; A Christian Understanding of ...*ions:* steam and narrow gauge railways, model railways, travel, ...den Lane, NW6 7YN. *T:* 081–451 0189.

...**Robert**; Member of Senate for Western Australia, 1949–75; ...two *d*. *Educ:* Carnarvon, Western Australia. Special Minister Prime Minister, Minister assisting Minister for Foreign Affairs ...uncil, 1972–73; Minister for Foreign Affairs, 1973–75; Leader ..., 1966–67; Deputy Leader of Opposition in Senate, 1969–72; Senate, 1972. *Recreation:* swimming. *Address:* 5 Walton Place, ...ustralia.

...BE 1985; FRSE 1979; Hon. Senior Research Fellow, Hunterian ...asgow, since 1990; *b* 18 Aug. 1925; *s* of Thomas Willett and ...1950, Mary Constance Hewitt; one *s* three *d*. *Educ:* Bolton ...University Coll., Oxford. MA (Oxon); Dip. Anthropology ...k, Inland Revenue, 1940; RAF Linguist, Japanese, 1943–44. ...and Gen. Archaeology, Manchester Museum, 1950–58; Hon. ...igerian Federal Govt, 1956–57, 1957–58; Archaeologist and ...uities, Nigerian Fed. Govt, 1958–63; Supply Teacher, Bolton ...verhulme Research Fellow, 1964; Research Fellow, Nuffield ...Prof. of Art History, African and Interdisciplinary Studies, ...ston, Ill, USA, 1966–76; Dir and Titular Prof., Hunterian ...w, 1976–90. Vis. Fellow, Clare Hall, Cambridge, 1970–71. ... Corresp. Member, Manchester Literary and Philosophical ...in the History of West African Sculpture, 1967, rev. edn, Ife: ...1971; African Art: An Introduction, 1971, rev. edn 1993; ...of Ancient Nigeria, 1980; articles in Encyc. Britannica, Man, ...frica, Jl of Nigerian Historical Soc., Odu, SA Archaeol Bull., ...reports and chapters in several books. *Recreations:* relaxing, Hunterian Museum, University of Glasgow, Glasgow G12 ...*ub:* Commonwealth Trust.

...d Member, Civil Aviation Authority and Group ...*b* 2 Oct. 1944; *s* of Reginald John Willett and ...garet Pope (separated 1993); two *s* one *d*. *Educ:* ...iv. (BA Hons); Open Business Sch. (MBA). RAF. Laker Airways, 1973–82; Flight Ops Inspectorate, CAA, ...PAN. *Recreation:* horse riding. *Address:* Civil Aviation ...South Area, Gatwick Airport, West Sussex RH6 0YR. *T:*

WILLETTS, David Lindsay; MP (C) Havant, since 1992; an Assistant Government Whip, since 1994; *b* 9 March 1956; *s* of John Roland Willetts and Hilary Sheila Willetts; ... [illegible] ... Principal Monetary Policy Div., 1982–84; Prime Minister's Downing Street Policy Unit, 1984–86; Dir of Studies, Centre for Policy Studies, 1987–92. PPS to Chm. of Cons. Party, 1993–94. Consultant Dir, Cons. Res. Dept, 1987–92. Director: Retirement Security Ltd, 1988; Electra Corporate Ventures Ltd, 1988. Mem., Social Security Adv. Cttee, 1989–92. Member: Parkside HA, 1988–90; Lambeth, Lewisham and Southwark FPC, 1987–90. *Publications:* Modern Conservatism, 1992; paper, The Role of the Prime Minister's Policy Unit, 1987 (Haldane Medal, RIPA); various pamphlets. *Recreations:* swimming, reading. *Address:* c/o House of Commons, SW1A 0AA. *T:* 071–219 3000.

WILLIAMS; *see* Rees-Williams, family name of Baron Ogmore.

WILLIAMS, family name of **Barons Williams of Elvel** and **Williams of Mostyn** and **Baroness Williams of Crosby**.

WILLIAMS OF CROSBY, Baroness *cr* 1993 (Life Peer), of Stevenage in the County of Hertfordshire; **Shirley Vivien Teresa Brittain Williams**; PC 1974; Co-founder, Social Democratic Party, 1981, President, 1982–88; Professor of Elective Politics, John F. Kennedy School of Government, Harvard University, since 1988; Director, Project Liberty, since 1990; *b* 27 July 1930; *d* of late Prof. Sir George Catlin, and late Mrs Catlin, (Vera Brittain); *m* 1st, 1955, Prof. Bernard Arthur Owen Williams (marr. diss. 1974), *qv*; one *d*; 2nd, 1987, Prof. Richard Elliott Neustadt. *Educ:* eight schools in UK and USA; Somerville Coll., Oxford (scholar; MA, Hon. Fellow, 1970); Columbia Univ., New York (Smith-Mundt Scholar). General Secretary, Fabian Soc., 1960–64 (Chm., 1980–81). Contested: (Lab) Harwich, Essex, 1954 and 1955, and Southampton Test, 1959; (SDP) Crosby, 1983; (SDP/Alliance) Cambridge, 1987. MP: (Lab) Hitchin, 1964–74; (Lab) Hertford and Stevenage, 1974–79; (first-elected SDP MP) Crosby, Nov. 1981–1983; PPS, Minister of Health, 1964–66; Parly Sec., Min. of Labour, 1966–67; Minister of State: Education and Science, 1967–69; Home Office, 1969–70; Opposition spokesman on: Social Services, 1970–71, on Home Affairs, 1971–73; Prices and Consumer Protection, 1973–74; Sec. of State for Prices and Consumer Protection, 1974–76; Sec. of State for Educn and Science, 1976–79; Paymaster General, 1976–79. Chm., OECD study on youth employment, 1979; Mem., Council of Advrs to Praesidium, Ukraine, 1991–. Mem., Labour Party Nat. Exec. Cttee, 1970–81. Visiting Fellow, Nuffield College, Oxford, 1967–75; Res. Fellow, PSI, 1979–85; Visiting Faculty, Internat. Management Inst., Geneva, 1979–88; Fellow, Inst. of Politics, Harvard, 1979–80 (Mem., Sen. Adv. Council, 1986–; Acting Dir, 1989–90); Director: Turing Inst., Glasgow, 1985–90; Learning by Experience Trust, 1986–94. Lectures: Godkin, Harvard, 1980; Rede, Cambridge, 1980; Janeway, Princeton, 1981; Regents', Univ. of Calif., Berkeley, 1991. Hon. Fellow, Newnham Coll., Cambridge, 1977. Hon. DEd CNAA, 1969; Hon. Dr Pol. Econ.: Univ. of Leuven, 1976; Radcliffe Coll., Harvard, 1978; Leeds, 1980; Bath, 1980; Hon. LLD: Sheffield, 1980; Southampton, 1981; Hon. DLitt Heriot-Watt, 1980; Hon. DSc Aston, 1981. *Publications:* Politics is for People, 1981; Jobs for the 1980s; Youth Without Work, 1981; (jtly) Unemployment and Growth in the Western Economies, 1984; A Job to Live, 1985. *Recreations:* music, hill walking.

WILLIAMS OF ELVEL, Baron *cr* 1985 (Life Peer), of Llansantffraed in Elvel in the County of Powys; **Charles Cuthbert Powell Williams**, CBE 1980; Opposition spokesman on Defence, since 1990 and on Environment, since 1992, House of Lords; *b* 9 Feb. 1933; *s* of late Dr Norman Powell Williams, DD, and Mrs Muriel de Lérisson Williams (*née* Cazenove); *m* 1975, Jane Gillian (*née* Portal), DL, JP; one step *s*. *Educ:* Westminster Sch.; Christ Church, Oxford (MA); LSE. British Petroleum Co. Ltd, 1958–64; Bank of London and Montreal, 1964–66; Eurofinance SA, Paris, 1966–70; Baring Brothers and Co. Ltd, 1970–77 (Man. Dir, 1971–77); Chm., Price Commn, 1977–79; Man. Dir 1980–82, Chm. 1982–85, Henry Ansbacher & Co. Ltd; Chief Exec., Henry Ansbacher Holdings PLC, 1982–85. Parly Candidate (Lab), Colchester, 1964. House of Lords: Dep. Leader of Opposition, 1989–92; Opposition spokesman on Trade and Industry, 1986–92, on Energy, 1988–90. Founder Mem., Labour Econ. Finance and Taxation Assoc. (Vice-Chm., 1975–77, 1979–83). Director: Pergamon Holdings Ltd, 1985–91; Mirror Group Newspapers Ltd, 1985–91, Mirror Group Newspapers PLC, 1991–92; Chm., Acoustiguide UK Ltd, 1989–. President: Campaign for Protection of Rural Wales, 1989–; Fedn of Economic Develt Authorities, 1990–. *Publication:* The Last Great Frenchman: a life of General de Gaulle, 1993. *Recreations:* cricket (Oxford Univ. CC, 1953–55, Captain 1955; Essex CCC, 1953–59); music, real tennis. *Address:* 48 Thurloe Square, SW7 2SX. *T:* 071–581 1783; Pant-y-Rhiw, Llansantffraed in Elvel, Powys LD1 5RH. *Clubs:* Reform, MCC.

WILLIAMS OF MOSTYN, Baron *cr* 1992 (Life Peer), of Great Tew in the County of Oxfordshire; **Gareth Wyn Williams**; QC 1978; a Recorder of the Crown Court, since 1978; *b* 5 Feb. 1941; *s* of Albert Thomas Williams and Selina Williams; *m* 1962, Pauline Clarke (separated); one *s* two *d*. *Educ:* Rhyl Grammar Sch.; Queens' Coll., Cambridge (Open Schol. (History) 1958; Univ. Prize, Jurisprudence 1962; Foundn Schol. 1964; LLB (1st Cl.) 1964; MA 1965). Called to the Bar, Gray's Inn, 1965, Bencher, 1991; Leader, Wales and Chester Circuit, 1987–89. Member: Bar Council, 1986–92 (Chm., 1992); Council of Justice, 1993–. Opposition front bench spokesman on NI, home and legal affairs, H of L, 1992–. President: Prisoners Advice Service, 1992–; Commonwealth and Ethnic Bar Assoc., 1993–. Trustee, NSPCC, 1993–; Patron, Redress Trust, 1993–. Pro-Chancellor, Univ. of Wales, 1994–. Fellow, Univ. of Wales, Aberystwyth, 1993. *Address:* Farrars Building, Temple, EC4Y 7BD. *T:* 071–583 9241.

WILLIAMS, Prof. Alan Harold; Professor in the Department of Economics, University of York, since 1968; *b* 9 June 1927; *s* of Harold George Williams and Gladys May Williams (*née* Clark); *m* 1953, June Frances Porter; two *s* one *d*. *Educ:* King Edward's, Birmingham; Univ. of Birmingham (BCom). Lecturer, Exeter Univ., 1954–63; Sen. Lectr and Reader, Univ. of York, 1964–68. Visiting Lecturer: MIT, 1957–58; Princeton, 1963–64; Director of Economic Studies, HM Treasury Centre for Administrative Studies, 1966–68. Member: Yorkshire Water Authority, 1973–76; DHSS Chief Scientists Research Cttee, 1973–78; Royal Commission on the NHS, 1976–78; various SSRC Cttees and Panels, 1973–; Nat. Water Council, 1980–83. Hon. DPhil Lund, 1977. *Publications:* Public Finance and Budgetary Policy, 1963; (with Robert Anderson) Efficiency in the Social Services, 1975; (with Robert Sugden) Principles of Practical Cost-Benefit Analysis, 1978; articles in Economica, Jl of Political Econ., Jl of Public Econs, Nat. Tax Jl, Jl of Health Econ., BMJ and elsewhere; numerous conf. papers on various aspects of public expenditure appraisal, esp. health and health care. *Recreations:* music, walking, teasing.

WILLIAMS, Rt. Hon. Alan John, PC 1977; MP (Lab) Swansea West since 1964; *b* 14 Oct. 1930; *m* 1957, Mary Patricia Rees, Blackwood, Mon; two *s* one *d*. *Educ:* Cardiff High Sch.; Cardiff College of Technology; University College, Oxford. BSc (London); BA (Oxon). Lecturer in economics, Welsh College of Advanced Technology; Free-lance

Journalist. Joined Labour Par... Fabian Society... [illegible] ... Technology, 1969–70; Oppo... Minerals, 1970–74; Minister ... DoI, 1976–79; Opposition s... 1980–83; opposition spokesm... Shadow Leader of the House... 1987–88. Chairman, Welsh ... 1966–67; Mem. Public Ac... 1979–86. Sponsored by TSSA ... *Club:* Clyne Golf.

WILLIAMS, Alan Lee, OBE ... 1972–74 and 1992–93, Chai... 1930; *m* 1974, Jennifer Ford. ... Service, RAF, 1951–53; Co... 1956–62. Dir-Gen., E-SU, 19... MP (Lab) Hornchurch, 1966–... State for Defence, 1969–70, 1... Party Defence Cttee, 1976–7... Control, 1975–79; Adv. Cour... of UN, NY, 1969; Chm., ... Movement, 1970–71, Treasu... Chairman: Peace Through N... for Strategic and Internat. St... RUSI, 1968–; Trilateral Com... City of London, 1969; Co. of ... DLitt (*hc*) Schiller Internat. Un... or the Open Sea?, 1971; Cr... Initiative: Europe's bid for equ... 1989; Islamic Resurgence, 199... Several, Blackheath, SE3 0QR.

WILLIAMS, Dr Alan Wynne ... Tom and Mary Hannah W... Grammar School; Jesus Colleg... in Environmental Science, Tri... watching sport. *Address:* Cwm... Carmarthen (0267) 235825.

WILLIAMS, Sir Alastair Edg...

WILLIAMS, Albert; General ... Technicians, 1985–92; Preside... 1988–92; *b* 12 Feb 1927; *s* ... Barnes); *m* 1954, Edna Bradley ... School of Building (1st and 2nd ... Apprentice bricklayer, Manche... for various contractors; Membe... 1958; Exec., Council of UCAT... Council, TUC, 1986–92; Dir, ... 1979–92; Operatives' Side Sec. ... Builders Trng Assoc., 1992–; ... Contract Services, 1994–. Ch... *Recreations:* poetry and work. *A*... 8XJ.

WILLIAMS, (Albert) Trevor ... Minnie Williams; *m* 1st, 1970 ... Fraser Duncan (*née* Milne); one ... Southport; Queens' Coll., Cam... Rotary Foundation Fellow, Uni... Director, 1965–68; various aca... Vis. Professor, Graduate Schoo... Sussex Univ.; Vis. Associate Pro... strategy at Hong Kong Univ., 1... 1992–93 (Vis. Prof., 1992–94). ... Futures Research, Univ. of Ste... Commission, 1978–79; Adviso... 1979; Dir, Henley Centre for F... Team Manager, Monopolies a... Futures Studies, 1976. *Recreation*... Hereford HR2 6LQ. *T:* Holme... NW5 1EJ. *Clubs:* Athenæum, I...

WILLIAMS, Alexander, CB 19... 1931; *s* of Henry and Dorothy ... one *s*. *Educ:* Grove Park Gramm... Bangor (BSc). National Servi... Southern Instruments, Camber... Radiation Science, 1959–78; He... Under Sec., Res. and Technol... Analytical Chemists, 1989–93. ... of Accuracy (with P. J. Campion... of radio-activity etc, to Internat... and Methods, etc. *Recreations:* b...

WILLIAMS, Sir Alwyn, Kt 19... Vice-Chancellor of University ... Geology, since 1988; *b* 8 June 1... 1949, E. Joan Bevan; one *s* or... College of Wales, Aberystwyth ... 1946–48. Harkness Fund Fellow... Lecturer in Geology in Univer... Pro-Vice-Chancellor, 1967–74, ... Head of Dept, Univ. of Birmin... Trustee, British Museum (Nat. ... Equip. and Phys. Sci. sub-cttees, ... Library, 1975–77; Scottish Tert... Councils, 1985–88; Chairman: ... Cttee on Scottish Agricl Colls, ...

Withdrawal/Redaction Marker
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
018. report	re: U.S. Government Report (2 pages)	01/06/1995	P1/b(1)

COLLECTION:
Clinton Presidential Records
First Lady's Office
First Lady's Press Office - Lisa Caputo
OA/Box Number: 6059

FOLDER TITLE:
Briefing Book of the First Lady - U.N. Fourth World Conference on Women, September 5-6,1995 [binder] [4]

2012-0094-F
jp3675

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
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b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
019. report	re: U.S. Government Report (2 pages)	08/29/1995	P1/b(1)

COLLECTION:
Clinton Presidential Records
First Lady's Office
First Lady's Press Office - Lisa Caputo
OA/Box Number: 6059

FOLDER TITLE:
Briefing Book of the First Lady - U.N. Fourth World Conference on Women, September 5-6,1995 [binder] [4]

2012-0094-F
jp3675

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
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EMBASSY OF THE
PEOPLE'S REPUBLIC OF BANGLADESH
BEIJING

No Pol/8(3)/95

The Embassy of the People's Republic of Bangladesh presents its compliments to the Embassy of the United States and has the honour to inform that the Hon'ble Prime Minister of Bangladesh Her Excellency Begum Khaleda Zia would like to meet Her Excellency Madam Hillary Clinton, the First Lady of the United States of America during the Fourth World Conference on Women (FWCW).

The Embassy wishes to inform further that at the meeting between Begum Khaleda Zia and Madam Hillary Clinton in Dhaka during the First Lady's recent visit to Bangladesh, the two leaders had agreed to meet again in Beijing during their participation in the FWCW.

The Prime Minister of Bangladesh will arrive in Beijing at 2015 hrs in the evening of September 3 and leave Beijing at 1300 hrs of September 6. In Beijing, she will stay at Grand Hotel at suite Number 9136.

The Embassy of Bangladesh would be very grateful is the Embassy of the United States of America in Beijing would kindly forward the request to appropriate authorities for a meeting between the two leaders at a time convenient to the US First Lady.

The Embassy of Bangladesh avails itself of this opportunity to renew to the Embassy of the United States of America the assurances of its highest consideration.

The Embassy of the
United States of America
Beijing

31 August 1995

EMBASSY OF BANGLADESH
Beijing

23/08 '00 20:17 TX/RX NO.0033 P.001

Unclassified

Fax Leader

Telephone: (86 10) 491 5588 ext 0406/8
Fax: (86 10) 492 2900

United Kingdom Delegation
to the United Nations
Fourth World Conference
on Women

DATE...31/8/95.....

FROM...MS. SUSAN MORTON, FIRST SECRETARY, BRITISH EMBASSY

TO...MR BRADY WILLIAMSON.....

FAX NO. 5050400.....PAGES (including leader)..1...

We would like to arrange a bilateral meeting between Mrs Clinton and Baroness Chalker, Minister for Overseas Development and Minister of State for Foreign Affairs, the Head of the British Delegation.

The available slots are from 12.00 on Monday 4 September or anytime on the morning of Tuesday 5 September. Baroness Chalker is of course able to be flexible on timing.

I would be grateful if you could contact me ~~by~~ on 90509569. You can also leave a message for me on 4915588 room 406 or 408 Or by fax 492 2900

S. Morton.

Request For Appointment With FLOTUS

September 1, 1995

From: Ms. Margit Savovich
Federal Minister for Human Rights & Minorities of the Republic of Yugoslavia

Contact: Ms. Ljiljana Nikshich
Embassy of Republic of Yuguslavia
tel. 532-3516; 532-3016

Other Details: No press or photographs requested. Ms. Savovich has official instructions to meet the First Lady to pass a message. Only Ms. Savovich knows the substance of the meeting. Ms. Savovich also serves in Yugoslavia as President of UNICEF and President of the Commission for Advancement Of Women In Yugoslavia. Ms. Nikshich offers to meet with USG personnel to discuss further the possibility of a meeting.

WHITE HOUSE SITUATION ROOM

PAGE 01

PRT: SOLIS
SIT: DESHAZER MCCORMICK NSC RICE SHEEHAN

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FM AMEMBASSY BUJUMBURA

TO RHEHAAA/THE WHITE HOUSE WASHINGTON DC PRIORITY
RUEHC/SECSTATE WASHDC PRIORITY 6662
INFO RUEHBJ/AMEMBASSY BEIJING PRIORITY 0006
UNCLAS BUJUMBURA 003698

E.0.12356: N/A
TAGS: OVIP, PHUM, PREL, CH, BY, US
SUBJECT: WIFE OF BURUNDI PRESIDENT TO ATTEND
- WOMENS' RIGHTS CONFERENCE IN BEIJING

ACTION REQUEST - SEE PARA TWO.

1. THE MFA HAS INFORMED US THAT MRS. PASCASIE NTIBANTUNGANYA, THE WIFE OF BURUNDI PRESIDENT SYLVESTRE NTIBANTUNGANYA, WILL ATTEND THE WOMENS' RIGHTS CONFERENCE IN BEIJING. SHE IS SCHEDULED TO ARRIVE IN BEIJING ON SEPTEMBER ONE AND WILL REMAIN THERE UNTIL THE END OF THE CONFERENCE. SHE CAN BE CONTACTED VIA THE BURUNDI EMBASSY IN BEIJING.

2. THE MFA ALSO TOLD US THAT MRS. NTIBANTUNGANYA WOULD LIKE TO MEET WITH FIRST LADY HILLARY RODHAM CLINTON. WE TOLD THE MFA WE WOULD FORWARD ITS REQUEST, BUT CAUTIONED THAT WE COULD MAKE NO COMMITMENTS ON BEHALF OF THE FIRST LADY.

KRUEGER
BT
#3698

NNNN
<MSGID> M1832335

WHITE HOUSE SITUATION ROOM

PRT: SIT SOLIS
SIT: NSC ROTH SCHWARTZ SUETTINGER SUM SUM2

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FM AMEMBASSY ROME

TO RUEHC/SECSTATE WASHDC IMMEDIATE 0830
RHEHAAA/WHITEHOUSE WASHDC IMMEDIATE
RUCNDT/USMISSION USUN NEW YORK IMMEDIATE 2862
INFO RUEHBJ/AMEMBASSY BEIJING IMMEDIATE 2248
RUEHGV/USMISSION GENEVA PRIORITY 3559
RUEHRC/USDA FAS WASHDC 1195
UNCLAS SECTION 01 OF 02 ROME 011994

FROM FODAG

DEPARTMENT FOR STATE/IO, ATTN: DAS MELINDA KIMBLE AND RALPH BRESLER
USAID FOR AA/BHR DOUG STAFFORD AND DAA/AFR LEN ROGERS
WHITEHOUSE FOR NSC, ATTN: ERIC SCHWARTZ
GENEVA FOR RMA

E.O. 12356: N/A
TAGS: OVIP (CLINTON, HILLARY), AORC, UN, WFP
SUBJECT: WORLD FOOD PROGRAM (WFP) EXECUTIVE DIRECTOR REQUESTS MEETING WITH FIRST LADY HILLARY CLINTON DURING FOURTH U.N. CONFERENCE ON WOMEN IN CHINA, SEPTEMBER 2-9, 1995

REF: ROME 11359

1. THIS IS AN ACTION MESSAGE.

2. SUMMARY: MS. JUDITH LEWIS (AMCIT), THE DIRECTOR OF THE OFFICE OF THE EXECUTIVE DIRECTOR OF WFP, CALLED FODAG (U.S. MISSION TO U.N. AGENCIES FOR FOOD AND AGRICULTURE) ON AUGUST 29 REQUESTING STATE/IO AND USAID/BHR ASSISTANCE IN SCHEDULING A MEETING BETWEEN THE FIRST LADY AND CATHERINE BERTINI (AMCIT), THE EXECUTIVE DIRECTOR OF WFP, IN CHINA AT THE SUBJECT CONFERENCE TO DISCUSS IMPROVEMENT IN THE COORDINATION AND TARGETING OF FOOD AID FOR WOMEN AND CHILDREN. MS. BERTINI WILL BE AVAILABLE FOR A MEETING ANY TIME DURING SEPTEMBER 2-9. STATE/IO AND USAID/BHR ASSISTANCE IS REQUESTED IN FOLLOWING UP ON THE REQUEST. END SUMMARY.

2. BRIEF BACKGROUND ON MS. BERTINI: MS. BERTINI WAS APPOINTED TO THE WFP EXECUTIVE DIRECTOR POSITION IN APRIL, 1992. JUST PRIOR TO ASSUNING THAT POSITION SHE WAS AN ASSISTANT SECRETARY IN THE U.S. DEPARTNENT OF AGRICULTURE AND PREVIOUSLY SERVED AS AN ACTING ASSISTANT SECRETARY IN THE DEPARTNENT OF HEALTH AND HUMAN SERVICES. AT WFP NS. BERTINI HAS ACTIVELY PRONOTED REFORMS DESIGNED TO INPROVE FINANCIAL MANAGENENT, PROJECT ACCOUNTABILITY, ENERGENCY RESPONSE NECHANISNS AND PROJECT PERFORNANCE REPORTING; TO CUT COSTS; AND TO REDUCE WASTE. IN 1995 WE ARE BEGINNING TO SEE THE POSITIVE INPACT OF THESE EXTENSIVE REFORNS.

3. BERTINI ON WONEN'S ISSUES: MS. BERTINI HAS BEEN PARTICULARLY ACTIVE IN THE AREA OF WONEN'S ISSUES. SHORTLY AFTER HER ARRIVAL AT WFP SHE ESTABLISHED AN ACTIVE RECRUITNENT PROGRAN FOR WONEN PROFESSIONALS AT THE SENIOR LEVELS OF THE ORGANIZATION. THIS PROGRAM IS NOW YIELDING RESULTS. FOR EXANPLE, OVER THE LAST YEAR AND A HALF WOMEN WERE RECRUITED FOR THE FOLLOWING SENIOR WFP POSITIONS: NEW DIRECTORS OF AUDIT (PHILIPPINES), PERSONNEL AND ADNINISTRATION (CANADA) AND THE NIDDLE EAST GEOGRAPHIC BUREAU (EGYPT), AND THE PROJECT MANAGER FOR THE FINANCIAL MANAGEMENT IMPROVENENT PROJECT (GERNANY). FURTHERMORE, NS. BERTINI HAS ESTABLISHED AN ON-THE-JOB TRAINING PROGRAM DESIGNED TO NOVE CURRENT WFP FEMALE EMPLOYEES INTO NORE RESPONSIBLE POSITIONS AS THEY CONPLETE REQUIRED TRAINING AND GAIN OPERATIONAL EXPERIENCE IN THE FIELD.

4. BERTINI ON WOMEN'S PROJECTS: SHORTLY AFTER HER ARRIVAL IN ROME, NS. BERTINI INITIATED A PROJECT DESIGN PROCEDURE WHICH INVOLVES TAKING A CLOSER LOOK AT POTENTIAL PROJECT BENEFITS TO WOMEN AND CHILDREN AND ALSO CONPARES THE BENEFITS TO THEN OF DIFFERENT PROJECT INTERVENTIONS. NS. BERTINI IS INTERESTED IN WORKING WITH OTHER U.N. ORGANIZATIONS IN CARRYING OUT JOINT PROJECTS THAT BENEFIT WONEN AND SHE IS ALSO INTERESTED IN THE NEW U.S. NULTI-YEAR WOMEN'S DEVELOPMENT PROJECT ANNOUNCED BY MRS. CLINTON EARLIER THIS YEAR. MS. BERTINI HAS ALREADY WRITTEN TO THE WHITE HOUSE REGARDING VARIOUS SUGGESTIONS SHE HAS ON HOW TO CARRY OUT JOINT U.N.-U.S. PROJECT ACTIVITIES TO IMPROVE THE LIVES OF WOMEN IN SOME OF THE POOREST

COUNTRIES OF THE WORLD.

5. THERE ARE TWO MAJOR ISSUES MS. BERTINI WOULD LIKE TO DISCUSS WITH THE FIRST LADY:

A) U.S. LEADERSHIP IN THE FOOD AID ARENA: TO DISCUSS THE ROLE OF U.S. FOOD AID IN HUMANITARIAN AND DEVELOPMENT ASSISTANCE AND THE IMPORTANCE OF U.S. LEADERSHIP AND PROGRAMS IN HUNGER REDUCTION AROUND THE WORLD.

B) NEW TARGETING APP
ROACHES: MS. BERTINI HAS BEEN INVITED BY THE QUEEN OF SPAIN AND EUROPEAN UNION COMMISSIONER EMMA BONINO TO PARTICIPATE IN A "HUMANITARIAN LEADERS MEETING" IN SPAIN IN MID DECEMBER, 1995. AT THE MEETING, MS. BERTINI WOULD
UNCLAS SECTION 02 OF 02 ROME 011994

FROM FODAG

DEPARTMENT FOR STATE/IO, ATTN: DAS MELINDA KIMBLE AND RALPH BRESLER
USAID FOR AA/BHR DOUG STAFFORD AND DAA/AFR LEN ROGERS

WHITEHOUSE FOR NSC, ATTN: ERIC SCHWARTZ
GENEVA FOR RMA

E.O. 12356: N/A
TAGS: OVIP (CLINTON, HILLARY), AORC, UN, WFP
SUBJECT: WORLD FOOD PROGRAM (WFP) EXECUTIVE DIRECTOR REQUESTS MEETING WITH FIRST LADY HILLARY CLINTON DURING FOURTH U.N. CONFERENCE ON WOMEN IN CHINA, SEPTEMBER 2-9, 1995

LIKE TO DISCUSS A PROPOSAL TO FUNDAMENTALLY CHANGE THE WAY FOOD AID IS TARGETED. SPECIFICALLY, SHE WOULD LIKE TO SEE FOOD DELIVERED DIRECTLY TO WOMEN BECAUSE SEVERAL STUDIES AND EVALUATIONS HAVE CONFIRMED THAT, EVEN UNDER CONFLICT CONDITIONS, WOMEN DISTRIBUTE FOOD MORE EQUITABLY THAN MEN.

6. ACTION: STATE/IO AND USAID/BHR ARE ASKED TO FOLLOW-UP WITH APPROPRIATE OFFICES IN THE WHITE HOUSE TO SEE IF MS. BERTINI CAN BE ADDED TO MRS. CLINTON'S SCHEDULE IN BEIJING. PLEASE ADVISE FODAG OF RESULT. WE ARE IN DAILY CONTACT WITH MS. BERTINI'S OFFICE, WHICH IS IN DAILY CONTACT WITH THE EXECUTIVE

WHITE HOUSE SITUATION ROOM

DIRECTOR. FORBORD
BT
#1994

NNNN
<MSGID> M1831685