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Praise be to almighty for his grace and blessings in enabling us to gather here today to discuss issues of humanity for the improvement of health and well- being of mankind, especially women, children and families. I am deeply honoured to be given this opportunity to address this August gathering of medical and health academicians on the occasion of the 14th Tun Dr Ismail Oration. I thank the academy of medicine for this honour and for choosing the theme of women's health.

2. The dawn of this new millennium has brought the theme of women's health and more recently gender, health and development to the centre stage of international and regional fora on developmental policies for economic and social development, primarily encompassing education, health care and empowerment of women. Gender inequity and inequality holds back the growth of individuals of both men and women, the development of countries, restricts choices for and by women and limits opportunities for their participation in society with direct and serious consequences on their health. Yet until recent years, these restrictions have been considered either unimportant or have been ignored. "The reality of women's lives has been invisible to man. This invisibility persists at all levels from the family to the nation. Though they share the same space, women and men live in different worlds" (The state of the world population 2000).

3. The first steps have been taken to end this invisibility. Access to Health care and education of girls and women have been the subject of recent international agreements, notably those reached at the 4th world conference for women in 1995; the world conference on education for all in 1990 and the international conference on population and development (ICPD) in 1994. In addition, the 1979 convention on the elimination of all forms of discrimination against women, which has the force of international law, has now been ratified by 165 out of 188 member states of the United Nations.

4. As a result, a growing number of countries have adopted population and development policies and social and public health policies that include measures to meet the health care and education needs of girls and women, including their reproductive health needs which is a vital contribution towards balanced growth and development. Most countries have placed measures to protect women's personal security and their rights in marriage, property, inheritance, political representation, and in the workplace; while efforts are increasingly being expanded to facilitate women into the mainstream of development.

5. Have we made the desired progress on women's lives and health? I propose to discuss this topic through a bird's eye review of the current status of women's health in specific areas of concern from the global as well as the national scenario.

6. Allow me first to touch upon the root cause of many ills and ill health of women especially in developing countries, that is, poverty. Despite many developmental gains in the last century, poverty continues to grow and the gap between the rich and poor and between developed and developing countries is widening. A disproportionate share of the burden of poverty rests on women and undermines their health. 70% of the 1.2 billion people living in poverty are female and there are twice as many women as men among the world's 900 million illiterate people (who, June 2000).

Poverty particularly for women means more than income deficiency, as they are also disadvantaged by other forms of impoverishment in areas such as literacy and education, skills and training, and employment and livelihood opportunities. These diminish their human development capacity and affect their health status directly and indirectly. For example, protein energy malnutrition is significantly higher in women in South Asia where almost half of the world's undernourished and poor reside, while iron deficiency anaemia affects double the number of women than men.

7. There is a scarcity of data and information available on the health status of the lowest 20% of the world's poorest people, the majority of whom are women. However a few facts emerge from the analysis of health and poverty. Sickness is a catastrophe which leads to economic ruin of families; poor women

lack access to modern health care and choose traditional medicine systems for reasons of cost, convenience and comfort. Inhibitory social roles and cultural norms further restrict their ability or willingness to seek health care. The socio-economic changes in many parts of the world have perpetuated poverty patterns where women are increasingly forced to become breadwinners. Poverty is also a significant factor behind stress and depression in women.

8. We are indeed fortunate that in Malaysia the linkages between poverty, development and ill health were recognised early after independence and poverty eradication efforts were formulated as the major thrust of all our national socio-economic development plans as embodied in the outline perspective plans. This remains a priority even in the current 8th Malaysia plan as the Government steps up its strategies to enable all people to enjoy the benefits of development as envisaged in vision 2020.

9. Recalling my early working life in Kedah, I remember clearly how difficult life was then for the rural people with less than 20% having electricity and piped water in their homes. Communication was limited to laterite roads or narrow bunds in between padi fields while schools and clinics were a luxury accessible to the more fortunate. Children especially girls were not encouraged to go to schools, nor women to health clinics. Women had little or no voice in matters pertaining to their own lives and they had to conform to traditions and practices passed on by their family and village elders which were at times detrimental to their own health.

10. With the start of government policies for rural and village development in the 1960's, as members of the district development team, we planned for basic infrastructure and essential facilities. Throughout the 60's and 70's, there was rapid progress not only in terms of physical facilities but also sought to correct the imbalance in human capacity development of the rural people. This led to massive programmes such as adult literacy classes, skills training, land resettlement schemes, modernisation of agriculture and fisheries and other initiatives to uplift their living standards.

11. More children started to go to schools but their poor health undermined by malnutrition, worm infestation, diarrhoeal diseases and chronic skin infection led to high rates of school dropouts and poor performances. Caring for the ill, pregnant women and children were largely in the hands of dukuns, bomohs and the bidan kampung. Hence, we literally had to deploy all our health team members to go from house to house on foot or on bicycle to talk to people on the need for them to seek modern health care in our clinics. In the early 70's, 54% of the population lived in poverty; 58% were illiterate and less than 30% of women had modern antenatal care.

12. Today, districts and villages have been totally transformed as a result of government's continued policies for equitable development and reduction of the equity gap. Good roads, transport and communication systems are now in place, so are modern schools and state of the art health clinics and hospitals. The advent of new electronic technology with smart schools and paperless hospitals will further enhance ability to access and avail up to date information on education and health care. 99% of our children are in schools and the majority of women obtain health care for themselves and their children. Poverty levels have decreased to 7.5% and we have emphasised on rehabilitation of the poorest of the poor since the mid 80's. Literacy levels have risen to 93.8% of the adult population and life expectancy has increased by more than 20 years since independence to 74 years for women and 71 years for men. We should be both proud and grateful for the remarkable progress achieved in a short span of time. At the Asia pacific ministerial meeting for children held recently in may, Malaysia is the only country among the Asia Pacific developing countries to have achieved all but one of the goals and therefore leads the way as an example of a country which has wisely invested in development of its children.

13. We can say the same for woman's health specifically maternal health. While many country programmes gave more priority to child survival, leading to an international cry in the 80's as to where has the "M" in "MCH" gone; Malaysia again has proven that its strategies have been balanced in giving equal emphasis to maternal health as well as to child health.

14. The international health community is concerned that while fertility and infant mortality has seen declines, yet maternal mortality remains high in many developing countries including that in our region.

The maternal mortality ratio in Indonesia is 450, Bangladesh 444 and India 410 per 100,000 live births while in the West, maternal deaths are a rare occurrence. It is common for a woman in Africa to bid farewell to her older children when about to give birth while mothers in Tanzania have a saying " I am going to the sea to fetch a new baby, but the journey is long and dangerous, and I may not return".

15. It is indeed a tragedy to face this grim reality in an era when modern technology and knowledge is available to prevent more than 80% of these deaths.

Simple and cost effective interventions such as improving access to quality antenatal care, delivery by a skilled health professional, adequate and timely referral for obstetric care and family planning can save lives of these women.

16. In the more developed countries, there have been vast improvements in women's reproductive health with near universal access to high quality care in pregnancy and childbirth, to life savings drugs and to safe surgical procedures, coupled with high levels of contraceptive use and low fertility.

17. Unfortunately, the situation is extremely different in the developing world where 99% of more than half million women die each year of causes and complications related to pregnancy and childbirth, the majority being women of sub-Saharan Africa and South Asia. This disparity is more glaring when we consider that the "life time risk" of a woman from a developing country dying in pregnancy or childbirth over the course of her lifetime is 33 times higher than for a woman in a developed country.

18. Though some progress has been made in developing countries with increase in contraceptive use by 10 fold and women having half as many children than they did 35 years ago, there remain huge gaps and unmet needs in many lesser developed countries in terms of access to quality health care. Globally, only 70% of deliveries have been preceded by even a single antenatal visit, while only 53% of all births are attended by trained personnel. Unavailability or poor utilisation of health facilities is compounded by cultural, religious and social taboos and practices as well as family and personal beliefs resulting in barriers to health care for those women in need.

19. Malaysia is a shining example of a country which has committed itself to reducing maternal mortality and has opened options for many other developing countries.

International health organisations such as WHO, UNICEF, UNFPA and the World Bank, international NGO's and governments have recognised our efforts. Our professionals have been invited to present Malaysia's story at many international meetings. I was honoured to be invited to present Malaysia's experience at the 10 years anniversary of the safe motherhood initiative in Washington in 1998 organised by the World Bank and UN agencies where Malaysia was selected as the developing country example. I was asked then as to what are the ingredients of Malaysia's success. I assured them that there are no magic bullets, nor a prescribed recipe to reduce maternal deaths and improve women's health.

20. Our experience, I believe, is one of sheer hard work, and dedication of all those who have contributed to the development of health and related sectors. We are fortunate to have been backed by sound socio-economic development plans within a consistent framework of health policies and strategies that have allowed for flexibility and adaptation, and we have been able to implement them in an environment of political, social and economic stability. We are indeed blessed with this setting which has enabled us to move on progressively and incrementally without any major disruption or calamity.

21. Priority accorded by our government in safeguarding health and social services in times of adversity has been evident during both the financial crisis of the 1980's and 90's. The health sector was not subjected to budget cuts, but instead received an increased allocation to cater for the greater utilisation of government health facilities by those who could no longer afford the private health services.

Neighbouring countries which did not have these protective mechanisms or safety net faced serious consequences of shortage of medicine and supplies and breakdowns in their health care systems.

22. We now see the fruits of our labour after 4 « decades of work in continuously upgrading our health care system especially rural health services and maternal and child health care which is pivotal for the reduction of maternal and child mortality. From a mainly urban based health care system at independence, since 1961 we have progressively put in place a comprehensive health infrastructure network with priority to the development of the rural health care system. Successive socio-economic development plans saw the reorganisation and restructuring of the rural health services to improve service availability and accessibility of the rural population to a more comprehensive range of health services including maternal and child health and bring them closer to homes. Upgrading of district hospitals, health centres and midwife clinics and strengthening training of health manpower were key initiatives in the 1970's and 1980's as was the development of MCH service content to integrate major components of services including family planning, nutrition and health education.

23. For example, midwives were retrained from 1975 to perform the multifunctional role as jururawat desa while approaches were utilised to reach out to underserved and marginalised groups to motivate women especially those pregnant and at high risk to seek health care in clinics and hospitals. We also made our own decisions based on our local conditions. For example in Kedah, when faced with insufficient trained midwives and with TBS's actively conducting deliveries and being highly preferred by women, we had to make a decision whether to continue to allow TBSs to conduct more than 70 per cent of the deliveries which resulted in many women dying from complications or to train them to handle deliveries safely and hygienically. We made a decision to train TBAs in the 60's and this led to a national TBA registration system being introduced from 1971. This was followed by a nationwide system in 1985 to retrain TBAs to detect danger signs of pregnancy and delivery and to refer pregnant women to health facilities to reduce unsafe home deliveries and deaths from preventable causes. Today 99% of our deliveries are attended by trained professionals from public and private sectors as compared to less than 30% during the 60's with 17% at home by trained midwives and 83% in private and public institutions (HMIS Ministry of Health 1999).

24. I have spoken of our TBA experience as an illustration of how we have worked through a strategy to achieve a win-win situation for the benefit of all concerned - professionals, TBAs, women and families. I realise that this is still a debatable issue today and many developing countries are faced with similar options- whether to train TBAs or not! 25. Malaysia has demonstrated that a multi strategy approach is the key to reduction of maternal mortality.

We have carried out intensive health education to overcome traditional and socio-cultural barriers and to improve access and utilisation of health care. We have upgraded midwifery skills and competence of professionals; strengthened district hospitals; devised functioning referral systems; improved linkages between health and hospital systems and mobilised community resources.

26. We have devised and implemented a colour coding prenatal risk assessment system since 1986 to accord each pregnant woman the appropriate level and category of health personnel she needs for a safe pregnancy and delivery. These main interventions of safe motherhood have been strengthened by monitoring and quality auditing mechanisms implemented from 1986 through the Quality Assurance Programme And From 1991 Through The Confidential Enquiry Of Maternal Deaths (CEMD).

27. As a result of Malaysia's consistent and sustainable strategies and programmes, the maternal mortality ratio has declined from 570 in 1957 to 20 per 100,000 live births in 1998 through the vital registration system and 38 through the confidential enquiry system. Infant mortality rate has fallen from 75 to 9 per 1,000 live births during the same period.

28. We must sustain the gains we have made to reduce maternal and infant mortality and improve safe motherhood, as this remains the major obstacle to women's health and remains the major contributory cause of death of women in the reproductive age group. This is more so in the face of the unprecedented spread of the HIV/AIDS pandemic which has seen a reversal in the declining trends of maternal and child mortality in Africa and is fast spreading to Asia especially south and south east Asia. Malaysia being surrounded by countries with high HIV/AIDS prevalence puts us in an extremely vulnerable position and we cannot be complacent. HIV/AIDS is a critical public health issue and is now the leading cause of death

in Africa. In hard hit countries, up to 25% adults are infected while the new wave of infection is fast spreading to women and more than half of new infections are in youth and young adults.

29. HIV/AIDS will impact on all developmental gains we have thus achieved if we do not take early, appropriate and effective action. From the start of the epidemic to the end of the year 2000, UNAIDS indicated that 21.8 million people have died of aids (equivalent to Malaysia's population being wiped off), out of which 9 million were women and 4.3 million were children below 5 years. In the year 2000 alone, there were half a million were children. There are now an estimated 36.1 million people living with HIV/AIDS, 16.4 million of whom are women and 1.4 million are children (UNAIDS UNGASS report June 2001).

30. Women are at particular risk of infection due to their own vulnerability; to poverty, abuse and violence, coercion by partners, husbands or older men.

They are also unable to have control over their bodies and to negotiate for safe sex and condom use. They lack information and education, access to health care and to counseling facilities. Women and girls are affected more than men and girls are forced to leave school when one or both parents die. They remain as aids orphans or take on the care of younger siblings. As poverty deepens, they maybe forced to earn a livelihood through means that will expose them to greater risk of infections. Women as mothers and grandmothers have to bear the responsibility of raising their children alone and supporting the family with a resultant heavy toll on their own health.

31. An estimated 45,152 cases of HIV/AIDS are reported in Malaysia out of which 2491 are women and 373 are children below the age of 12 years. The infection rate for women is 4.6 % which indicates a potential reservoir for infection of women and newborns through maternal to child transmission.

32. Malaysia has taken steps to address HIV/AIDS through a national plan of action for prevention, control, education, surveillance and care. However I believe we can and must do much more to prevent especially the young - both boys and girls, and women from being infected. We need to integrate a more comprehensive range of services to prevent, manage and control HIV/AIDS within the existing women's health programmes since HIV/AIDS is intrinsically linked to reproductive health and sexual behaviour of men and women.

33. We must make sure that girls and women have the necessary education, information, skills, and services to protect themselves and we must educate boys and men towards a culture of taking responsibility and to avoid risk-taking behaviour. We need to mobilise all resources for frank and targeted public education and approaches that can influence behaviour changes. Adolescents and young adults must receive timely and correct information on sexuality and sex education so they can prevent and protect themselves not only from HIV/AIDS but also other forms of STD's, reproductive tract infections and teenage pregnancies.

34. It is time we work together to provide a holistic, non discriminatory and non-stigmatising set of services for prevention, treatment, counseling and care of people living with the virus, their families and those affected. Public debate is ongoing to avail treatment at lower cost for those in need including anti retroviral drugs for women during and after pregnancy. Governments have to commit to resources for the prevention and management of HIV/AIDS and to provide an enabling facilitatory legal, social and public support environment, upon which all sectors and community groups can put in place more sustainable initiatives.

The recently concluded special session of the UN general assembly on HIV/AIDS on 27 June 2001 called for "strong leadership by governments, concerted efforts of the UN and full and active participation of the entire multilateral system, civil society, the business community and the private sector to address the global crisis" (UNGASS HIV/AIDS report June 2001).

35. As Malaysia progresses to a developed nation by the year 2020, women's health problems and priorities will naturally change. Hence, the traditional MCH programme that was put in place mainly to

provide for care in the reproductive processes and to ensure survival of women and children must be able to cope and cater for other emerging issues of women's health today. The second national health and morbidity survey in 1996 showed that women exercise much less frequently than men and have higher prevalence of overweight and obesity. In addition they also suffer from the effects of the life styles of men such as smoking and unhealthy sexual behaviour. I am pleased to note that our current women's health programme focuses on wellness and well- being and that a life cycle approach is adopted to provide for a broad range of health care for women. It is time that we consider the "total" woman in relation to the societal, environmental and personal factors that affect her whole person and body to keep her healthy physically, mentally and socially as a wife, mother and an individual.

36. Encouraging women to take control of their health for the prevention of life style diseases are positive steps. I am also pleased that Malaysia's newly formulated mental health programme is geared to promote good mental health and to reduce stress related disorders including domestic violence. By the year 2020, 6% of our population will be above the age of 60 years. With the increased life expectancy of women as a result of upliftment of their societal and economic status, we need to improve their quality of life for them to be healthy, happy and productive as they have a good one third or 25 years after completing their reproductive functions. Hence, care of elderly women will assume importance in women's health programme in the coming years with the demographic phenomena of both feminisation of aging and poverty.

37. I will now touch on another perspective of gender and health, that of women for health. Women play a significant role in health care not only for themselves but also for others, both in the formal and informal health care sector. In the formal sector, the figures of the Ministry of Health bears testimony to the last that out of more than 100,000 people working in the Ministry of Health, more than 30,000 or one third are nurses who are almost all women. It is encouraging to note that the number and proportion of women in the professional groups have increased over the years, and these include doctors, dentists, medical scientists and pharmacists. However the number of women in high decision making positions is still low though recent trends are encouraging. In the informal sector, a woman's role in health care covers a wide scope. It starts from the home, where women not only nuture their children and care for all members, but they also are involved in their education and imparting living skills. Hygiene and safety of the household is almost the exclusive responsibility of women in many cultures, as also the growing of crops and procurement of food.

She is the first to administer simple cures for family ailments and cares for the old and disabled in her family.

38. An area of increasing complexity and concern in women's health is that of reproductive and sexual health and behaviour of adolescents and youth. Bearing in mind the hard facts and consequences they present in terms of health, social and behavioural problems, we must be ready to provide education on their sexuality and on responsible behaviour. With the earlier onset of sexual maturity and later marriage in our countries, the longer period of puberty makes them more vulnerable to premarital sexual activity and with it the exposure to infections including HIV/AIDS and pregnancy. We can no longer shy away from the fact that children need family life or sex education and contrary to the belief that this leads to increased sexual activity or experimentation, recent studies have indicated the reverse and that teenage pregnancies can be significantly reduced. In Malaysia, along with other countries, since ICPD 1994, we have implemented innovative approaches to address this issue through peer education and training using participatory modules, interactive youth web sites, youth workshops and parental education. However, we need to upscale our initiatives to cover more youths in and out of schools and in workplace. I am pleased to note that Malaysia's PROSTAR programme of the Ministry of Health and reproductive health of adolescents programme of FFPAM is being shared and used by ASEAN countries and beyond.

39. Another growing concern of public health and human rights is that of violence against women. Women can experience physical and mental abuse at any time in their life cycle whether during childhood or adulthood.

It is estimated in the Asia pacific region that 10-50% of women reported that they have been physically

abused by an intimate partner in their lifetime (ESCAP report 2000). Women and girls are the most frequent victims of violence and forced prostitution while sex trafficking and sex tourism is a growing problem. Domestic violence is on the increase and since this has serious consequences for her physical and mental health, we have to adopt a broad based public health approach to deal with this problem. Malaysia has taken positive steps in this direction with the domestic violence act of 1996, a code of conduct for the prevention of sexual harassment in the workplace and public awareness programmes. The recent move initiated by the ministry to amend section 8.2 of the federal constitution is a bold step to end the invisible or unseen aspects of discrimination against women. This will surely open the doors in sensitising policy makers to ensure the mainstreaming of gender appropriate and women friendly policies, strategies and programs; and empowering women and men towards the achievement of women's health as a basic human right.

40. We should count our blessings. In Malaysia we are in an advantaged position where efforts of our leaders and government have yielded many positives much to the envy of many developing countries. Today there are more girls enrolled in tertiary education, women are empowered to make their own decisions and are fast gaining economic independence. They enjoy a good health status and participate in all spheres of life. These essential beginnings are already in existence and we need now to mobilise all our resources in a true spirit of partnership to safeguard and improve health of all our women. We are fortunate not to face serious constraints as the sanctions in Iraq, extremist groups such as the Talibans of Afghanistan, or civil strife as in Kosovo and Somalia. In these situations, women have been drained due to poverty and hardship, their rights and freedom denied, they are forced to succumb to rape, violence, even honour killings and other inhumane practices.

41. Let us move forward to answer the call of all our international commitments including the fourth world conference on women in 1995 which endorsed that "women have the right to the enjoyment of the highest attainable standard of physical and mental health" and that health is a basic human right for everyone regardless of race, social class, political standing and gender.

42. I end by a quote from Kofi Anan, the secretary general of the United Nations. In his recent keynote address on healthy women: healthy world, at the awards banquet of the global health council, he said "if we are going to build a more prosperous and equitable global society, we will have to make a major investment in public health in the developing world. The most effective way to channel that investment is to give priority to the health of women, and, above all, to make sure that they have the freedom, the power and the knowledge to take decisions suffer ill-health, the whole society pays a higher price". Let us pray that these words of wisdom will guide us to a start of a new beginning.

I thank you.